

Kentucky

UNIFORM APPLICATION

FY 2026/2027 Combined MHBGSUPTRS BG
Application Behavioral Health Assessment and Plan
SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/28/2025 9.42.17 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2026

End Year 2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID LECJQDCLHVE5

I. State Agency to be the SUPTRS BG 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 SUPTRS BG Grantee of the Block Grant

First Name Sarah
Last Name Johnson
Agency Name Cabinet for Health and Family Services
Mailing Address 275 East Main Street 4W-G
City Frankfort
Zip Code 40621
Telephone (502) 234-8984
Fax (502) 564-4826
Email Address Sarah.Johnson@ky.gov

State CMHS Unique Entity Identification

Unique Entity ID LECJQDCLHVE5

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

Agency Name Cabinet for Health and Family Services
Organizational Unit Department for Behavioral Health, Developmental and Intellectual Disabilities
Mailing Address 275 East Main Street 4W-G
City Frankfort
Zip Code 40621

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

First Name Katie
Last Name Marks
Agency Name Department for Behavioral Health, Development, and Intellectual Disabilities
Mailing Address 275 East Main Street 4W-F
City Frankfort
Zip Code 40621
Telephone 502-782-6106
Fax 502-564-5478
Email Address katie.marks@ky.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ☒ Yes ☐ No

First Name

Last Name
Agency Name
Mailing Address
City
Zip Code
Telephone
Fax
Email Address

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

From

To

V. Date Submitted

Submission Date 8/28/2025 9:40:04 AM

Revision Date 8/28/2025 9:40:25 AM

VI. Contact Person Responsible for Application Submission

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Dr. Steven Stack

Signature of CEO or Designee¹: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:



COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

Andy Beshear
GOVERNOR

Capitol Building, Suite 100
700 Capital Avenue
Frankfort, Kentucky 40601
(502) 564-2611
Fax: (502) 564-2517

January 30, 2020

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

To Whom It May Concern:

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

This letter serves as the certification of the Department for Behavioral Health, Developmental & Intellectual Disabilities, Commonwealth of Kentucky, Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) will comply with all state and federal law, federal regulations, federal executive orders, policies, and guidelines governing this program that are lawful and not enjoined by court order.

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

Sincerely,

A handwritten signature in black ink, appearing to be "AB", written over the printed name "Andy Beshear".

Andy Beshear
Governor

AN EQUAL OPPORTUNITY EMPLOYER M/F/O

State Information

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

Fiscal Year 2026

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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.
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5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91- 616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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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.).
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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Steven J. Stack, MD, MBA _____

Signature of CEO or Designee¹: Steven Stack

Title: _____ Cabinet Secretary_____

Date Signed: 7/22/2025

mm/dd/yyyy

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.
OMB No. 0930-0168 | Approved: 05/28/2025 | Expires: 01/31/2028

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart II of the Public Health Service Act		
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Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57

Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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- 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;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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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: Dr. Steven Stack

Signature of CEO or Designee¹: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:



**COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR**

Andy Beshear
GOVERNOR

**Capitol Building, Suite 100
700 Capital Avenue
Frankfort, Kentucky 40601
(502) 564-2611
Fax! (502) 564-2517**

January 30, 2020

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

To Whom It May Concern:

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

This letter serves as the certification of the Department for Behavioral health, Developmental & Disabilities, Commonwealth of Kentucky, Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) will comply with all state and federal law, federal regulations, federal executive orders, policies, and guidelines governing this program that are lawful and not enjoined by court order.

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

Sincerely,


Andy Beshear
Governor

State Information

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

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
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 Grant to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 U.S.C. 300x-9
Section 1920	Crisis Services	42 U.S.C. 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial, and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91- 616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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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: Steven J. Stack, MD, MBA_____

Signature of CEO or Designee¹: Steven Stack_____

Title: Cabinet Secretary_____

Date Signed: 7/22/2025_____
mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Kentucky BSCA Funding Plan 2026

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

Since December 2021, Kentucky has experienced 14 natural disasters that resulted in a federally declared disaster, including two natural disasters (a tornado in Western Kentucky – DR-4630-KY- and a flood in Eastern Kentucky – DR-4663-KY), various community-level crisis situations (officer-involved accidents, fires, officer-involved shootings, etc.), in addition to continued impacts from COVID-19 have increased the need for improved mental health preparedness and response plans, especially for those with Serious Mental Illness and Severe Emotional Disturbance (SMI/SED) and Substance Use Disorders (SUD). Prior to July 2022, disaster and crisis responses were provided by the Kentucky Community Crisis Response Board/Team in connection with Kentucky Emergency Management (KYEM) and supported by the Kentucky Department for Public Health (DPH). As a result of KYEM's stated lack of capacity to respond to the behavioral health needs of Kentucky residents effectively and efficiently during disasters and community crisis situations, the program was attached by Memorandum of Understanding to the Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) effective Aug. 1, 2022. This transfer occurred during one of the largest and most devastating floods and subsequent disaster response in Kentucky history. The Kentucky Community Crisis Response Team was officially moved by legislation to the Department for Behavioral Health, Developmental & Intellectual Disabilities in July 2023, providing accountability, sustainability, and ongoing emergency preparedness funding from DPH to DBHDID.

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

Before the July flooding in Eastern Kentucky and DBHDID's reorganization to include disaster preparedness for behavioral health, the Department provided grant writing and project oversight and implementation of the state's Individual/Regular Services Program (ISP/RSP) and Disaster Case Management Program (DCMP) for Western Kentucky (DR-4630-KY). Additionally, DBHDID applied for and received the ISP/RSP and DCMP grants for the Eastern Kentucky floods (DR-4663-KY) after the Department absorbed community crisis and disaster response responsibilities.

DBHDID maintained management of these grants throughout their lifecycle, serving nearly 70,000 people. Additionally, Kentucky has submitted applications for the ISP and RSP for three subsequent disasters that occurred within the first four months of 2025. Funding for these programs is currently on pause at the federal level, and they have yet to be awarded.

Kentucky's two major disasters in 2021 and 2022, coupled with the reorganization of the Division of Behavioral Health into two divisions (Mental Health and Substance Use Disorder) and the creation of a branch with a specific focus on preparedness efforts, highlighted the need to not only update the state's behavioral health emergency preparedness and response plan but also to rebuild the KCCRT and support community mental health agencies in increasing their ability to maintain continuity of operations in the event of a natural disaster or other community crisis.

To facilitate this process, \$50,000 approved BSCA allotment 1 funds were utilized to engage a facilitator who supported a statewide behavioral health landscape analysis and solicited feedback for updating the state's behavioral health emergency preparedness and response plan, which was last renewed in 2016. This process is nearly finalized. When complete, the plan will emphasize continued services for those with SMI/SED/SUD during a crisis or disaster. An initial convening brought together community and state-level behavioral health providers and behavioral health advocacy organizations, including persons with lived experience, to solicit initial information. Additionally, the facilitator supported the convening of state emergency management agencies and other first responders, including law enforcement, to secure their buy-in and feedback on the development of an updated plan. Agencies and entities included in this level of the landscape analysis process are representatives from Kentucky Emergency Management, Federal Emergency Management Agency (FEMA), Voluntary Organizations Active in Disasters, KCCRT members, American Red Cross, and other disaster response entities. A third meeting will be held to convene state- and community-level agencies (Dept. for Public Health (DPH), local health departments, Department of Education (KDE), Family Resource and Youth Services Centers (FRYSC), Cabinet for Justice and Public Safety agency representatives, including those from the Department of Juvenile Justice and the Department of Corrections (DOC), the Administrative Office of the Courts, Department for Community Based Services (DCBS), Department for Aging and Independent Living (DAIL), and the Department for Medicaid Services (DMS)). Also included will be state-level agencies that support the delivery of behavioral health services, including substance use disorders, for youth and adults and include representation of those with lived experience (State Interagency Council for Services and Supports to Children and Transition Age Youth (SIAC), Behavioral Health Planning & Advisory Council Members, Kentucky Interagency for Suicide Prevention). Individual key stakeholder interviews will be conducted representing the various sectors involved. The information gathered during the summits will then be used to craft an update to the behavioral health emergency preparedness and response plan, which will guide future efforts in the event of natural disasters and community crisis responses. By convening all noted stakeholders, DBHDID can leverage the variety of resources available to address the behavioral health needs of individuals with SMI and SED in the Commonwealth in future disaster responses.

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

As this process is in place with \$50,000 from Allotment 1 that were sufficient for completion and dissemination of the plan, **no additional funds were or are being requested from Allotment 2, Allotment 3 or Allotment 4 for area 1.**

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

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

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

Three staff members are tasked with supporting emergency planning. Additionally, the Department has recruited internal staff members who are part of a response team to coordinate KCCRT responses and provide support during a crisis or disaster. All staff with relevant jobs have community crisis and disaster response support as a task included in their job descriptions. No funds were utilized for these components in Allotment 1, as emergency preparedness funds and other Block Grant funds were leveraged to ensure that those with SMI and SED are served because of these services. Approved funds of \$110,000 from Allotment 2 were used to hire a Program Coordinator to support these efforts as responses and disasters quickly exceed the current capacity of the newly developed system. This individual serves in a programmatic function, supporting the coordination of disaster and KCCRT responses. This position was filled in state fiscal year 24.

Funds in the amount of \$110,000 from Allotment 3 were approved to continue this position. Funds in the amount of \$100,000 from Allotment 4 are requested to continue this position as we work to identify additional funding opportunities for sustainability.

As capacity is being enhanced through staffing, the Division of Mental Health is actively seeking learning opportunities and relationship-building events to connect with emergency managers at the community level. The Division of Mental Health Director attended the International Association of Emergency Management conference in Savannah, GA, on Nov. 14-17, 2023 and interacted with approximately 10 of the state’s emergency managers (EMs). As an invited presenter, the Director also presented on

Kentucky's Behavioral Health response during the Nov. 2024 conference in Long Beach, CA. Those conferences provided a forum to discuss opportunities for utilization of the KCCRT, as well as plans to begin one-on-one and regional meetings with EMs. The Director also discussed the importance of Community Mental Health Centers being visible within any crisis or disaster response. The Director highlighted the importance of the CMHCs being involved in any community training exercise. Staff members hold 1:1 meetings with EMs to build relationships and make connections between EMs and the local CMHC, which provides services to their community. Current DBHDID staff have submitted proposals for and have been accepted to present at the 2025 conference to be held in Louisville, Kentucky in November.

Staff continue to seek out trainings that support their professional development so that they may support our community partners and volunteer members of KCCRT in addressing the behavioral health needs of those in Kentucky with SMI, SED and SUD during and after community disasters and traumatic events.

We are requesting \$10,000 from Allotment 4 to disseminate a Kentucky developed crisis de-escalation model created in partnership with a University of Kentucky researcher focused on trauma and first responders. This training was created and initial dissemination occurred using Allotment 3 funds. The training utilizes the Psychological First Aid model with a specific focus on supporting individuals with SMI, SED, and SUD during and after a community disaster event.

Staff continue to provide technical assistance to the CMHCs as they continuously update their Emergency Operations Plan (EOP) and their Continuity of Operations Plans (COOP). The recommendations for the COOP plans include identifying a "buddy" CMHC who will provide support if a CMHC goes offline during a crisis or disaster. During the July 2022 Eastern Kentucky flood, one of Kentucky's 14 CMHCs had 50 staff members lose their homes in the disaster. During the initial days of the flood, two other CMHCs in the state provided backup services to ensure that their clients received continuity of care when they came back online. Additionally, their 988 calls were transferred to a backup center in the state for August 2022 to provide assurances that residents of the region had access to immediate 988 responses. These strategies will be operationalized in the CMHC EOP and COOP plans to ensure that individuals with SMI/SED continue to receive services during an emergency.

Costs for these efforts are and were being covered through State General Funds, the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and American Rescue Plan Act allocations. No Allotment 1, 2, 3 or 4 funds were utilized for this component.

In area 2, Kentucky is requesting \$110,000 to continue a Program Coordinator position and training development with Allotment 4.

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

DBHDID manages the Kentucky Community Crisis Response Team (KCCRT), which delivers behavioral health support following critical incidents affecting first responders and communities statewide. KCCRT responds to events such as line-of-duty deaths, responder suicides, mass casualty incidents, fatal crashes, child fatalities, and other traumatic disruptions. In addition, DBHDID provides behavioral health

support in times of disasters through Project Recovery. Since the devastating tornadoes of 2021 in Western Kentucky and the 1,000-year historic floods in Eastern Kentucky in 2022, DBHDID has provided behavioral health support through all 14 of Kentucky's federally declared disaster incidents.

In 2024, KCCRT deployed to 31 incidents, supporting over 450 individuals. By June 30, 2025, it had deployed 34 times, reaching more than 705 people, primarily public safety professionals and frontline personnel. This includes responses to the 2025 flooding and 2025 tornado events, where KCCRT provided support to affected communities, emergency operations center staff, and responders. The KCCRT supports emergency services and emergency management personnel, school communities, business and industry, and disaster survivors with volunteer peers specifically trained to identify those with SMI, SED, and SUD needs and ensure they are connected to appropriate resources.

As noted in Response 1, the DBHDID reorganization and the August 2022 attachment by Memorandum of Understanding (MOU) moved the Kentucky Community Crisis Response Team from Kentucky Emergency Management to DBHDID. The KCCRT is currently administered through the Division of Mental Health, Promotion, Prevention, and Preparedness Branch, developed during the department's reorganization in July 2022. State statute moved KCCRT to DBHDID in July 2023.

However, the team's strength and capacity diminished due to a lack of support for the KCCRT during COVID-19. More than 370 people were on the team roster when DBHDID acquired the files; however, requests to deploy for community crisis events highlighted that it was challenging to elicit a sufficient commitment from team members to respond adequately to all situations. Additionally, the number of response requests has increased as awareness of the resource has grown, and emergency management and first responders have realized that the service is available in the state. However, the volunteers who respond to requests for assistance are often the same three to five individuals.

As a result of the low number of respondents for these crisis responses and the fact that credentials had lapsed for many of the members, DBHDID has undertaken extensive recruitment, training, and credentialing. Funds from the BSCA monies in Allotment 1, 2 and 3 have been utilized to support this effort, in addition to funds from the Department for Public Health, which provides the base costs for support of the team, allowing DBHDID to leverage multiple funding streams to support the rebuilding of this initiative.

BSCA Allotment 1 and 2 funds were utilized to provide access to multiple trainings to re-credential team members who wished to continue their efforts with KCCRT. DBHDID team members surveyed those on the roster to determine their interest in continuing involvement with KCCRT. BSCA funds also enabled the recruitment of behavioral health providers, especially those working within the state's Community Mental Health Center network. These individuals include Peer Support Specialists, Assertive Community Treatment teams, Targeted Case Managers, prevention staff, houseless outreach specialists, and others identified by the CMHCs to respond in a community crisis or natural disaster. Additionally, marketing will be utilized to solicit the involvement of first responders and emergency management professionals to round out the KCCRT's membership.

A training plan has been developed, and veteran volunteers have received refreshers. During FY24 and FY25, additional training was provided to new team members. Those include:

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

Additionally, DBHDID developed a Psychological First Aid 201 specific to Kentucky disaster responses. Allotment 1 funds for training equaled \$87,150. Allotment 2 added \$60,000 to continue expanding the KCCRT roster. An additional \$62,411 was approved from Allotment 3 to enhance capacity to support those with SMI, SED, and SUD who experience a community-level disaster. **Within Allotment 4, we are requesting \$37,411 to continue training support to KCCRT volunteers who deploy to communities and support the behavioral health needs of those with SMI, SED, and SUD.**

DBHDID recently completed a two-year, \$7 million Disaster Resilience Grant awarded by SAMHSA. During the implementation of that project, partner agencies installed portable telehealth stations that were available to consumers who might not otherwise have access to behavioral health services. Additionally, during recent disasters, there was a need for these types of services in the communities most affected by the tornadoes and the flooding. As a result, DBHDID assembled five portable ATLAS (Accessing Telehealth through Local Area Stations) to be deployed to the Disaster Resource Centers (DRCs) during a community disaster. DRCs are considered a one-stop shop for accessing multiple services that disaster survivors need (food, clothing, replacement driver's licenses, FEMA applications, etc.). By locating an ATLAS station in the DRC, survivors begin to normalize the emotions they may be feeling because of the disaster and recognize that accessing behavioral health services is equivalent to replacing clothing and furniture they may have lost during the disaster. Those ATLAS Stations have been utilized multiple times over the past 14 declared disasters. Two additional ATLAS Stations have been deployed through other funding streams to support a rural community that has been significantly impacted by suicide loss of middle-aged men.

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

The \$5,240 cost for implementing the five additional portable ATLAS Stations was covered by Allotment 1. No additional funds are requested for this purpose in Allotment 2, Allotment 3 or Allotment 4.

DBHDID also administers the Olmstead Housing Initiative program and the Projects for Assistance in Transition from Homelessness (PATH) grant, which includes funds to support the unhoused in accessing permanent housing. DBHDID also provides a small amount of flexible state General Funds to CMHCs for

adults with SMI to assist with non-recurring case management/housing needs with no other source. Additionally, a Homeless Outreach Team has existed for 21 years in Jefferson County, Kentucky (urban). The team model used in Louisville features targeted case managers, peer support specialists, and other behavioral health professionals. The model will be translated for additional areas (suburban, rural) and will be mobilized to return disaster survivors to their homes quicker, providing non-recurring resources to support housing and utility deposits. These outstanding debts prevent the individual from accessing housing, pest treatments, and essential home goods (beds, cookware, etc.). The resources will be available non-recurring up to a maximum allotment of \$2,000 per household. They will follow the state's PATH grant Policies and Procedures requirements. All other funding sources for these types of payments will be accessed before utilizing the BSCA funds. Several CMHCs have already established outreach teams working with unhoused individuals. They are already providing other types of support during traumatic events, and adding the housing assistance program to their program portfolio will enhance their acceptance and effectiveness in times of crisis or natural disaster. Allotment 1 included \$32,242 in funds for this purpose. An additional \$25,000 was designated in Allotment 2. SMI and SED program administrators will work in concert with disaster case managers to identify the needs of individuals identified as SMI/SED and determine if resources can be provided to those impacted by the floods and tornadoes. **No funds were requested in this area for Allotment 3 and none are being requested in Allotment 4.**

A total of \$124,632 was approved for this section in Allotment 1. A total of \$85,000 was approved in Allotment 2 for training and housing assistance. An additional \$62,411 was approved in Allotment 3 to cover costs for enhanced training for mobile crisis responders. **DBHDID is requesting \$37,411 from Allotment 4 to cover continued training dissemination for KCCRT volunteers and community partners to increase readiness to support the behavioral health needs of those with SMI, SED and SUD during natural disasters and traumatic community events.**

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

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

The Regional Interagency Councils (RIAC) operate as the locus of accountability for the system of care, providing a structure for coordination, planning, and collaboration of services and supports at the local level to children, adolescents, and transition-age youth and their families, especially those experiencing

SED and SUD, to help them function better at home, in school, in the community, and throughout life. There are 18 RIACs across the state. Each council is composed of members representing CMHC, AOC, DCBS, FRYSC, Office of Vocational Rehabilitation, Kentucky Education Cooperatives/Special Education Services, Department of Juvenile Justice, local health departments, a parent of a child with BH needs who is or has been a consumer of system of care services and supports, and one TAY youth who has BH disorder who is receiving or has received a service to address MH, SU, or co-occurring. Collaboration is also encouraged with any other local public or private agency that provides services and support to these populations.

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

RPCs have also received information on the "Handle With Care" program and have started promoting it in their communities. Handle With Care involves a consistent relationship between first responders and emergency services personnel who alert the school that the child was involved in a situation and may be at increased risk of trauma symptoms in the days and weeks to follow. Schools are trained to understand these symptoms and how to utilize trauma-informed best practices to support the student during the time following the crisis. These programs have been expanded to support the many Kentucky children who have been exposed to trauma in the aftermath of the Western Kentucky tornadoes and the Eastern Kentucky flooding and subsequent disaster events. The goal is to reduce the impact of these events on all children, especially those identified as SED.

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

- Provide reimbursement to youth with lived behavioral health experience for service on RIACs and RIAC youth council to increase youth voice in the community-level work of the council. This will ensure that youth needs are identified, especially in relation to community crises and natural disasters. Youth are reimbursed for attendance at each meeting. They also receive resources for travel costs to support attendance, as many communities are in rural areas and do

not have mass transit. Funds are for 1 youth for each RIAC for 12 monthly meetings. TAY Program Administrators would provide technical assistance to the teams to ensure that the youth voice is utilized effectively and meaningfully and that they are not just tokenized members of the RIACs. **These funds were doubled in Allotment 2 to increase the number of youths who can participate in these efforts. Allotment 1 totaled \$11,760, and Allotment 2 totaled \$24,000. Kentucky continued the initiative with Allotment 3 in the amount of \$24,000 and requests to do so again with Allotment 4.**

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

The two pilot locations have hired a behavioral health therapist to serve specifically on the team and support the youth and their families in accessing services. Additionally, a youth Peer Support Specialist has been hired for two pilot site teams to specifically support the youth who are involved and increase the likelihood that they will have agency and voice in the decisions made affecting them. Youth will be connected to the youth Peer Support Specialist on their first offense to create an early diversion initiative away from the problem behaviors.

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

The approved Allotment 1, Allotment 2 and Allotment 3 amounts for this initiative we \$210,000 for each Allotment. Kentucky is requesting the same amount from Allotment 4 to continue this initiative.

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

TGFV is structured similarly, making it easier for schools to embed it in their current programming schedule. It builds protection among students by providing opportunities for pro-social involvement, establishing positive norms, promoting bonding to pro-social peers, and increasing personal and social skills. It also mitigates risks associated with problem behaviors by

addressing poor social skills, peer rejection, inappropriate social behaviors, and friends who engage in problem behaviors. Curricula is available for all age groups from elementary through high school levels.

For this pilot project, DBHDID will partner with the New Vista Regional Prevention Center, located at one of the CMHCs, to provide training and technical assistance on the Too Good for Violence (TGFV) curriculum to at least two schools in Fayette County. At least 12 teachers or other school personnel will be trained to implement the curriculum, and a minimum of five implementers will be trained as trainers. Approximately 2,400 students in four grades and at least two schools will complete the TGFV curriculum. **This project continues. No additional funds are requested from Allotment 2, Allotment 3 or Allotment 4.**

- Additionally, three pilot sites were identified and family Peer Support Specialists have been made available to support parents whose children have become involved in the child welfare system in accessing services in the community. These services include Nurturing Parents, Kentucky Strengthening Ties and Empowering Parents (KSTEP), Self-Management and Recovery (SMART), Parent Cafes, and other parent-focused programs and resources. **DBHDID received approval of \$80,000 in Allotment 1, and \$90,000 in both Allotment 2 and 3 for this initiative. We are requesting additional funds in the amount of \$90,000 from Allotment 4.**
- Plans also include providing support to Jefferson County (Louisville) to develop a strategic plan to address Youth Gun and Violence Prevention as one additional step to reduce the impacts of violence in that community. **This initiative utilized the \$10,000 approved in Allotment 1 and will continue. No additional funds were requested from Allotment 2, and 3 and none are requested in Allotment 4.**

DBHDID is in the exploration stage of implementing the Mobile Response and Stabilization System (MRSS) in Kentucky as the mobile crisis response system for youth and their families.

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

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

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

This initiative has been renamed the Kentucky Rapid Response and Stabilization System (KRRSS). Partners are reviewing the required components for implementation of the evidence-based model to determine which need to be available when the initiative goes live and which can be added as the service matures in Kentucky. Initial plans indicate that Kentucky will implement the model in two to three communities as pilots before expanding the components that are successful in the state.

BSCA funds have been utilized to support the initial installation of MRSS, to include:

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

The environmental scan, gap assessment, and system readiness have been completed, but are being adjusted due to a lack of funding for full implementation by the Kentucky State General Assembly. Implementation is expected to be slower than originally anticipated but will move forward. DBHDID is also leveraging 988 Supplemental funds with BSCA funds for this initiative. **Allotment 1 included the approval of \$50,000 for this initiative. For Allotment 2, Kentucky was approved for \$123,991 to continue this effort. An additional \$125,000 was approved for Allotment 3 and DBHDID requests the same amount of \$125,000 for Allotment 4. This request meets the required 5% crisis set aside for crisis (minimum \$42,071).**

DBHDID has developed a strong relationship with the Kentucky Administrative Office of the Courts and their Mental Health Judicial Commission. Through the commission, communities across the state are developing collaboratives to improve the systematic handling of individuals with SMI and SED who become involved with the judicial process. A statewide summit was held in May 2023 where action planning at the community level began. Town hall listening sessions are being held over the next month to complete a landscape analysis of needs across the state. Finally, each community convened a local collaborative to develop its own action plan. The action plan included the delivery of Mental Health First Aid and Youth Mental Health First Aid to justice-involved partners to increase awareness of Serious Mental Illness, Severe Emotional Disabilities, Substance Use Disorders, and other behavioral health conditions that may make individuals vulnerable to increased involvement in the judicial system. **Kentucky was approved for \$50,000 from each Allotment 1 and 2 to organize and hold training of trainings in MHFA/YMHFA to increase the capacity of DBHDID to ensure that each community can train key stakeholders in the evidence-based program. No funds were requested for MHFA/YMHFA from Allotment 3 or 4.**

DBHDID supports the implementation of behavioral health services for children and youth served by the state child welfare agency and is seeking to implement a statewide clinical and functional assessment and treatment planning process for children with child welfare involvement. **In Allotment 4, DBHDID plans to utilize \$110,000 in BSCA funding to contract with the University of Louisville to:**

- 1) Provide consultation and technical assistance to child welfare and behavioral health staff regarding the implementation of screening, assessment, evidence-based treatment, case planning, and progress monitoring.
- 2) Coordinate and conduct training on implementing evidence-based screening, assessment, treatment, case planning, and monitoring, as well as monitor clinician CANS certification.
- 3) Work with internal and external entities to plan and implement strategies to improve assessment of behavioral health needs and service delivery to children in out-of-home care.
- 4) Input and analyze data to monitor compliance of provider agencies in the use of the CANS and associated interventions and project outcomes, and use results in training, consultation, and interagency planning and implementation activities.
- 5) Write reports for federal and state partners and reference materials related to project goals, implementation, and progress.

The clinical consult will support the Department for Community Based Services regional and field staff, Community Mental Health Center providers, and the private childcare community with implementing the statewide clinical and functional assessment and treatment planning, developing and delivering training on the data collection tool, selection and provision of evidence-based treatment, and development of assessment-driven case planning and progress monitoring. The consultant will also collaborate with external systems to analyze project data, develop plans to enhance the responsiveness and service delivery within the existing system of care for children and youth served by the child welfare system, and draft reports to support related initiatives.

Total approved Allotment 1 funds for this section were \$411,760. Kentucky was approved \$497,991 from Allotment 2 to continue and expand the RIAC, FAIR Team, Child Welfare, and MRSS initiatives, and to add the MHFA/YMHFA TOT for justice-involved stakeholders. Allotment 3 continued the RIAC, FAIR Team, Child Welfare and MRSS initiatives, and added the collaboration with the University of Louisville to support the implementation of the functional needs assessment for a total request of \$559,000 in this area. DBHDID requests funding for \$559,000 in Allotment 4 to continue these initiatives.

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

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

quarterly throughout the year to those working with youth across the state. These initiatives will continue and are supported by other funding streams.

The DBHDID Promotion, Prevention and Preparedness branch completed a toolkit to help disaster survivors deal with anniversaries and has disseminated broadly to the communities through print materials and virtual webinars. Supporting Behavioral Health Wellness (Western Kentucky Natural Disaster Anniversary Kit for Schools) was released in November 2022 before the one-year anniversary of the Dec. 10 and 11 tornadoes that ripped through Western Kentucky. And a similar toolkit for Eastern Kentucky was released in May 2023. As part of a school preparedness initiative with the Department for Public Health, the anniversary kits were digitally and physically distributed, and 12 virtual synchronous trainings were held to disseminate the information included. Additionally, personalized technical assistance is available to schools to review current policies and procedures related to preparedness to reduce trauma-related impacts of traumatic situations.

Additionally, DBHDID was awarded a Garrett Lee Smith (GLS) Suicide Prevention grant in August 2022. This grant focuses its initial efforts in Western Kentucky and the anticipated increase in mental health needs following the disaster there. Research shows that behavioral health needs tend to increase about a year to 18 months after the event during the reconstruction phase of a disaster. The project focuses on implementing an evidence-informed intervention entitled “CODE RED,” which is described as a universal safety planning tool. All students in four pilot districts and middle and high school staff are receiving the intervention, which focuses on identifying specific people and activities that can support a person in crisis. Local educational cooperatives and other community partners are also being trained and have been disseminating the intervention in other school districts.

Additionally, with the 988 Supplemental funding provided by SAMHSA from the Bipartisan Safer Communities Act, this initiative was expanded to include all educational cooperatives in the state, creating streamlined access to mobile crisis services. Each delivery of CODE RED includes information related to 988 and how to access and utilize the Crisis and Suicide Lifeline. As part of a school preparedness effort with DPH, the DBHDID trained 50 trainers in CODE RED and provided key items for them to utilize when implementing the training (wristbands and journals). Mini-grants for 30 communities support the delivery of CODE RED training among youth-serving agencies. By spreading CODE RED across the state, more individuals can be prepared for their worst days, which can span a multitude of disasters impacting the community.

Also, DBHDID administered the Crisis Counseling Program grants (ISP and RSP) for Western and Eastern Kentucky and the Disaster Case Management Program grant in both areas. Crisis Counseling Program efforts ran for two years after the incident and have now concluded.

DBHDID also served on the Department for Medicaid’s Mobile Crisis Planning grant, providing insight and subject matter expertise around implementing a new mobile crisis response system model with a standardized triage system for calls coming into the state’s 988 centers. CMHCs in all 14 regions are accredited to answer 988 calls. While many callers can resolve their crises during the phone call, CMHCs serve as providers of mobile crisis services in the state.

The Division of Mental Health developed a statewide learning series focused on increasing the capacity of the behavioral health workforce related to addressing trauma from crisis and natural disaster survivors. While no BSCA funds are anticipated to be utilized for this process, it will grow from the

training list identified in Question 3 of this plan. The goal will be to ensure that those providing services in communities affected by crises and disasters can deliver appropriate, trauma-informed care. Also included will be crisis intervention/de-escalation trainings to support providers in establishing initial rapport in a way that minimizes additional stress and trauma for survivors.

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

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

No funds for this section were requested from Allotment 1, 2, or 3 and none are being requested from Allotment 4 as DBHDID is leveraging other funding sources for these initiatives.

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

Through Kentucky's 988 Capacity grant, Kentucky has implemented a Bootcamp Translation project to ensure that all 988 marketing is accessible to all Kentuckians, including those who have historically not utilized the services. The Bootcamp Translation project is an evidence-based multi-component method designed to create and disseminate marketing messages in a community. Boot Camp Translation employs a community-based participatory research approach to develop and test message and dissemination strategies for healthcare issues with topics chosen based on community and state priorities and/or funding opportunities. With funding from Allocation 1 of the BSCA, the project was expanded to create and disseminate marketing materials focusing on those with SMI/SED in rural areas of Kentucky. The process includes multiple synchronous and asynchronous data collection points from those with lived experiences within the community priority population. The feedback is then utilized to create messages, which are tested to ensure they resonate with the target populations. Once approved, the messages will be disseminated in the target geographic regions of the state. **Allocation 1 included approval of \$50,000 for the Bootcamp Translation Project focused on the SMI and SED in rural areas of Kentucky. No additional funding is requested in Allocation 2, Allocation 3 or Allocation 4.**

Additionally, the state is committed to increasing behavioral health access to those with SMI, SED and SUD who are deaf and hard of hearing and is leveraging funding from other sources to increase

interpreter services to ensure that this population has access to appropriate services and is informed of those services through linguistically appropriate marketing. **Allocation 2 included \$30,000 in funds to support access to training and services for individuals with SED/SMI who identify as deaf and hard of hearing. Allocation 3 included \$25,000. DBHDID is requesting \$25,000 from Allocation 4 to continue these services.**

In the 988 space, DBHDID created a resource directory that reflects all Kentuckians as well as the geographic uniqueness that underscores each respective geographic region. (Appalachian, rural, farm community, suburban, urban). The FindHelpNowMentalHealthky.gov website includes a variety of resources, including available appointments and treatment beds, in each of Kentucky's 120 counties. The resource directory is linked to the FindHelpNowKy.gov site, which has been in existence for several years and focuses on resources for those experiencing substance use disorders. The co-branding with this site has increased exposure and the site serves as a first-line resource for 988 call centers, warm lines, and other crisis centers in the state.

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

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

Allocation 1 included approval of \$50,000 for the Bootcamp Translation Project focused on those identified as SMI/SED in rural Kentucky. Allocation 2 included \$30,000 to increase access to those with SMI/SED who are deaf and hard of hearing and Allocation 3 included \$25,000. DBHDID is requesting an additional \$25,000 to support increased access for those with SMI/SED who are deaf and hard of hearing in Allocation 4.

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

Utilizing BSCA funds, DBHDID partnered with Mental Health America-Kentucky (MHA-KY), a statewide advocacy organization, to implement a statewide learning series designed to increase workforce capacity to address Early Serious Mental Illness (ESMI) and First Episode Psychosis (FEP). Given the increased stress and trauma resulting from two major disasters in the state over the last year, coupled with nearly three years of COVID-19 impacts, behavioral health needs have skyrocketed among Kentucky's children, transition-age youth, and young adults. Identifying early their mental health issues will support them in returning to non-traumatic functioning without further progression of their symptoms. Kentucky currently has eight FEP teams across the state. The focus of this learning series was to enhance the services these FEP teams provide and build awareness and education in areas of the state without current FEP teams. Early identification, through awareness and effective screening, with

subsequent early and effective service delivery, can dramatically affect negative trajectories traditionally associated with early psychosis and serious mental illness. For that to happen, clinical providers and youth-serving agencies must be trained to recognize early issues related to mental health and to provide developmentally appropriate clinical care. The learning series focused on supporting them in doing just that.

The learning series focused on global topics and provided skill-building opportunities. The Early Assessment and Support Alliance (EASA), who are the national consultants for Kentucky's first episode psychosis (FEP) program, were utilized in the overall development and in the delivery of some of the trainings. In addition, current FEP teams and statewide CMHC staff identified as key contacts for FEP were utilized in developing this learning series. Global topics did not have a participant limit and were targeted statewide to providers who serve youth and young adults. Some sessions focused on the implementation process to ensure more effective early implementation of these services. CMHC clinical staff serving this population were encouraged to attend as DBHDID currently supports FEP sites and is building capacity to support additional sites with other funding sources. MHA-KY coordinated and hosted the trainings and supported marketing and registration efforts. Some of the learning series involved individuals with relevant lived experience, including some Peer Support Specialists. They were compensated for their time and effort in creating/providing the training sessions if doing so was not included in their current employment. **Allocation 1 included approval of \$113,300 for the learning series, as noted above.**

From Allocation 2, Kentucky was approved to use \$110,000 to support the enhancement of the fidelity review process for the Coordinated Specialty Care (CSC) teams that exist in the state. Kentucky's state program staff have provided initial fidelity reviews for CSC teams, but the programming has grown, and additional implementation assistance is needed to adequately review, train and coach CSC teams across the state. The fidelity review process will ensure that FEP services follow the Coordinated Specialty Care evidence-based program, a recovery-oriented treatment program designed for individuals with first-episode psychosis. The fidelity review process will support behavioral health providers in ensuring their service delivery meets the high standards that help ensure the best outcomes for these individuals and provide adequate coaching and training based on the needs identified in the review process. **We are requesting an additional \$110,000 from Allotment 4 to continue and expand the fidelity review process in support of our Coordinated Specialty Care teams.** This meets the 10% set aside amount for ESMI/FEP – minimum - \$84,411.

For Allocation 3, Kentucky was approved for \$85,000 to meet the 10% set aside amount for ESMI/FEP, to create a community education and outreach plan targeted toward key crisis providers (colleges, universities, police, fire, EMS, judicial system, etc.) to increase community awareness surrounding engagement and treatment for individuals experiencing early psychosis symptoms. Funds were also utilized to provide training and technical assistance to crisis providers as they initially interact with individuals experiencing their first episode of psychosis, as well as to fully develop key referral processes and formalized care pathways between crisis and CSC/FEP providers. These efforts are intended to improve and enhance initial and ongoing care for those experiencing FEP.

In addition to the funded components noted above, the state is working to expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) into the suicide prevention space. SBIRT is a screening process used to identify, reduce, and prevent substance use disorder. Working with the Pacific Institute

of Research and Education, Kentucky's Division of Substance Use Disorder has created a statewide initiative to inform and enhance usage of SBIRT through a train-the-trainers implementation approach. Plans for Kentucky are to include suicide prevention screenings into this process to impact identification and treatment and enhance suicide prevention efforts. The goal is that each time SBIRT is presented, suicide screening is included. No BSCA funds will be utilized for this effort.

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

DBHDID has also developed a strategic plan to guide the direction of the system of care work over the next three to five years. The Children's Behavioral Health Branch is working with The Innovations Institute at the University of Connecticut to assess and identify system factors impacting how children, youth, young adults, and their family's access and experience the system to inform needed changes and additions to Kentucky's service array. The effort began with a mapping of care pathways for families. As noted above, it included an environmental scan related to the systems policies, practices, and programs related to mobile crisis response. Multiple stakeholder input opportunities will be provided, and the results of the feedback and guidance will be utilized to develop the strategic plan. Once developed, the plan will be presented to those who initially provided feedback and then to members of the entire system of care. No BSCA funds will be used for this effort.

Additionally, DBHDID will be evaluated the FAIR Team and DCBS pilot projects, as well as training initiatives for effectiveness and long-lasting impact. Funds for this work in the amount of \$83,299 were included and approved in Allocation 1. No additional funds from Allocation 2, 3 or 4 were or are requested.

Total approved for this section in Allocation 1 was \$196,599. The total approved for Allocation 2 is \$110,000 for the fidelity review process enhancement. The total approved in Allocation 3 was \$85,000 for the crisis outreach and education plan and related development of training, technical assistance, a referral process, and identified and formalized care pathways for key stakeholders. The total requested for Allocation 4 is \$110,000 to support and enhance the fidelity review process for Kentucky CSC teams.

The overall Allocation 4 request is \$841,411 from the BSCA allocation for Kentucky. See the budget below for a complete overview of these costs. The requests for Allocation 4 include 10% to meet the ESMI/FEP set-aside requirements and 5% to meet the crisis set-aside requirements.

2026 - 2027 Budget/Allocation 4 for Kentucky BSCA Funding Plan 2026

		BSCA Allocation 1	BSCA Allocation 2	BSCA Allocation 3	BSCA Allocation 3
		\$832,991	\$832,991	\$841,411	\$841,411
Question #	Project	Approved Funding Allocation 1	Approved Funding Allocation 2	Approved Funding Allocation 3	Requested Funding Allocation 4
#1 - Develop/enhance components of your state's mental health emergency preparedness and response plan	Update state behavioral health emergency preparedness plan (three facilitated sessions with key stakeholders for input, development of plan and report back out to the communities)	\$50,000	\$0	\$0	\$0
		Total Question 1 FY 23 -Approved - \$50,000	Total Question 1 FY 24-Approved - \$0	Total Question 1 FY25 - Approved - \$0	Total Question 1 FY26 - Requested - \$0
#2 - Develop/enhance a state behavioral health team	Development of a branch to include preparedness; including crisis/disaster language in job descriptions, professional development/learning opportunities (crisis conference), relationship opportunities, hiring new staff member (program coordinator). Program Coordinator hired in Year 2. Allocation 3 covered ongoing salary. Allocation 3 will continue to cover ongoing salary.	\$0 (costs leveraged from other funding streams)	\$110,000	\$110,000	\$100,000
	Creation and dissemination of crisis de-escalation model information	\$0	\$0	\$0	\$10,000

		Total Question 2 FY23 – Approved- \$0	Total Question 2 FY 24 – Approved -\$110,000	Total Question 2 FY 25 -Approved - \$110,000	Total Question 2 FY 26 -Requested -\$110,000
#3 – Plans to develop/enhance multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state.	Recruitment, credentialing, training of Kentucky Community Crisis Response Team for responses during community crisis and natural disasters related to behavioral health needs/trainings to support crisis intervention/de-escalation	\$87,150	\$60,000	\$62,411	\$37,411
	Establish 5 portable Atlas Stations for use in DRC	\$5,240	\$0	\$0	\$0
	Housing assistance for those who are unhoused	\$32,242	\$25,000	\$0	\$0
		Total Question 3 FY 23 -Approved -\$124,632	Total Question 3 FY 24 - Approved - \$85,000	Total Question 3 FY 25 - Requested - \$62,411	Total Question 3 FY 26 - Requested - \$37,411
#4 - Develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/SMI	Youth engagement in RIACS	\$11,760	\$24,000	\$24,000	\$24,000
	FAIR Team Pilot Project	\$210,000	\$210,000	\$210,000	\$210,000
	Too Good for Violence TOT and curriculum	\$50,000	0	0	\$0
	Child Welfare Pilot Project	\$80,000	\$90,000	\$90,000	\$90,000
	Jefferson County Youth Gun and Violence Prevention Strategic Plan	\$10,000	0	0	0
	MRSS – 5% recommended set aside for crisis	\$50,000	\$123,991	\$125,000	\$125,000
	YMHFA/MHFA Trainings to justice involved staff (in concert with community action plan development) to support clients who are SMI/SED	\$0	\$50,000	\$0	\$0

	Partner with University of Louisville for a clinical consultant position and .10 FTE for data analysis; Implementation of statewide clinical and functional assessment and treatment planning for children with child welfare involvement.	0	0	\$110,000	\$110,000
		Total Question 4 – FY23 - Approved - \$411,760	Total Question 4 – FY24 - Approved - \$497,991	Total Question 4 – FY25 - Approved - \$559,000	Total Question 4 – FY26 - Requested - \$559,000
#5 - Develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence	Work with University of Kentucky Trauma Informed Care Institute, wellness toolkit, CODE RED implementation, RSP implementation, crisis response, statewide learning series to support workforce capacity to address trauma (all costs are leveraged from other funding streams)	\$0	\$0	\$0	\$0
		Total Question 5 – FY23 - Approved – \$0	Total Question 5 – FY24 Approved- \$0	Total Question 5 – FY25 Approved- \$0	Total Question 5 – FY26 Requested- \$0
#6 - Develop/enhance culturally and linguistically tailored messaging	Utilize Bootcamp Translation Process to develop and implement culturally and linguistically appropriate messages for those with SMI/SED in rural areas.	\$50,000	\$0	\$0	\$0

	Increasing access to services for those with SMI/SED who are Deaf and Hard of Hearing, implement an environmental scan of diverse resources in the state, creation of bed registry/resource directory for 988 crisis call takers, trainings to support increased capacity to serve diverse populations, leveraging of existing populations for message dissemination	\$0	\$30,000	\$25,000	\$25,000
		Total Question 6 – FY23 - Approved - \$50,000	Total Question 6 - FY24 - Approved- \$30,000	Total Question 6 FY25 - Approved- \$25,000	Total Question 6 FY26 - Requested- \$25,000
#7 – Other mental health emergency/crisis behavioral health practices or activities that the state plans to develop or enhance.	Expansion of SBIRT to include suicide prevention, provide technical assistance to providers on utilizing EPSDT funding from Medicaid to cover behavioral health services, development of a strategic plan for the Children’s Behavioral Health System of Care (all costs are leveraged from other funding streams)	\$0	\$0	\$0	\$0
	Evaluation of FAIR Team Pilots, Child Welfare Pilots, training delivery	\$83,299	\$0	\$0	\$0

	ESMI/FEP Learning Series-10% set aside for FEP/ESMI	\$113,300	\$0	\$0	\$0
	Implement more robust Fidelity Review for current funded First Episode Psychosis Teams (10% set Aside for FEP/ESMI)	\$0	\$110,000	\$0	\$110,000
	Community education/outreach plan for key crisis providers to enhance community engagement and awareness of FEP and to streamline referral processes between crisis programming and CSC. 10% set aside for FEP/ESMI	\$0	\$0	\$85,000	\$0
		Total Question 7 Approved- FY23 - \$196,599	Total Question 7 FY24 - Approved- \$110,000	Total Question 7 FY25 - Approved- \$85,000	Total Question 7 FY24 - Requested- \$110,000
		Total Approved Allocation 1- FY23 \$832,991	Total Approved Allocation 2 – FY24 \$832,991	Total Approved Allocation 3 – FY25 \$841,411	Total Requested Allocation 4 – FY26 \$841,411

State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name	
	Not Applicable
Title	
	KY Cabinet For Health and Family Services
Organization	
	Behavioral Health, Developmental and Intellectual Disabilities

Signature:

Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

DISCLOSURE OF LOBBYING ACTIVITIES

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

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

1. * Type of Federal Action: ☐ a. contract ☒ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	2. * Status of Federal Action: ☐ a. bid/offer/application ☒ b. initial award ☐ c. post-award	3. * Report Type: ☒ a. initial filing ☐ b. material change
4. Name and Address of Reporting Entity: ☒ Prime ☐ SubAwardee * Name KY ST Cabinet/Health/Family Services * Street 1 275 E. Main Street Street 2 * City Frankfort State KY: Kentucky Zip 40601 Congressional District, if known:		
5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime: 		
6. * Federal Department/Agency: Substance Abuse and Mental Health Servic		7. * Federal Program Name/Description: 2026-2027 MH-SUD Combined Block Grant CFDA Number, if applicable:
8. Federal Action Number, if known: 		9. Award Amount, if known: \$
10. a. Name and Address of Lobbying Registrant: Prefix * First Name NOT Middle Name * Last Name APPLICABLE Suffix * Street 1 Street 2 * City State Zip		
b. Individual Performing Services (including address if different from No. 10a) Prefix * First Name NOT Middle Name * Last Name APPLICABLE Suffix * Street 1 Street 2 * City State Zip		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure. * Signature: ss/ Steven Stack * Name: Prefix Dr * First Name Steven Middle Name * Last Name Stack Suffix MD, MBA Title: Cabinet Secretary Telephone No.: 502-564-7042 Date: 08/04/2025		
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

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 prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public 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 SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has a mission to promote health, well-being, and resilience for all, facilitate recovery for people affected by mental illness and substance use, and support people with intellectual disabilities. The DBHDID vision is that all Kentuckians have access to quality services and supports to live full and healthy lives.

DBHDID values include:

- Collaboration. We believe collaboration is essential to achieve our work;
- Choice. We believe all people should have the fullest possible control over their own lives;
- Respect. We believe all people are valuable and have the right to lead meaningful, productive lives;
- Equity. We believe in equity and eradication of disparities to ensure all people have access to quality services;
- Advocacy. We believe in supporting all people to advocate for themselves and others; diverse voices should be sought, heard, and considered in making decisions;
- Trauma-Informed & Resilience-Oriented Approaches. We believe in trauma-informed systems that promote individual, community and organizational resilience; and
- Excellence. We believe that service is collaborative, represents consumer needs, assures optimal use of public resources, and achieves the highest possible standard.

Kentucky's DBHDID current key priorities include:

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

Kentucky's DBHDID administers a comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI), children with serious emotional disturbance (SED) and their families, adults, and youth with substance use disorders (SUD), and individuals with co-occurring mental health and substance use disorders. DBHDID is developing a statewide network of early intervention services and supports to address transition-age youth and young people experiencing multiple behavioral health issues, including first-episode psychosis. DBHDID strives to further promote access to a full continuum of care for mental health and substance use disorders and to provide necessary resources and data to assist community providers in local-level decision-making, including policies, program development and the provision of evidence-based practices. Kentucky is also working to enhance behavioral health crisis intervention programming across the state, as well as the integration of behavioral health and physical health care. DBHDID promotes access to a full continuum of care for mental health and substance use disorders and advances the recognition that mental health and freedom from addiction is essential to overall health.

Included in Kentucky's community-based system of behavioral health care is a long-standing and robust program for the prevention of substance use disorders.

Within DBHDID, there are five divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; Program Integrity; Substance Use Disorder; and Mental Health.

DBHDID's Division of Substance Use Disorder (DSUD) is comprised of the Director's Office and two branches. The DSUD Director's Office includes a broad dashboard of subject matter expertise. The Division Director, two Assistant Directors, and several cross division program staff including a Federal Programs Specialist, a communications lead, a behavioral health and justice lead, and an Administrative Specialist are included in the Director's Office. The two branches include:

Substance Use Prevention and Promotion Branch – Oversees and supports programs across the state in the use of evidence-based prevention strategies to decrease risk factors and enhance protective factors and resilience, with the goal of reducing rates of substance use among residents of Kentucky. Prevention and Promotion Branch efforts focus on reducing or delaying the initiation of substances and related consequences. This branch includes several Prevention Enhancement Specialists, workforce development and youth empowerment leadership, coordination with the 14 regional prevention centers, Synar coordination, and additional support for Kentucky's robust statewide system of substance use prevention.

Adult Substance Use Treatment and Recovery Services Branch – Oversees and supports the administration of community-based, outpatient and residential services for individuals with substance use disorders across the state and medications for opioid use disorder (MOUD). This branch manages several statewide specialty programs for key SUD populations, (e.g., pregnant women; women with dependent children; service members, veterans, and their families), coordinates efforts to build a recovery-oriented system of care across the lifespan and provides guidance and technical assistance on the implementation of evidence-based practices across the commonwealth. Some programs housed within this branch include recovery housing and other recovery support and harm reduction services for persons with SUD, older adults with SUD, re- entry coordination for individuals with SUD/OD serving out of jails/prisons, statewide coordination with the Office of Drug Control Policy to support treatment access expansion and services for Neonatal Abstinence Syndrome (NAS), and AmeriCorps support.

Also included within the DSUD is Kentucky Overdose Response Effort (KORE) – Administers the State Opioid Response (SOR) grant made available by SAMHSA. KORE is guided by the Recovery-Oriented System of Care framework and strives to expand access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery, and harm reduction services and supports in high-risk geographic areas of the state.

DBHDID's Division of Mental Health (DMH) is comprised of the Director's Office and three branches. The DMH Director's Office includes a broad array of subject matter expertise. The Division Director, two Assistant Directors, and several cross division program staff, including a Budget Specialist, deaf and hard of hearing services staff, integrated care programming staff, the block grant coordinator, Behavioral Health Services Information System (BHSIS) staff, as well as an Administrative Specialist, are all included under the Director's Office umbrella. The three branches include:

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

Children's Behavioral Health and Recovery Services Branch – Oversees the services and supports for children and youth across the state who have or are at-risk of developing behavioral health concerns and their families, including children with SED. This branch works with community providers across the state to provide oversight and technical assistance regarding the delivery of a continuum of behavioral health care that includes early intervention, treatment and recovery services and supports. This branch manages several statewide and regional initiatives including adolescent substance use prevention and treatment, high-fidelity wraparound services, youth and family peer support, early childhood mental health services, and others. The Kentucky Service and Infrastructure eXpansion (KY SIX) System of Care grant, awarded by SAMHSA is administered through this branch as well.

Adult Mental Health and Recovery Services Branch - Oversees the planning and implementation of mental health services for adults with SMI across the state. This branch provides training and technical assistance to providers regarding the delivery of an array of evidence-based practices that focus on treatment and recovery services and supports for adults with SMI. Specific evidence-based practices include Assertive Community Treatment (ACT), peer support, supported employment, utilizing the Individual Placement and Support (IPS) model, and permanent supportive housing. This branch also includes statewide leadership for programming related to older adults with SMI, targeted case management for adults with SMI, liaisons to state psychiatric hospitals, Kentucky's Projects for Assistance in Transition from Homelessness (PATH) grant coordination, assisted outpatient treatment (AOT), and Olmstead coordination for adults with SMI. Early Interventions for First Episode Psychosis (FEP) program coordination is also included in this branch.

The Division of Program Integrity provides support for all DBHDID divisions, including DMH and DSUD. Program Integrity consists of three branches including:

Data Analytics Branch – Oversight of application development and integration; business informatics; facilities information and system management; and the electronic medical records (EMR) project.

Program Support Branch – Coordinates contract monitoring; education/event coordination (including approvals of training

curricula submitted for certification of community support associates, peer support specialists, and targeted case managers), risk management and mortality reviews; and legislation/regulation reviews.

Substance Use Disorder Program Licensure Branch – Brings together the Driving Under the Influence (DUI) program and the Narcotic Treatment Program (NTP) with the licensure of alcohol and other drug entities (AODE). The AODE licensure program oversees the outpatient and residential SUD treatment facilities that are licensed, regulated and inspected annually. This responsibility was transferred to DBHDID from the Office of Inspector General in April of 2023. The DUI program monitors and regulates the statewide network of DUI programs certified to provide alcohol and other drug assessments, education, and treatment services for those convicted of DUI. The NTP program provides oversight to those entities licensed to provide methadone treatment. This branch works closely with the DSUD.

DBHDID is a member of the Juvenile Justice Oversight Council, and staff participate in three subcommittees of the State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC); Standardized Screening and Assessment, Service Engagement and Retention, and Kentucky Rapid Response and Stabilization Services. In addition, the chair of one of the Juvenile Justice Advisory Board Subcommittees is a mandated member of SIAC.

On August 11, 2022, the Judicial Commission on Mental Health was created via court order. Please see the attached order uploaded in the attachments for this section of the application. This commission was tasked with exploring, recommending, and implementing transformative changes to improve system-wide responses to justice involved individuals with mental illness, substance use disorder, or intellectual/developmental disabilities. This commission is comprised of representatives from the judicial and legal communities, juvenile, criminal, and child protective systems, the legislature, the business community, organizations with substantial interest in these matters, and other state/local leaders. The Secretary of the Cabinet for Health and Family Services, as well as the DBHDID Commissioner are included on this commission.

According to the 2020 U.S. Census data (Kentucky - Census Bureau Profile), Kentucky's population consists of the following race and ethnicity estimates: 82% White/Caucasian; 8.4% Black/African American; 1.7% Asian; .3% American Indian/Alaska Native; .08% Native Hawaiian/Pacific Islander; 2.1% Some Other Race; and 5.4% Two or More Races. Approximately 4.6% of Kentucky's population reported as Hispanic or Latino. Kentucky has no federally or state designated tribes.

According to the 2020 U.S. Census data approximately 16.4% of Kentuckians are considered to be living in poverty, as opposed to an estimated 12.5% of the total U.S. population. 2020 U.S. Census data also estimates Kentucky's median U.S. household income at \$61,118.

Kentucky has traditionally been near the bottom of state spending as rankings have ranged from 44th to 47th in pre-COVID 19 years. In 2024, Kentucky's ranking dropped to the lowest amount of per-client in state spending (Government Mental Health Spending By State). This report also indicates that Kentucky provides behavioral health services to 3.6% of the population and ranks lowest in the percentage of expenditures per client. However, costs associated with opioid use disorder and fatal overdose, such as costs of health care, substance use treatment, criminal justice, lost productivity, reduced quality of life, and the value of statistical life loss, are higher in Kentucky. According to a Center for Disease Control (CDC) report that highlighted the economic impact of the opioid crisis, Kentucky ranked fourth in highest economic impact. Kentucky's combined per-resident costs from opioid use disorder (OUD) and its resulting deaths in 2017 was \$5,491, including \$3,007 for OUD deaths. Total state costs were nearly \$24.5 million, about \$11.7 million for OUD and \$13.4 million for OUD deaths.
<https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7015a1-H.pdf>

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

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) 194A.030, DBHDID is designated as the primary state agency for developing and administering programs for the prevention, identification and treatment of behavioral health disorders (adults and children), including developing and administering treatment, rehabilitation, and recovery support services for individuals with behavioral health disorders and developmental and intellectual disabilities. The department receives state general funds allocated for the prevention and treatment of behavioral health (mental health and substance use) disorders in a biennial budget and is charged with administering the funds to achieve its service and quality goals.

DBHDID is part of the Cabinet for Health and Family Services (CHFS), one of the largest agencies in state government. In addition to DBHDID, the following agencies are included within this cabinet:

Department for Aging and Independent Living (aging, long-term care, and dementia services);
Department for Community Based Services (adult and child protection, child welfare, public assistance; guardianship; family resource centers);
Department for Medicaid Services (Medicaid authority, including managed care);
Department for Public Health (local and state public health programs);
Department for Family Resource Centers and Volunteer Services (training, technical assistance and other support to local school-based family resource and youth services centers to help connect children and families to needed services as a way to remove non-academic barriers to learning. This division also includes SERVE Kentucky which engages Kentuckians in volunteerism and service

to positively impact communities); and
Office for Children with Special Health Care Needs.

Additionally, the CHFS Secretary's Office includes the following structure:

Office of Administrative Services;
Office of Application Technology Services; Office of Finance and Budget;
Office of Human Resources Management;
Office of Inspector General (regulatory and licensure responsibilities for all health care, childcare, and long-term care facilities in Kentucky, including child placement/adoption facilities);
Office of Legal Services;
Office of Data Analytics (manages Kentucky Health Benefit Exchange);
Office of Public Affairs; and
Small Business Ombudsman.
<https://www.chfs.ky.gov>

DBHDID has authority for inpatient psychiatric care for the indigent and operates or contracts for several adult mental health inpatient facilities. The majority of care in these facilities is provided with state general funds. Three of the four are Institutes for Mental Disease (IMD) designated facilities. Please see the Kentucky State Psychiatric Facility document uploaded as an attachment to this section of the block grant application for the most recently available information.

Kentucky Correctional Psychiatric Center (KCPC) is an inpatient psychiatric hospital, located within a state correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation for competency and criminal responsibility and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, KCPC facilitates outpatient competency evaluations through contracts for professional services with CMHCs. The facility's average daily census in SFY 2024 was 44 persons.

Kentucky does not operate any state-funded inpatient facilities for children/youth under 18 years of age. There are currently 679 operational child psychiatric beds located in 13 privately licensed hospitals that are geographically located in eight of the 14 CMHC regions. Please see the Kentucky hospital report for children uploaded as an attachment to this section of the block grant application for the most recently available information.

Other residential care for children in Kentucky includes psychiatric residential treatment facilities (PRTFs), private child caring (PCC) facilities, and therapeutic foster care (TFC) contracted by the Department for Community Based Services (DCBS), Kentucky's child welfare agency.

The Office of Inspector General, an entity within the Secretary's Office at CHFS, is the regulatory agency for licensing all health care facilities, child care, 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 DBHDID.

DBHDID collects monthly data from community mental health centers and other funded providers. This data supports DBHDID's efforts to monitor client-level demographic and diagnostic statistics, service utilization, and staffing used to provide direct behavioral health services. This data (including service data for mental health, substance use, and developmental/intellectual disabilities) is evaluated monthly and each data file is required to meet a set of accuracy, completeness, and timeliness standards. DBHDID relies on this data for various reporting and analysis purposes, including federal block grant reports, national outcome measures (NOMS), treatment episode data set (TEDS), client-level data (CLD) reporting, and the Uniform Reporting System (URS). It is also used for SMHA/SSA profiles, surveys, and other data-driven initiatives. Kentucky has successfully reported CLD using the original MH-CLD methodology since the inception year. Similarly, Kentucky has successfully reported URS data since the inception year of 2002.

Daily, DBHDID collects data from its state-operated and state-contracted facilities for behavioral health, including two state-owned/operated psychiatric hospitals, one state-owned/contracted psychiatric hospital, and one state-contracted psychiatric hospital. The state-contracted psychiatric hospital is located within a medical facility in Eastern Kentucky. Three of the state psychiatric hospitals maintain data using the same electronic health record (EHR); the unit within a medical facility manages data with a similar EHR. The data collected from these systems by the DBHDID includes client-level admission and discharge information and includes demographics, diagnostic, and living arrangement (housing) status at admission and discharge. This data is evaluated monthly according to facility utilization expectations and requirements. DBHDID uses this data for internal operations and facilities management responsibilities.

Prevention process measures are recorded through Kentucky's web-based Prevention Data System (PDS). The PDS is patterned after the Center for Substance Abuse Prevention (CSAP) minimum data set to collect information related to the type of primary prevention services used to reduce and prevent substance use disorders among the residents of the commonwealth. Information is collected on:

- Implementation of strategies based on community needs assessments and selected for that specific population's needs;

- Delivery of prevention services, including collaborations with schools, businesses, government agencies and individuals, policy changes, and curricula implementation;
- Use of the six CSAP strategies of information dissemination, education, alternative activities, community based processes, environmental, and problem identification, and referral strategies;
- Identification of the demographic composition of population served, including number served.

The Prevention Data System is maintained by Substance Use Prevention and Promotion Branch staff in the Division of Substance Use Disorder. Reports, like other special projects of the branch, are developed in conjunction with regional prevention center (RPC) directors. Branch staff collaborate with RPC staff to review reports monthly.

The reports give RPC directors the ability to evaluate activities and effectiveness at the county level, and information is used to plan for future activities; as well, for state staff to track progress towards attaining work plan objectives. The regional prevention centers are required by contract to enter data on their substance use disorder prevention efforts on a monthly basis. The PDS data is used in the compiling of Kentucky's annual Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant Report. The system is also used for the collection of mental health promotion and prevention, and suicide prevention efforts in the state.

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

The KIP survey is modeled after the National Monitoring the Future Survey. During the last survey period for which data is available (2021), 93,812 students from 127 school districts across the state participated in the KIP Survey. Before the COVID-19 pandemic, the KIP survey was conducted in even-numbered years. However, the 2020 administration was postponed due to the pandemic. Instead, the survey was conducted in fall 2021, once students returned to full-time, in-person learning. As a result of Kentucky legislation which required active versus passive consent for participation, the 2023 administration was paused to ensure that processes could be developed that align with the state statute's requirement for parental consent for all health and wellbeing surveys administered in Kentucky schools. As a result, the most recent KIP administration was in the fall of 2024. While it is still too early to report the full data from the latest administration, initial findings suggest a lower response rate and fewer participating school districts compared to previous years, which will impact the generalization of survey data. Kentucky will continue to monitor the situation and support effective survey administration.

Kentucky also monitors usage rates through the National Survey on Drug Use and Health (NSDUH), which is implemented annually among randomly selected youth aged twelve and older, and the Youth Risk Behavioral Survey System (YRBSS). The most recent administration of the YRBSS in Kentucky occurred early in 2023 prior to the enactment of the active consent legislation. The NSDUH data allows for tracking general usage rates among youth ages 12-17 on an annual basis. NSDUH also provides much needed adult data which is used to set priorities for the over 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 and mental health preventionists complete thorough needs assessments to guide their community-level efforts.

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 and structure, use of data and information relevant to desired outcome management across DBHDID. 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 information technology representatives from the 14 CMHCs and other contracted providers. This team makes recommendations concerning information management to the department. The committee facilitates the development of data-related contract items between the department and CMHCs. As a central function, the committee provides direction and assistance in the continued development of the information system to manage a public behavioral health system.

The Quality Management and Outcomes Team (QMOT) is comprised of the quality assurance officers from the 14 CMHCs. This team provides direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across the department. The team evaluates outcomes that support the provision of quality services and explores areas for improvement.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Kentucky is divided into 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 as the planning authority for behavioral health programs in each region and these generally align with the area development districts (ADD) throughout the state. County and municipal governments generally do not provide community behavioral health services. A regional board is an independent, non-profit organization that is governed by a volunteer board of directors that broadly represents stakeholders (including individuals with lived experience, and family members) and counties in the region. All regional boards are licensed by the Cabinet for Health and Family Services as a "community mental health center". Please see the map uploaded under attachments for this section.

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, (including those with SED/SMI) substance use disorder services for adults and adolescents, and services for individuals with co-occurring disorders are provided in county level clinics and a number of services provided off-site in homes, schools 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 use, they also support some secondary and tertiary prevention strategies (using funds other than those set aside for primary prevention) when those activities directly support the primary prevention goals for each region identified through a comprehensive needs assessment.

With its available resources of state general funds, block grant/other federal funds, and awarded agency funds, DBHDID contracts with the 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 behavioral health systems of care for adults and children, including crisis care. They are required to report their plans for development regarding key system components, within an Annual Plan & Budget process.

DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, implementation of evidence-based practices, and service effectiveness and accountability. DBHDID contracts with several CMHCs and a few other community-based, non-profit, entities to provide additional services to populations of focus, including individuals with SED/SMI/SUD. 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 or who experience homelessness or are at risk of experiencing homelessness.

DBHDID collects relevant mental health client-level data (MH-CLD), treatment episode data set (TEDS), and electronic health record (EHR) data monthly from the following entities:

14 community mental health centers;
Two state-owned psychiatric hospitals;
One state-owned/contracted psychiatric hospital;
One state-contracted psychiatric hospital;
Four intermediate care facilities for individuals with intellectual disabilities; and
Two non-profit agencies contracted to provide long-term care nursing for individuals with mental illness and/or intellectual disabilities.

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 14 community mental health centers (CMHC) who provide a full continuum of behavioral health services to nearly four (4%) percent of the state's population of approximately 4.5 million people. However, a number of changes have impacted the behavioral health delivery system, including the implementation of Medicaid managed care, implementation of the Affordable Care Act with a state-run health exchange and expanded Medicaid coverage, several approved Medicaid state plan amendments, an expansion of the behavioral health provider network, and numerous new and amended state laws and regulations. The COVID 19 pandemic forced behavioral health providers to rethink their methods of delivering service. All 14 CMHCs delivered services via telehealth during the pandemic, and several CMHCs developed creative ways to continue to safely provide in-person services as necessary and preferred. Many providers continue to provide hybrid service packages. The CMHCs remain a strong and viable provider safety net for Kentucky citizens enrolled in Medicaid or other insurance plans, as well as those that are uninsured, underinsured or transitioning into and

out of insurance coverage.

The following offers a brief history of system changes:

In November 2011, Kentucky transitioned its Medicaid program to managed care by initiating contracts with managed care organizations (MCOs) to provide services to Kentucky's Medicaid enrollees. Behavioral health was included in the managed care model, which extended to all of Kentucky's 120 counties. As of February 2025, there are five contracted MCOs in Kentucky. These MCOs include Aetna Better Health of Kentucky, Humana Healthy Horizons in Kentucky, Passport Health Plan by Molina Healthcare, UnitedHealthcare Community Plan, and Wellcare of Kentucky.

In May 2013, the decision to expand Medicaid eligibility in Kentucky pursuant to the Affordable Care Act was announced, allowing individuals and families earning up to 138% of the federal poverty line to enroll in an insurance plan. Kentucky created Kynect, an online health insurance marketplace to allow citizens to learn about and select health insurance plans, as well as access other public assistance benefits. This system allows Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began January 1, 2014. By July 2022, total Medicaid/CHIP enrollment in Kentucky was up to more than 1.6 million people. That amounted to nearly 37% of all Kentucky residents covered by Medicaid. This growth was driven by Medicaid expansion as well as the COVID 19 pandemic (including the Families First Coronavirus Response Act, which paused Medicaid eligibility redeterminations throughout the COVID 19 public health emergency). During 2023, 38.8% of Kentuckians (1,733,465) were enrolled in Medicaid and 14.8% (663,176) were enrolled through Medicaid expansion. According to the Kentucky Department for Medicaid Services (DMS), as of February 24, 2025, 32.7% (1,463,505) Kentuckians are enrolled in Medicaid and 10.5% (470,731) are enrolled as part of Medicaid expansion.

Historically, Kentucky was in the minority of states that did not have a Medicaid benefit for substance use treatment, except for pregnant women. Since 2014, substance use treatment services have been reimbursable through Medicaid. During the same time period, additional professionals and organizations became eligible to apply for and become Medicaid providers for behavioral health services.

Today the number of behavioral health providers who are able to seek reimbursement for Medicaid payment, through the MCOs, continues to grow. As of April 2025, the following number of actively licensed providers are in Kentucky:

- 4,473 Licensed Clinical Social Workers (per the Kentucky Board of Social Work)
- 555 Licensed Marriage and Family Therapists
- 2,663 Licensed Professional Clinical Counselors
- 822 Licensed Psychologists
- 115 Licensed Professional Art Therapists
- 611 Licensed Clinical Alcohol and Drug Counselors

Department of Professional Licensing at https://oop.ky.gov/active_lic_dir.aspx

In addition, a registered peer support specialist (for SUD services) was created as a new provider type by the Kentucky Board of Alcohol and Drug Counselors. As of April 2025, there are 20 active registered alcohol and drug peer support specialists. This is in addition to numerous certified peer support specialists with lived experience in mental health and substance use disorders who are certified as providers to provide services through other various agencies.

Several new licensure categories have been created including, behavioral health services organizations (BHSO) and multi-specialty groups (MSG). As of April 2025, Kentucky has 1,276 alcohol and other drug entities (AODE) that are actively licensed to provide services. Included in that number are 204 BHSOs/MSGs as well as a few programs that provide only Driving Under the Influence (DUI) programming.

A few Medicaid services are limited in organizational categories (e.g., residential crisis units), but most services are open to all licensed professionals. A growing number of federal qualified health centers (FQHCs), rural health clinics (RHCs), and primary care providers are developing new or expanded behavioral health services. Furthermore, Kentucky has four CMHCs identified as Certified Community Behavioral Health Clinics (CCBHC), providing comprehensive quality care reimbursed through an enhanced rate based on historical costs. As of January 2026, an additional six CMHCs will join the CCBHC demonstration project. CCBHCs are required to provide the following comprehensive scope of services: crisis mental health services; screening; assessment and diagnosis; outpatient mental health and SUD services; person-centered treatment planning; primary care screening and monitoring of key health indicators; targeted case management; psychiatric rehabilitation; peer support, including family and youth; and community-based mental health care for members of the armed forces and veterans. The populations of focus for these services include individuals with SED/SMI/SUD.

In 2018 Kentucky's Section 1115 demonstration was approved. This demonstration, called TEAMKY, allows Kentucky to test and develop innovative programs utilizing evidence-based interventions that drive better health outcomes and quality of life for beneficiaries. The initial approval of this demonstration included substance use disorder (SUD) to ensure a broad continuum of care is available to citizens of Kentucky. The SUD implementation plan was approved in October of 2018 and implemented in July 2019. This supported Kentucky's expansion of access to critical levels of care and adopted the American Society of Addiction Medicine (ASAM) criteria as the standard for evidence-based treatment. In July 2024, the reentry demonstration was approved under the TEAMKY 1115 Demonstration. The reentry demonstration allows Kentucky to provide limited coverage for a targeted set

of services to incarcerated individuals in state prisons and youth development centers 60 days prior to release. The pre-release benefit package is designed to improve care transitions for individuals returning to the community by promoting continuity of coverage and proactively identifying and planning for physical, behavioral health and health-related social needs. The reentry implementation plan is pending approval.

Kentucky DMS has been collaborating with DBHDID to implement a 1915(i) state plan amendment (SPA) aimed at supporting adults with serious mental illness (SMI) and, when applicable, co-occurring substance use disorder (SUD). This SPA is designed to address the priorities outlined in Senate Joint Resolution (SJR) 72, which passed during the 2022 regular legislative session. Approved by the Centers for Medicare & Medicaid Services (CMS) in March 2025, this SPA will offer housing-related supports, supported employment and supported education, transportation, medication management, caregiver respite, assistive technology, and case management to eligible adults with SMI and co-occurring SUD.

With the many changes that have occurred in the behavioral healthcare system, and that continue to occur, the need for a significant number of new regulations has ensued.

One catalyst for new legislation and regulatory changes has been the escalation of the overdose crisis in Kentucky. According to Kentucky's Office of Drug Control Policy, the number of overdose deaths in Kentucky (2,257) peaked in 2021. In 2022, the number of reported overdose deaths decreased 2.5% from the 2021 and again by 9.8% in 2022. Please see the 2023 Drug Overdose Report uploaded as an attachment to this section of the application. According to the Office of Drug Control Policy's 2023 Overdose Fatality Report, fentanyl was identified in 79.1%, and methamphetamine was identified in 55.2% of those overdose deaths. While the COVID 19 pandemic was a contributing factor, the increased presence of highly potent synthetic fentanyl within the drug supply was a significant driver in the rise of overdoses. Synthetic fentanyl is now found in a variety of substances including heroin, pressed pills, methamphetamine, cocaine, and benzodiazepines. As such, Kentucky continues to enhance access and availability of evidence-based practices, including overdose reversal medications, medications for opioid use disorder (MOUD), harm reduction strategies, strategies that support families with a loved one suffering from addiction, and public education, awareness, and stigma reduction. Such interventions have shown to be effective at reducing risk of overdose, improving treatment retention, and increasing the likelihood of long term recovery. The Kentucky Overdose Response Effort (KORE) is housed within the Division of Substance Use Disorder at DBHDID, and with the provision of SAMHSA's State Opioid Response funding, KORE supports the implementation of high quality, evidence-based opioid and stimulant use prevention, treatment and recovery support programs and initiatives throughout the commonwealth. All age groups have been affected by this epidemic and concerted efforts to support children and youth, including substance exposed infants, and children placed in out-of-home care due to substance use, overdose, or incarceration of parents, are a top priority.

In a partnership with the University of Kentucky's Injury Prevention and Research Center (KIPRC), DBHDID launched a statewide resource portal (Find Help Now - KY). This website began with substance use disorder resources (Search Substance Use Disorder Treatment - KY | Find Help Now) and has now grown to include a portal for mental health services (FindMentalHealthNowKY.org), recovery housing programs (Find Recovery Housing Now), and naloxone distributors (Find Naloxone Now Kentucky - FINDNALOXONE).

For several years, Kentucky DBHDID has been working to strengthen a recovery-oriented system of care for individuals experiencing mental illness, substance use disorders (SUD), or co-occurring mental health and substance use disorders. DBHDID collaborates with a diverse range of organizations that include individuals with lived experience, such as adults, young adults, transition-age youth, parents, and family members, including those with SED/SMI/SUD. Key partners include:

- National Alliance on Mental Illness (NAMI) – Lexington and Louisville affiliates
- Kentucky Partnerships for Children and Families (KPFC)
- People Advocating Recovery (PAR)
- Young People in Recovery (YPR)
- Mental Health America of Kentucky (MHA-KY)
- Bridgehaven – A nationally recognized therapeutic rehabilitation program for adults with serious mental illness (SMI) in Louisville, KY, which also houses the statewide Center for Peer Excellence.

DBHDID is committed to expanding access to evidence-based services across Kentucky, ensuring that programs are developed with direct input from the individuals they serve.

Kentucky has traditionally been underfunded for community-based behavioral health services. When Direct Intervention: Vital Early Response Treatment System (DIVERTS) services were added into the continuum of care for adults with SMI, approximately seven million dollars from state psychiatric hospital budgets were reallocated to the CMHCs serving each respective hospital catchment area. This rebalancing of funds was necessary to allow the creation of Assertive Community Treatment (ACT) teams, permanent supportive housing programming, individual placement and support (IPS) employment programming, and peer support programming, in an effort to divert adults with SMI from inpatient/institutional care, at a time when there were no other payor sources for these services. As state/federal funding streams for inpatient and community-based behavioral health care change, funding for both inpatient and outpatient treatment will need to be considered.

Kentucky has worked for many years to create a responsive crisis system of care for individuals with behavioral health challenges

in need of care 24/7. DBHDID provides crisis services through contracts with the 14 CMHCs and utilizes blended funding streams to support these services. The different CMHC regions provide crisis services in a variety of ways. Some regions have crisis stabilization units for overnight care, some have 23-hour crisis beds, some have mobile crisis units that travel for outreach, and others have robust walk-in services as needed. With the effects of the pandemic, statewide behavioral health crisis services have become even more relevant. Kentucky began implementing the 988 initiative in 2019 after receiving its first federal grant to support the transition of the National Suicide Prevention Lifeline (NSPL) to 988. However, the state has been developing its statewide crisis call system for over 20 years, starting when the first five call centers joined the NSPL in 2005. When 988 went live in July of 2022, 11 of the state's CMHCs were operational in the network. As of December 2024, all 14 CMHCs now participate in that effort. Implementation of 988 and suicide prevention efforts are focused on all Kentuckians. Providers are responsible for ensuring all staff participate in relevant training to be prepared to respond with appropriate services and in ensuring that their policies and procedures ensure access to appropriate and evidence-based services for all citizens.

During a reorganization effective July of 2022, the oversight and operation of the Kentucky Community Crisis Response Team (KCCRT) was moved to the Division of Mental Health. This team provides an organized, rapid, and effective response to support survivors, first responders, volunteers, and their communities in the aftermath of a crisis event. The KCCRT is comprised of a broad array of professional personnel, including law enforcement, first responders, mental health professionals, public health workers, educators, and more. DBHDID is the designated agency responsible for applying for and managing federal behavioral health disaster funds when a disaster is declared and includes individual assistance designation. In light of Kentucky's 2021 tornado outbreak in Western Kentucky and 2022 1,000- year flooding in Eastern Kentucky, the department applied for and administered more than \$10 million in Crisis Counseling Program and Disaster Case Management funds from the Federal Emergency Management Agency in partnership with SAMHSA. In response to subsequent flooding in Eastern Kentucky in the winter of 2025, DBHDID is currently in the application process for a Crisis Counseling Program grant to support residents who have been affected by the latest round of disasters to impact the commonwealth.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Supreme Court of Kentucky

2022-42

ORDER

RE: ESTABLISHMENT OF THE KENTUCKY JUDICIAL COMMISSION ON MENTAL HEALTH

Section 1. Purpose. The Kentucky Judicial Commission on Mental Health (the Commission) is created to develop, implement, and coordinate initiatives designed to improve the courts' interaction with and the administration of justice for individuals with mental illness, substance use disorders, and intellectual disabilities. The Commission also seeks to educate the general public about accessing available court services and programs.

The Commission recognizes that improving the lives of Kentuckians who are affected by mental illness, substance use disorder, and intellectual disabilities and who are involved in the justice system requires complex, interdisciplinary education and solutions in addition to judicial leadership at the highest level. The judicial system has a profound impact on services provided to children, adults, and families of this Commonwealth, and the stakes are exceptionally high. As gatekeepers for families and individuals in crisis, courts must make life-altering decisions that require knowledge of numerous highly complex issues including, but not limited to, childhood and adult trauma, abuse, neglect, intellectual and developmental disabilities, substance use, family violence, poverty, racism, and military combat. Our courts need to be equipped with the technology, education, training, and resources to make well-informed decisions.

Many entities and individuals throughout the Commonwealth share a desire for, and commitment to, improving the services available to Kentuckians. The Commission will seek to coordinate and implement a comprehensive, interdisciplinary effort aimed at improving the administration of justice. Current impediments to this goal which the Commission seeks to overcome include, but are not limited to:

1. Overcrowded dockets that strip courts of sufficient time to thoughtfully consider the multiple issues that persons with mental illness, substance use disorders, and/or intellectual disabilities present;
2. A lack of adequate education and training in identifying and addressing the unique needs of individuals with mental illness, substance use disorders, and/or intellectual disabilities present;
3. A lack of communication, coordination, and collaboration between and among the courts, the state, and local mental health providers, law enforcement, attorneys, and mental health advocates;

4. A need for specialized, multidisciplinary, legal training, and the means to develop and share best practices;
5. A lack of technology to efficiently manage dockets and to track and analyze cases and caseloads involving mental health, substance use disorder, and/or intellectual disability challenges; and
6. A lack of community resources to provide adequate services to minors, adults, and families.

Section 2. Authority. Section 109 of the Kentucky Constitution establishes the Court of Justice, and Section 110(5)(b) vests the Chief Justice with the duty and responsibility to perform all necessary administrative functions relating to the Courts of this Commonwealth. Section 14 of the Kentucky Constitution further ensures open and speedy access to our court system.

Section 3. Membership. The Commission will consist of a minimum of twenty-five (25) members appointed by the Chief Justice and, as necessary for the work of the Commission. Said members shall serve for two year terms, subject to re-appointment. Members shall be residents of the Commonwealth of Kentucky. The composition of the Commission shall be diverse and inclusive. The Chief Justice will designate a Justice of the Supreme Court to serve on the Commission and that Justice will serve as the Chairperson of the Commission. The Chief Justice will appoint a Judge of the Court of Appeals as the Vice-Chairperson of the Commission.

The members shall include members of the judiciary, members of the juvenile, criminal, and child protection systems, legislative members, representatives of the business and legal communities, representatives of foundations or organizations with a substantial interest in mental health matters, and other state and local leaders who have demonstrated a commitment to mental health matters affecting Kentuckians.

The Chief Justice recognizes that participation by a broad spectrum of persons involved with the mental health, juvenile, criminal, and child welfare systems is critical to the Commission's success. Accordingly, the Commission is authorized to appoint non-voting, advisory members as necessary to ensure the Commission is informed by experts in multiple disciplines. Advisory members may attend Commission meetings and may serve on committees as determined by the Commission.

Section 4. Responsibilities. The Commission is charged with the following goals, purposes, and responsibilities:

1. Develop a strategic plan for strengthening courts and the administration of justice in relation to Kentucky's courts;
2. Identify and assess current and future needs for the courts to be more effective in achieving positive outcomes for Kentuckians with mental illness, substance use disorders, and intellectual disabilities;

3. Promote best practices and programs that are data-driven, evidence-based, and outcome-focused;
4. Improve collaboration and communication among courts and the mental health system stakeholders;
5. Endeavor to increase resources and funding and maximize the effective and efficient use of available judicial system resources;
6. Promote appropriate judicial training regarding mental health, substance use disorder and intellectual disabilities, systems, and services;
7. Educate the general public about accessing available court services and programs;
8. Establish a collaborative model that will continue systemic improvement within the judiciary beyond the tenure of individual Commission members;
9. Provide regular progress reports to the Supreme Court of Kentucky;

Section 5. Bylaws. The Commission shall propose bylaws and other internal regulations for approval by the Chief Justice as necessary for the performance of the Commission's duties and may form committees to assist in its work.

Section 6. Review. The Commission will submit an annual written report to the Supreme Court, subject to more frequent reporting as required by the Supreme Court or the Commission's bylaws. The Supreme Court will review and evaluate the work of the Commission on an annual basis.

This Order shall be effective upon entry and until further Order of this Court.

Entered this 11th day of August 2022.

All sitting; all concur.


CHIEF JUSTICE

Kentucky State Owned/Operated/Contracted Psychiatric Facilities

State Hospital/Location Operation	ADC* SFY 2021	ADC* SFY 2022	ADC* SFY 2023	ADC* SFY 2024
Western State Hospital/ Hopkinsville State Owned/Operated	112	116	143	143
Central State Hospital/ Louisville State Owned/Operated	46	48	52	47
Eastern State Hospital/Lexington State Owned/Contracted	111	119	136	149
Appalachian Regional Hospital (ARH) Psychiatric Center/Hazard Contracted	61	71	84	79
TOTAL	330	354	415	418

*ADC = Average Daily Census

Data Source: DBHDID Client Event Data/Report ID: FIS_ADC



Kentucky Hospitals with Licensed Psychiatric Beds for Children and Adolescents

[Baptist Health Corbin](#)

1 Trillium Way, Corbin 40701
Telephone: 606.528.1212
Beds for Children: 0
Beds for Adolescents: 11
In-Person Assessment: Available at any
Baptist Health Hospital ER

[Bourbon Community Hospital](#)

9 Linville Drive, Paris 40361
Telephone: 859.987.1139
Beds for Children: 0
Beds for Adolescents: 9
In-Person Assessment: Available
Mobile Assessment: Available for
professional referrals
Phone Assessment: Available for
professional referrals
Video Assessment: Available

[Cumberland Hall](#)

270 Walton Way, Hopkinsville 42240
Telephone: 270.518.1919
Beds for Children: 10
Beds for Adolescents: 24
In-Person Assessment: Available
Video Assessment: Available for
chemical dependency program

[Lincoln Trail Behavioral Health System](#)

3909 S. Wilson Road, Radcliff 40160
Telephone: 270.351.9444
Toll Free: 800.274.7374
Beds for Children: 5
Beds for Adolescents: 63 (22 beds are
for Willows Program, age 9-17)
In-Person Assessment: Available
Video Assessment: Available

[Norton Children's Hospital](#)

200 E. Chestnut Street, Louisville 40202
Provider Referral [Portal](#)
Provider Referral: 502.559.7337
Telephone: 502.629.6305
Beds for Children: 8
Beds for Adolescents: 12
In-Person Assessment: Available at any
Norton Hospital ER

[Rivendell Behavioral Health Hospital](#)

1035 Porter Pike, Bowling Green 42103
Telephone: 270.843.1199
Toll Free: 800.548.2621
Beds for Children: 10
Beds for Adolescents: 95
In-Person Assessment: Available
Phone Screening: Available
Video Assessment: Available for
non-emergency conditions

[RiverValley Behavioral Health Hospital](#)

1000 Industrial Drive, Owensboro 42301
Telephone: 270.689.6800
Toll Free: 800.433.7291
Beds for Children: 40
Beds for Adolescents: 40
In-Person Assessment: All hospital admissions
Mobile Assessment: Available for 7 local counties
Phone Assessment: Professional consultations available
Video Assessment: Consultations available

[SUN Behavioral Health](#)

820 Dolwick Drive, Erlanger 41018
Telephone: 859.376-5126
Beds for Children: 25
Beds for Adolescents: 50
In-Person Assessment: Available
Video Assessment: Available

[The Brook - Dupont](#)

1405 Browns Lane, Louisville 40207
Telephone: 502.896.0495
Beds for Children: 24
Beds for Adolescents: 0
In-Person Assessment: Available
Video Assessment: Available for professional referrals

[The Brook - KMI](#)

8521 LaGrange Road, Louisville 40242
Telephone: 502.426.6380
Beds for Children: 0
Beds for Adolescents: 46
In-Person Assessment: Available
Video Assessment: Available for professional referrals

[The Ridge Behavioral Health System](#)

3050 Rio Dosa Drive, Lexington 40509
Telephone: 859.269.2325
Toll Free 800.753.4673
Beds for Children: 16
Beds for Adolescents: 32
In-Person Assessment: Available
Mobile Assessment: Available for Fayette County schools
Phone Assessment: Available for professional referrals
Video Assessment: Available for professional referrals

[UKHealthCare - Kentucky Children's Hospital](#)

1000 S. Limestone, 1st Floor, Lexington 40536
Telephone: 859.323.5000
Toll Free: 800.776.2673
Provider Referral [Page](#)
Beds for Children: 7
Beds for Adolescents: 10
In-Person Assessment: Available at the Makenna David Pediatric Emergency Center at 1000 S. Limestone, 1st Floor

[UofL Healthcare – Peace Hospital](#)

2020 Newburg Road, Louisville 40205
Louisville Area: 502.451.3333
Central/Eastern KY Area: 859.313.3515
General Information: 502.451.3330
Beds for Children: 42
Beds for Adolescents: 105
In-Person Assessment: Peace Hospital, Central/Eastern KY Office, and at UofL and CHI Hospitals.
Mobile Assessment: JCPS, Bullitt County Schools, Oldham County Schools, and at Louisville UofL and CHI Hospitals

* Assessment options may change at any time due to workforce availability, policy, or resource availability. Please contact hospitals for current information.

Beds for Children (0-12 years of age) in Operation = 181

Beds for Adolescents (13-17 years of age) in Operation = 498

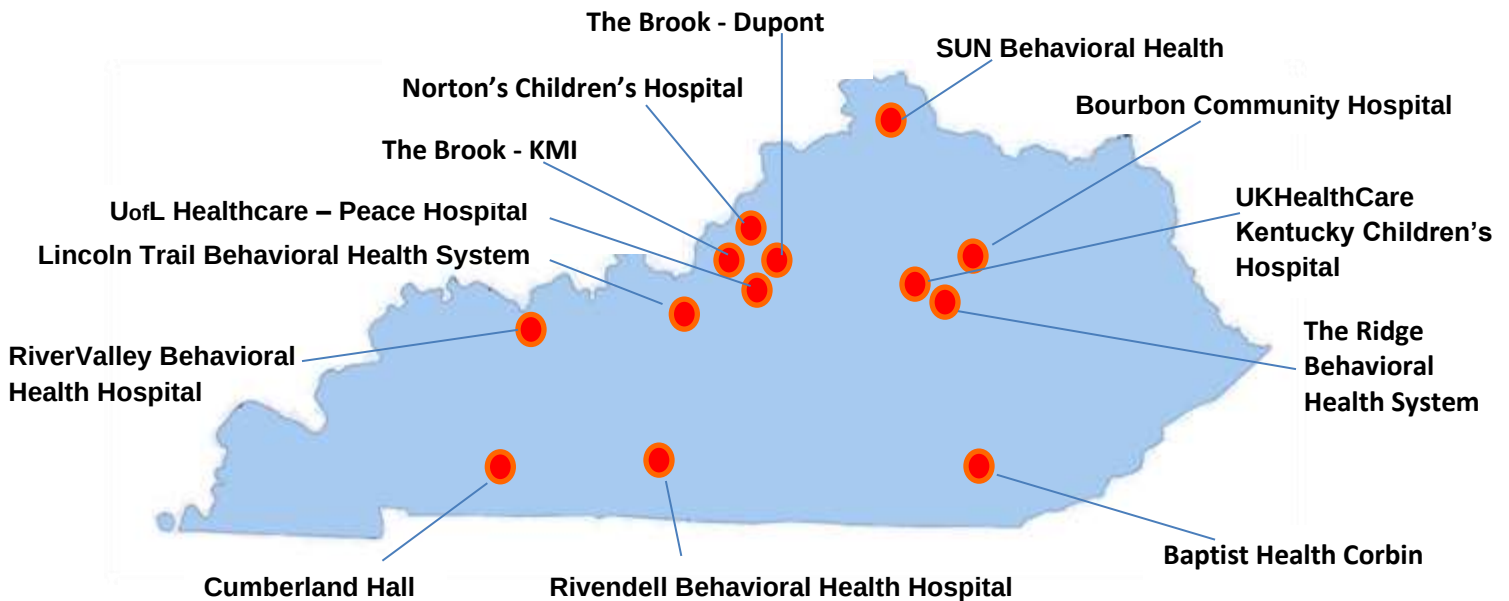
Beds for Children and Adolescents (0-17 years of age) in Operation = 679

Please send updates to Christie.Penn@ky.gov.

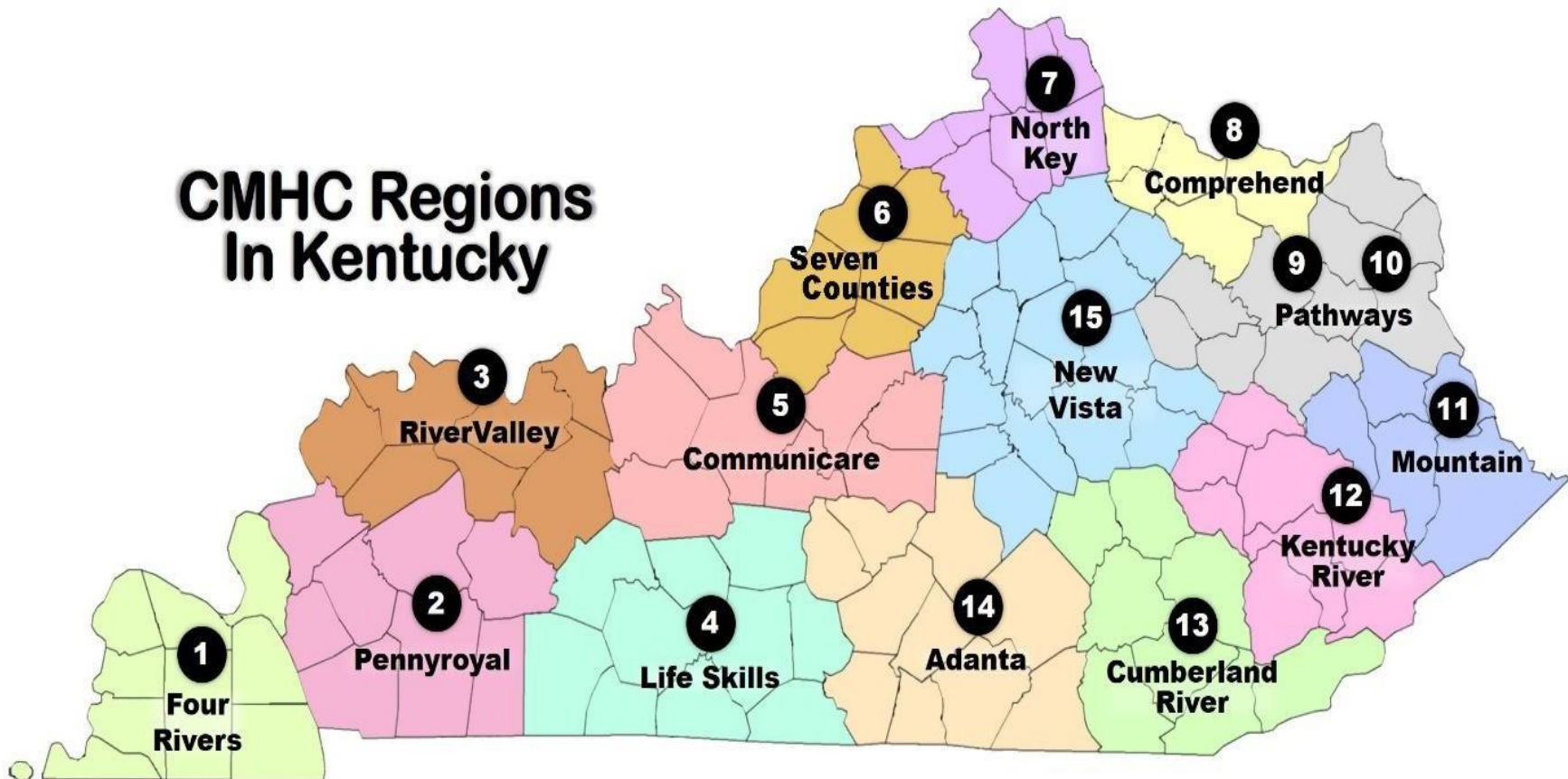
Bed data is from [2023 Kentucky Annual Hospital Utilization and Services Report: January 1 through December 31, 2023](#)

[Annual Health Care Facilities and Services Reports](#)

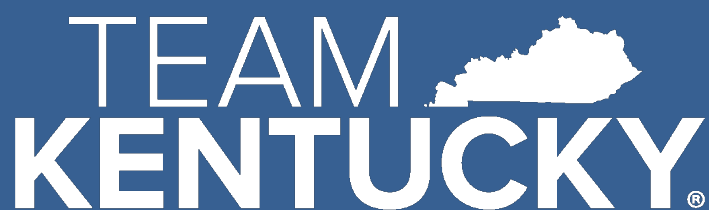
Updated 3-21-25



CMHC Regions In Kentucky



Note of Clarification: Regions 9 & 10 were originally two different boards but merged in 1982 and are now counted as one region, thus there are a total of 14 boards, but they are represented with numbers 1 - 15.



JUSTICE AND
PUBLIC SAFETY CABINET

2023 Drug Overdose Fatality Report

Keith L. Jackson, Secretary
Justice & Public Safety Cabinet

Van Ingram, Executive Director
Office of Drug Control Policy



**KENTUCKY INJURY PREVENTION
AND RESEARCH CENTER**

Prepared by

Meghan Steel (meghansteel@uky.edu)

Lara Daniels (lara.daniels@uky.edu)

Released by

Kentucky Injury Prevention and Research Center (KIPRC)

2365 Harrodsburg Road, B340

Lexington, KY 40504

as bona fide agent for the Kentucky Department for Public
Health

Prepared for

Kentucky Office of Drug Control Policy



Table of Contents

Kentucky's Progress on Addiction Recovery	1
Key Findings from 2023	4
Drug Overdose Deaths by Race	8
Drug Overdose Deaths by Age	10
Substances Found in Drug Overdose Decedent Toxicology Testing	13
Drug Combinations Identified through Toxicology	19
County-Level Maps	20
Age-Adjusted Mortality Rates by County	23
About the Annual Overdose Fatality Report:	31
Definitions	31
Data Sources	31

Disclaimers

The U.S. Centers for Disease Control and Prevention includes both the deaths of Kentucky residents and non-residents in their reporting. Kentucky's overdose report includes only the deaths of Kentucky residents, which has been the standard since the Kentucky General Assembly first required this annual report. The Kentucky Office of Drug Control Policy includes resident deaths only to better target harm reduction and prevention activities for Kentuckians.

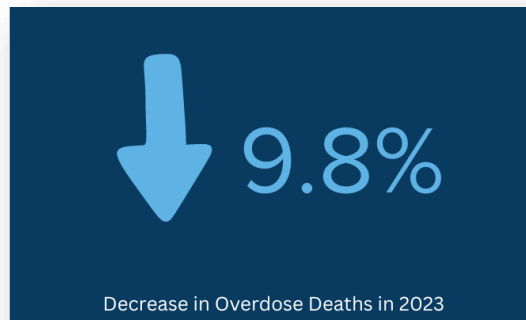
Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 are suppressed in accordance with state data management policy. Data are provisional and subject to change.

Produced by the Kentucky Injury Prevention and Research Center as bona fide agent for the Kentucky Department for Public Health, May 2024. This project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of cooperative agreement 1 NU17CE010186 totaling \$5.4 million with 0% financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC, HHS, or the U.S. government. For more information, please visit [CDC.gov](https://www.cdc.gov).

Kentucky's Progress on Addiction Recovery

For the second year in a row, the Beshear-Coleman administration has secured a decrease in drug overdose deaths.

- In 2023, there were 1,984 overdose deaths. This was a decrease of 9.8% from 2022.
- In 2022, there were 2,200 overdose deaths. This was a decrease of 2.5% from 2021 and was the first year Kentucky saw a decrease in overdose deaths since 2018.
- In 2021, there were 2,257 overdose deaths. This was a 14.5% increase from 2020 and was the highest number of overdose deaths ever reported in Kentucky.
- In 2020, there were 1,964 overdose deaths. This was a 49% increase from 2019.



According to the 2023 Kentucky Drug Overdose Fatality Report, fentanyl accounted for 79.1% and methamphetamine accounted for 55.2% of overdose deaths, which continue to be the most prevalent drugs contributing to overdoses in the state. The report also indicates that 35- to 44-year-olds had the highest number of drug overdose deaths in 2023 at 571, but this age group did mark a decrease of 13.4% from 2022.

Since taking office, the Beshear-Coleman administration has worked tirelessly to fight the drug epidemic in Kentucky by increasing treatment resources and law enforcement support. Due to these efforts, in 2023, Kentucky saw:

- 160,000 doses of Narcan distributed;
- 84 syringe exchange program sites served 35,918 unique participants;
- 96,780 overdose reversal medication kits distributed;
- 18,100 individuals provided substance-use treatment services;
- 14,630 individuals received help in accessing recovery services;
- 26 Kentuckians sought treatment through the Kentucky State Police Angel Initiative;
- 3,920 incoming calls made to the KY HELP Call Center with 14,087 outgoing follow up calls; and
- 265,170 fentanyl pills, 208.3 pounds of fentanyl, 822 pounds of methamphetamine and more than 310 pounds of cocaine seized with the support of Kentucky's Counterdrug Program.

The state has also increased the number of treatment beds by 50% since Gov. Beshear took office in 2019. The administration has also recorded the three lowest recidivism rates in over a decade.

Recently, Gov. Beshear announced a [new website](#) to support Kentuckians seeking second chances find a job, get an education or continue recovery. The site also connects business leaders with resources to help them hire second-chance talent. Additionally, the state's [Treatment Access Program](#) also allows those without health insurance to enter residential treatment, and the [Recovery Ready certification](#) helps communities support residents who are seeking help for drug or alcohol addiction.

Last year, Gov. Beshear announced a new searchable website to help people in recovery find housing, [FindRecoveryHousingNowKY.org](#).

The Governor has continued to fight the state's drug epidemic from his time as attorney general, when he led the nation in the number of individual opioid lawsuits filed by an attorney general. Now, Gov. Beshear is working to make sure the hundreds of millions of dollars in settlement funds go to treatment and the communities impacted.

- \$131,741,583 distributed in grant and pass through funding from the Office of Drug Control Policy.

As of publication of this report, Kentucky:

- Has a rate of residential treatment beds per 100,000 of 70.34. This is more than twice the rate of any of Kentucky's border states.
- Has helped 751,000 Kentuckians receive treatment in the first 10 counties to become certified Recovery Ready Communities.

TREATMENT RESOURCES

KY HELP Call Center 833-8KY-HELP

The KY HELP Call Center, created in 2017 through a partnership with Operation UNITE, remains available to those with a substance use disorder, or their friends or family members, as a quick resource for information on treatment options and open slots among treatment providers. Individuals may call 833-8KY-HELP (833-859-4357) to speak one-on-one with a specialist who will connect them with treatment as quickly as possible.

The Kentucky Injury Prevention and Research Center (KIPRC)

The Kentucky Injury Prevention and Research Center (KIPRC) at the University of Kentucky College of Public Health manages a vital website, www.findhelpnowky.org, for Kentucky health care providers, court officials, families and individuals seeking options for substance abuse treatment and recovery. It offers real-time information about available space in treatment programs, and guides users to the right type of treatment for their needs. The site provides a search engine for drug treatment, helping users locate treatment providers based on location, facility type, and category of treatment needed.

KSP Angel Initiative

The Kentucky State Police (KSP) Angel Initiative is a proactive program designed to help people battle addiction. Anyone suffering from a substance use disorder can visit one of KSP's 16 posts located throughout the commonwealth to be paired with a local officer who will assist with locating an appropriate treatment program. The Angel Initiative is completely voluntary, and individuals will not be arrested or charged with any violations if they agree to participate in treatment. For more information about the Angel Initiative, visit the KSP website at <http://kentuckystatepolice.org/angel-initiative/>.

FindRecoveryHousingNowKY.org

FindNaloxoneNowKY.org

SecondChance.ky.gov

Key Findings from 2023

In 2023, 1,984 Kentuckians lost their lives to drug overdose, a rate of 45.9 deaths per 100,000 residents. This is a 9.8% decrease from 2022. A review of the resident cases autopsied by the Kentucky Office of the State Medical Examiner and submitted by Kentucky coroners indicates that in 2023:

- A total of 496 residents of Jefferson County died from a drug overdose, a decrease from 518 resident deaths in 2022.
- The age group of 35- to 44-year-olds had the highest number of drug overdose deaths in 2023 at 571 deaths. This is a decrease of 13.4% from 659 deaths among that age group in 2022.
- In 2023, the number of drug overdose deaths increased for residents who were four years old and younger and for those between the ages of 55 and 74.
- The following data on drug types are based on identification through toxicology reports for all drug overdose deaths that occurred in Kentucky in 2023:
 - Fentanyl was found in 1,570 drug overdose deaths, representing 79.1% of the total drug overdose deaths that year and a decrease of 7.1% from the 1,690 drug overdose deaths involving fentanyl in 2022.
 - Methamphetamine was found in 1,095 drug overdose deaths, representing 55.2% of the total drug overdose deaths that year and a decrease of 6.2% from the 1,168 drug overdose deaths involving methamphetamine in 2022.
 - Cocaine was found in 427 drug overdose deaths, representing 21.5% of the total drug overdose deaths that year and an increase of 14.8% from the 372 drug overdose deaths involving cocaine in 2022.
 - Acetylfentanyl was found in 778 drug overdose deaths, representing an increase of 58.5% from the 491 drug overdose deaths involving acetylfentanyl in 2022.
 - Oxycodone was found in 154 drug overdose deaths, representing a decrease of 7.2% from the 166 drug overdose deaths involving oxycodone in 2022.
 - Heroin was found in 43 drug overdose deaths, representing a decrease of 15.7% from the 51 drug overdose deaths involving heroin in 2022.
 - Alprazolam was found in 158 drug overdose deaths, representing an increase of 1.3% from the 156 drug overdose deaths involving alprazolam in 2022.
- Among Black Kentuckians, 264 lost their lives from a drug overdose, an increase from the 259 Black resident deaths in 2022.
 - The rate of drug overdose deaths among Black residents in 2023 was 68.3 deaths per 100,000 Black residents, which was 51.8% greater than the rate of deaths among white residents and an increase from the 67.6 deaths per 100,000 Black residents in 2022. The rate for white residents in 2023 was 45 deaths per 100,000 residents, a decrease from the 51.4 deaths per 100,000 white residents in 2022.

**NOTE: The U.S. Centers for Disease Control and Prevention includes both the deaths of residents and non-residents in their reporting, this is the first time this reporting mechanism has been used in the past several years. Kentucky's overdose report includes only the deaths of Kentucky residents, which has been the standard since the Kentucky General Assembly first required this annual report. Resident deaths only are included to better target harm reduction and prevention activities for Kentuckians.*

Table 1: Kentucky Counties with the Highest Rates of Drug Overdose Deaths among Residents in 2023

	Kentucky County	Rate of Drug Overdose Deaths per 100,000 Residents	Count of Drug Overdose Deaths
1	Estill	187.3	27
2	Lee	155.9	11
3	Breathitt	150.6	18
4	Powell	121.1	16
5	Floyd	109.9	35

Counties with rates based on counts less than 10 have been excluded from this list. Data are provisional and subject to change.

Table 2: Kentucky Counties Where the Highest Counts of Drug Overdose Deaths Involving Fentanyl Occurred, as Identified through toxicology in 2023

	Kentucky County	Drug Overdose Deaths Involving Fentanyl
1	Jefferson	494
2	Fayette	160
3	Kenton	56
4	Madison	56
5	Pike	36

Counts are based on where the death occurred and not on the county of residence; thus, counts could include residents of other counties and/or states. Data are provisional and subject to change.

Table 3: Kentucky Counties Where the Highest Counts of Drug Overdose Deaths Involving Methamphetamine Occurred, as Identified through Toxicology in 2023

	Kentucky County	Drug Overdose Deaths Involving Methamphetamine
1	Jefferson	294
2	Fayette	80
3	Madison	46
4	Pike	38
5	Kenton	26

Counts are based on where the death occurred and not on the county of residence; thus, counts could include residents of other counties and/or states. Data are provisional and subject to change.

Drug Overdose Deaths by Race

Table 4: Counts of Kentucky Resident Drug Overdose Deaths by Race, 2021–2023

Race	2021	2022	2023
Black	233	259	264
White	2,005	1,903	1,692
Other	19	38	28

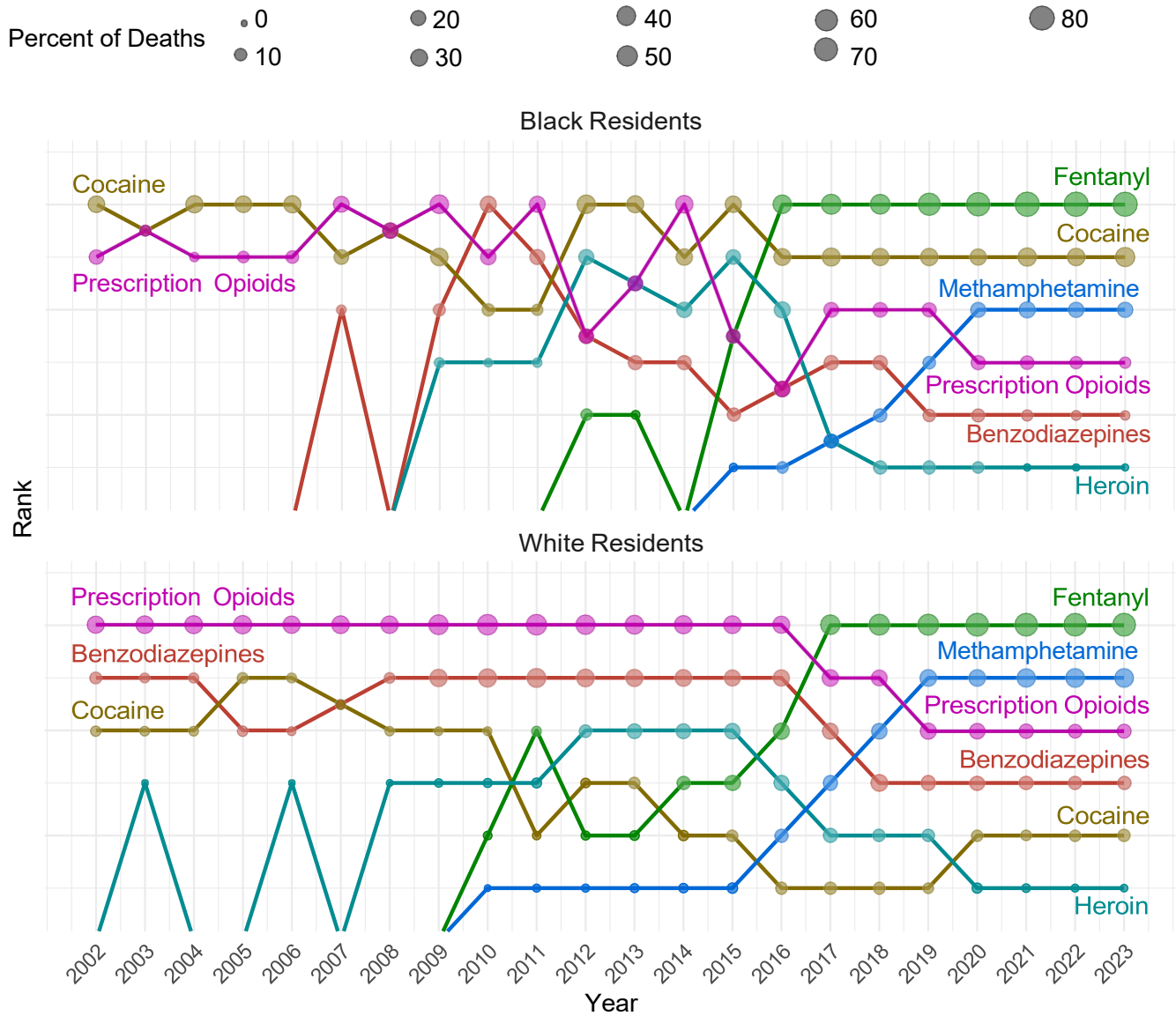
Data are provisional and subject to change.

Table 5: Age-Adjusted Rate for Kentucky Resident Drug Overdose Deaths by Race, 2021–2023

Race	2021	2022	2023
Black	60.7	67.6	68.3
White	53.9	51.4	45.0
Other	11.4	20.0	16.2

Rates are presented as the number of drug overdose deaths per 100,000 population. Data are provisional and subject to change.

Figure 1: Top Drugs Identified by ICD-10 Code on the Death Certificates of Kentucky Resident Drug Overdose Decedents by Race, 2002–2022



Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data are provisional and subject to change.
Data extracted May 2024.

Drug Overdose Deaths by Age

Table 6: Counts of Kentucky Resident Drug Overdose Deaths by Age Group, 2021–2023

Age	2021	2022	2023
0–4	<5	6	9
5–14	0	<5	<5
15–24	139	119	92
25–34	485	446	363
35–44	675	659	571
45–54	495	516	477
55–64	372	347	362
65–74	82	89	95
75–84	5	14	9
85+	<5	<5	<5

Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

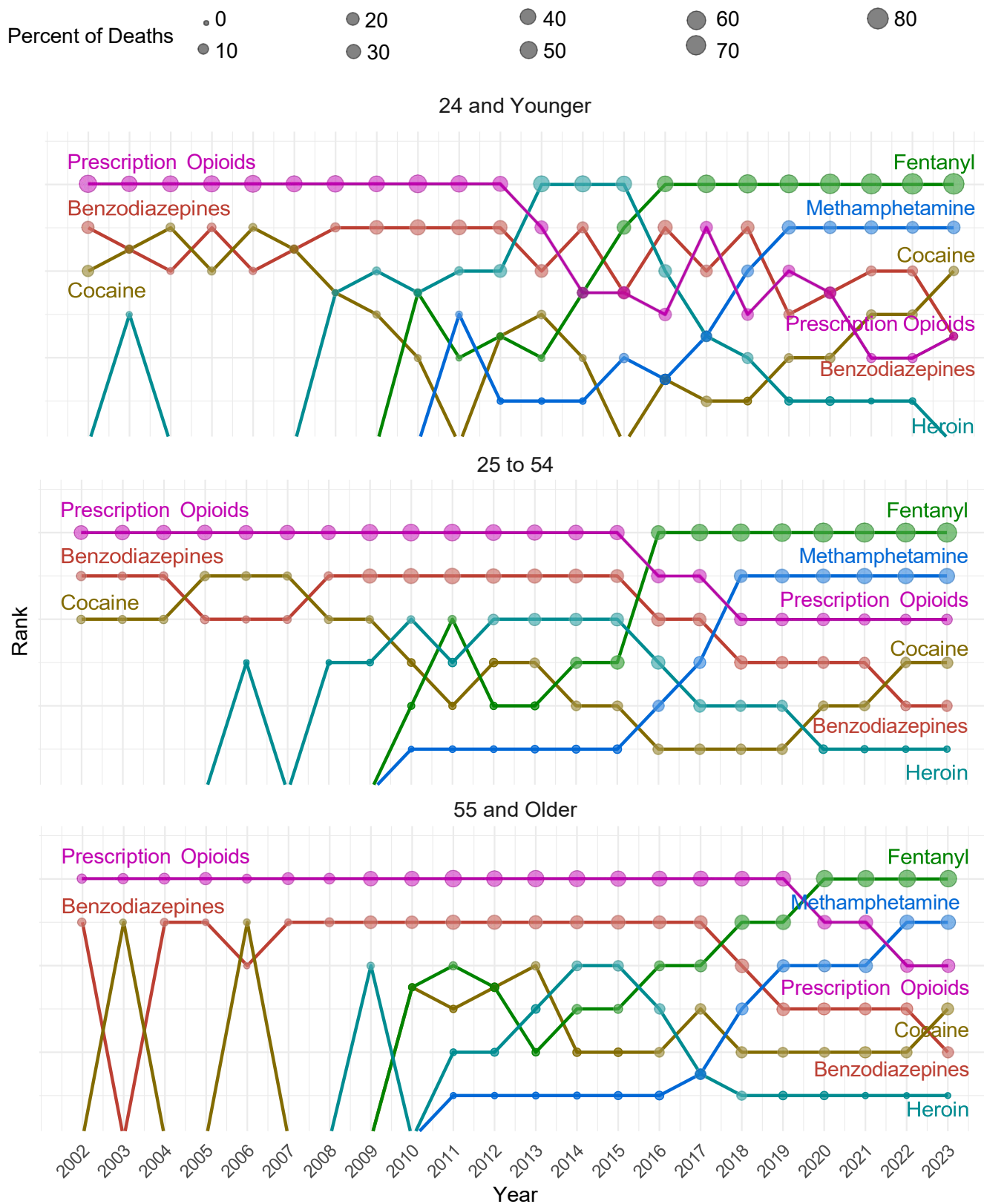
Table 7: Age-Specific Rates of Kentucky Resident Drug Overdose Deaths, 2021–2023

Age	2021	2022	2023
0–4	*	*	*
5–14	0.0	*	*
15–24	23.4	20.0	15.4
25–34	82.3	75.3	61.3
35–44	120.2	117.3	101.6
45–54	88.8	93.0	86.0
55–64	62.4	59.1	61.6
65–74	17.3	18.7	19.9
75–84	*	5.9	*
85+	*	*	*

Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

* Rates based on counts greater than zero but less than 10 have been suppressed in accordance with state data management policy.

Figure 2: Top Drugs Identified by ICD-10 Code on the Death Certificates of Kentucky Resident Drug Overdose Decedents by Age Group, 2002–2022



Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data are provisional and subject to change.
Data extracted May 2024.

Substances Found in Drug Overdose Decedent Toxicology Testing

Table 8: Counts of Substances Identified through Toxicology Testing of Drug Overdose Deaths that Occurred in Kentucky, 2023

Substance	Frequency
Fentanyl	1,570
4-ANPP	1,356
Methamphetamine	1,095
Amphetamine	848
Acetylfentanyl	778
Cocaine	427
Gabapentin	371
THC	363
Ethanol	318
Morphine	184
Alprazolam	158
Hydrocodone	155
Oxycodone	154
Clonazepam	150
Buprenorphine	98
Oxymorphone	95
Dihydrocodeine	91
Hydromorphone	89
Methadone	87
Nordiazepam	78
Oxazepam	66
Caffeine	56

Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Identified drugs are not mutually exclusive. If results are positive for more than one drug, each drug is included in its respective category counts. Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

Table 8, cont.: Counts of Substances Identified through Toxicology Testing of Drug Overdose Deaths that Occurred in Kentucky, 2023

Substance	Frequency
Diazepam	51
Temazepam	50
Heroin	43
Tramadol	42
Codeine	36
Nicotine	32
Desmetramadol	29
Delta-8 THC	27
Lorazepam	24
Carfentanil	18
Diphenhydramine	14
Naloxone	14
Acetaminophen	13
Phentermine	11
Acetone	10
Pseudoephedrine	10
Xylazine	10
Acrylfentanyl	9
Cyclobenzaprine	9
Fluoxetine	9
Quetiapine	9
Midazolam	8

Toxicology data are available only for deaths that occurred in Kentucky, (n= 2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Identified drugs are not mutually exclusive. If results are positive for more than one drug, each drug is included in its respective category counts. Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

Table 8, cont.: Counts of Substances Identified through Toxicology Testing of Drug Overdose Deaths that Occurred in Kentucky, 2023

Substance	Frequency
Trazodone	8
Amitriptyline	7
Butyrl Fentanyl	7
Hydroxyzine	7
Chlordiazepoxide	6
Dextro	6
Nortriptyline	6
Butalbital	5
Meprobamate	5
Mitragynine	5
Amiodarone	<5
Amlodipine	<5
Duloxetine	<5
Methanol	<5
Olanzapine	<5
Phenylpropanolamine	<5
Salicylates	<5
Venlafaxine	<5
Chlorophenylpiperazine	<5
Citalopram	<5
Desvenlafaxine	<5
Dextrorphan	<5

Toxicology data are available only for deaths that occurred in Kentucky, (n= 2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Identified drugs are not mutually exclusive. If results are positive for more than one drug, each drug is included in its respective category counts. Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

Table 8, cont.: Counts of Substances Identified through Toxicology Testing of Drug Overdose Deaths that Occurred in Kentucky, 2023

Substance	Frequency
Doxepin	<5
MDA	<5
Metoprolol	<5
Mirtazapine	<5
Phenobarbital	<5
Sertraline	<5
Aripiprazole	<5
Atenolol	<5
Brompheniramine	<5
Bupropion	<5
Carisoprodol	<5
Doxylamine	<5
Flurazepam	<5
Isopropanol	<5
Lamotrigine	<5
MDMA	<5
Methylphenidate	<5
Nordoxepin	<5
Norsertraline	<5
Para-Fluorofentanyl	<5
Pentobarbital	<5
Topiramate	<5

Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Identified drugs are not mutually exclusive. If results are positive for more than one drug, each drug is included in its respective category counts. Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

Table 8, cont.: Counts of Substances Identified through Toxicology Testing of Drug Overdose Deaths that Occurred in Kentucky, 2023

Substance	Frequency
Zolpidem	<5
1,1-Difluoroethane	<5
6-Beta-Naltrexol	<5
Alcohol (Serum)	<5
Benztropine	<5
Bromazolam	<5
Chlorpheniramine	<5
Clonidine	<5
Dicyclomine	<5
Diltiazem	<5
Ephedrine	<5
Etizolam	<5
Etomidate	<5
Furosemide	<5
GHB	<5
Haloperidol	<5
Ibuprofen	<5
Labetalol	<5
Lidocaine	<5
MCP	<5
MDMB-Fubinaca	<5
Methocarbamol	<5

Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Identified drugs are not mutually exclusive. If results are positive for more than one drug, each drug is included in its respective category counts. Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

Table 8, cont.: Counts of Substances Identified through Toxicology Testing of Drug Overdose Deaths that Occurred in Kentucky, 2023

Substance	Frequency
Nabumetone	<5
Naproxen	<5
Phencyclidine	<5
Phenytoin	<5
Pregabalin	<5
Promethazine	<5
Propranolol	<5
Pyrilamine	<5
Risperidone	<5
Tianeptine	<5
Trihexyphenidyl	<5

Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Identified drugs are not mutually exclusive. If results are positive for more than one drug, each drug is included in its respective category counts. Counts greater than zero but less than five were suppressed in accordance with state data release policy. Data are provisional and subject to change.

Drug Combinations Identified through Toxicology

Table 9: Most Common Two-Drug Combinations Identified through Toxicology for all Drug Overdose Deaths that Occurred in Kentucky, 2023

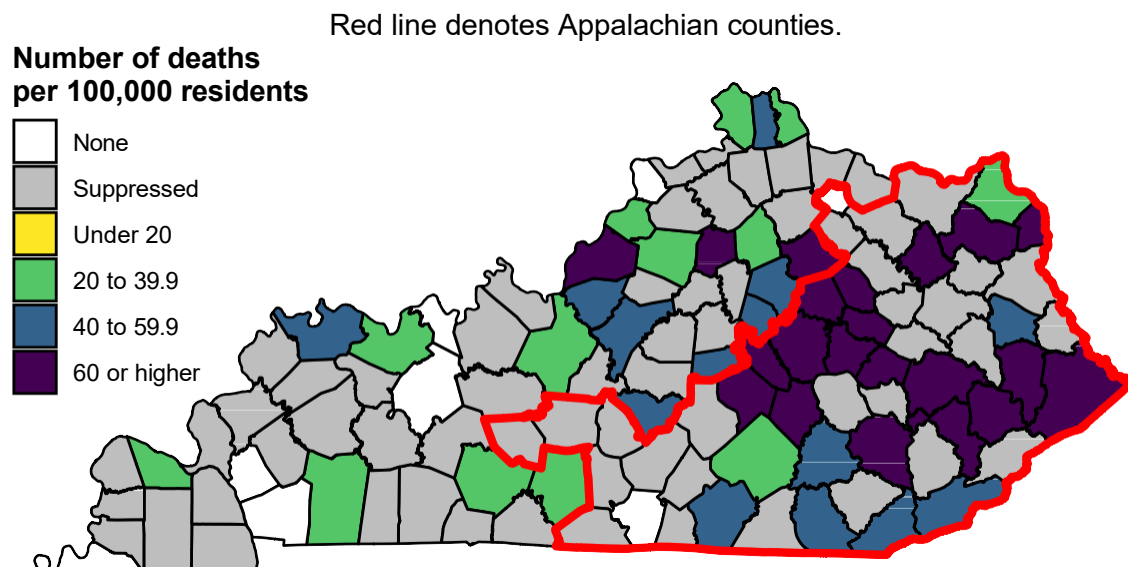
Drug Combination	Total Count of Deaths	Black Decedents*	White Decedents*
4-ANPP, Fentanyl	1,347	201 (72.3%)	1,121 (62.8%)
Fentanyl, Methamphetamine	840	91 (32.7%)	735 (41.2%)
Amphetamine, Methamphetamine	826	67 (24.1%)	743 (41.6%)
Acetylfentanyl, Fentanyl	773	103 (37.1%)	658 (36.8%)
4-ANPP, Acetylfentanyl	771	102 (36.7%)	657 (36.8%)
4-ANPP, Methamphetamine	718	79 (28.4%)	626 (35.1%)
Amphetamine, Fentanyl	652	65 (23.4%)	573 (32.1%)
4-ANPP, Amphetamine	565	58 (20.9%)	495 (27.7%)
Acetylfentanyl, Methamphetamine	419	39 (14%)	374 (20.9%)
Cocaine, Fentanyl	367	135 (48.6%)	224 (12.5%)
Acetylfentanyl, Amphetamine	334	27 (9.7%)	301 (16.9%)
4-ANPP, Cocaine	316	115 (41.4%)	193 (10.8%)
Fentanyl, THC	284	50 (18%)	229 (12.8%)
4-ANPP, THC	245	43 (15.5%)	198 (11.1%)
Ethanol, Fentanyl	231	63 (22.7%)	161 (9%)
Fentanyl, Gabapentin	229	9 (3.2%)	220 (12.3%)
4-ANPP, Gabapentin	204	7 (2.5%)	197 (11%)
Methamphetamine, THC	189	22 (7.9%)	164 (9.2%)
Acetylfentanyl, Cocaine	175	57 (20.5%)	113 (6.3%)
Cocaine, Methamphetamine	172	52 (18.7%)	115 (6.4%)

* Count (% of deaths with available toxicology)

These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Drug combinations are not mutually exclusive. If results are positive for more than one included combination of drugs, each combination is included in their respective category counts. Data are provisional and subject to change.

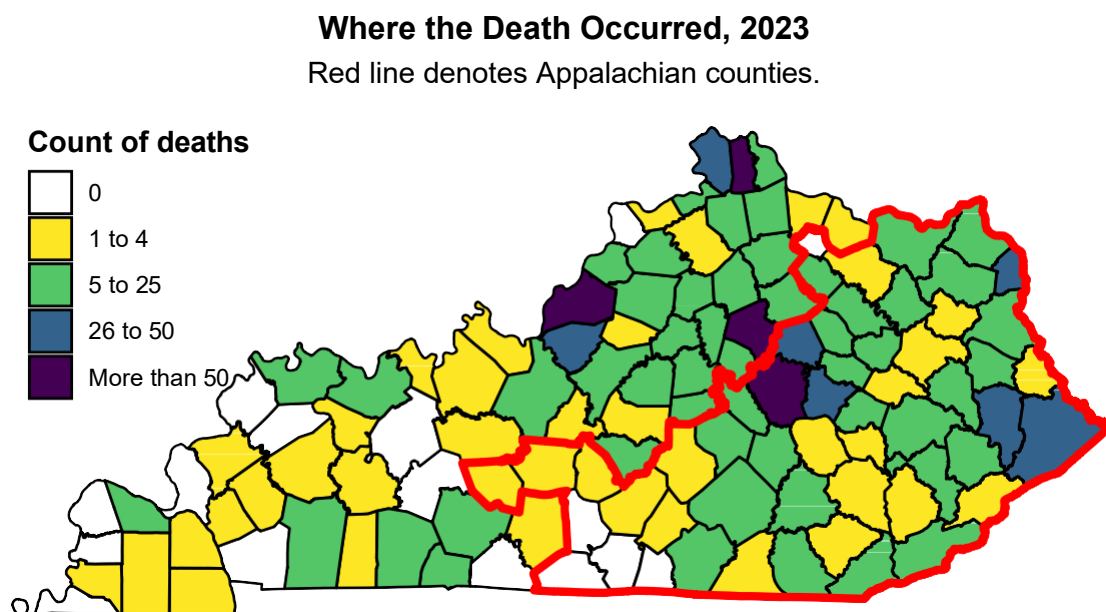
County-Level Maps

Figure 3: Age-Adjusted Rates of Drug Overdose Deaths by Kentucky County of Residence, 2023



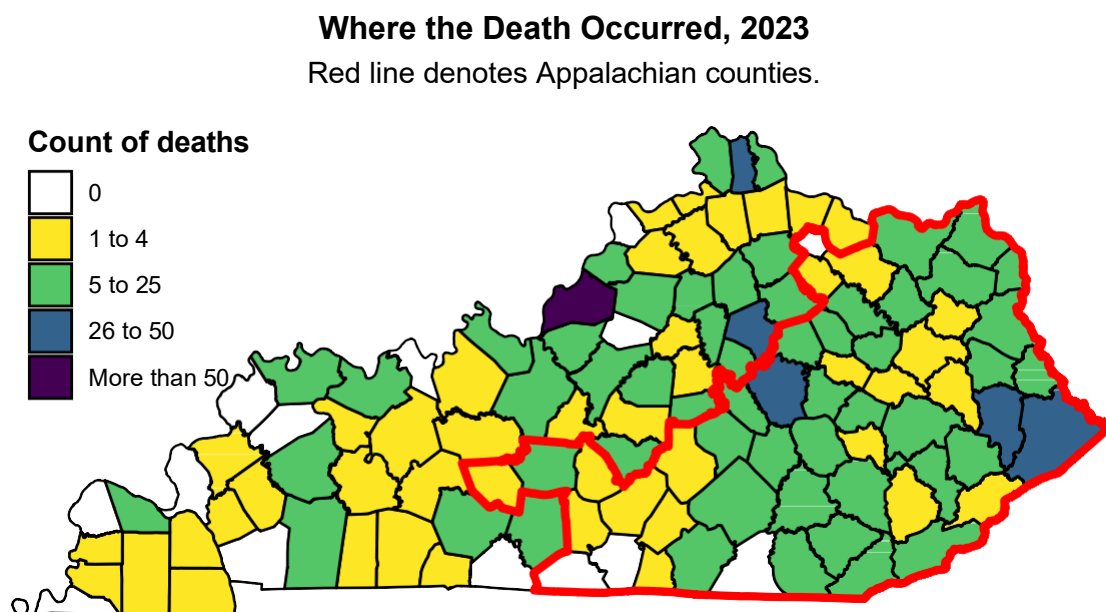
Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Kentucky Death Certificate Database, Kentucky Office of Vital Statistics, Cabinet for Health and Family Services. May 2024.

Figure 4: Count of Drug Overdose Deaths Involving Fentanyl, as Identified through Toxicology, by the Kentucky County



Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Drug Overdose Fatality Surveillance System (DOFSS). May 2024.

Figure 5: Count of Drug Overdose Deaths involving Methamphetamine, as Identified through Toxicology, by the Kentucky County



Toxicology data are available only for deaths that occurred in Kentucky, (n=2,097). These deaths may include some non-Kentucky residents and will exclude Kentucky residents who died in other states. Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Drug Overdose Fatality Surveillance System (DOFSS). May 2024.

Age-Adjusted Mortality Rates by County

Table 10: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Adair	<5	Suppressed
Allen	<5	Suppressed
Anderson	8	Suppressed
Ballard	<5	Suppressed
Barren	10	23.8
Bath	9	Suppressed
Bell	12	50.7
Boone	35	26.1
Bourbon	15	85.9
Boyd	42	94.2
Boyle	17	56.8
Bracken	<5	Suppressed
Breathitt	18	150.6
Breckinridge	6	Suppressed
Bullitt	40	51.6
Butler	<5	Suppressed

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table 10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Caldwell	<5	Suppressed
Calloway	<5	Suppressed
Campbell	26	28.7
Carlisle	<5	Suppressed
Carroll	<5	Suppressed
Carter	21	90.4
Casey	<5	Suppressed
Christian	14	23.5
Clark	26	72.9
Clay	16	68.9
Clinton	<5	Suppressed
Crittenden	<5	Suppressed
Cumberland	0	0.0
Daviess	22	22.5
Edmonson	<5	Suppressed
Elliott	<5	Suppressed

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table 10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Estill	27	187.3
Fayette	136	43.8
Fleming	<5	Suppressed
Floyd	35	109.9
Franklin	34	61.9
Fulton	0	0.0
Gallatin	7	Suppressed
Garrard	11	61.9
Grant	8	Suppressed
Graves	<5	Suppressed
Grayson	<5	Suppressed
Green	<5	Suppressed
Greenup	14	39.3
Hancock	0	0.0
Hardin	38	35.7
Harlan	13	57.3

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table 10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Harrison	5	Suppressed
Hart	7	Suppressed
Henderson	18	44.3
Henry	6	Suppressed
Hickman	<5	Suppressed
Hopkins	<5	Suppressed
Jackson	5	Suppressed
Jefferson	496	66.3
Jessamine	28	56.2
Johnson	12	59.3
Kenton	80	45.3
Knott	13	100.0
Knox	<5	Suppressed
Larue	5	Suppressed
Laurel	33	54.0
Lawrence	7	Suppressed

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table 10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Lee	11	155.9
Leslie	<5	Suppressed
Letcher	5	Suppressed
Lewis	9	Suppressed
Lincoln	17	76.4
Livingston	<5	Suppressed
Logan	7	Suppressed
Lyon	0	0.0
Madison	63	72.1
Magoffin	8	Suppressed
Marion	6	Suppressed
Marshall	<5	Suppressed
Martin	8	Suppressed
Mason	<5	Suppressed
McCracken	14	20.7
McCreary	<5	Suppressed

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table 10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
McLean	<5	Suppressed
Meade	6	Suppressed
Menifee	8	Suppressed
Mercer	6	Suppressed
Metcalfe	<5	Suppressed
Monroe	<5	Suppressed
Montgomery	18	62.8
Morgan	7	Suppressed
Muhlenberg	7	Suppressed
Nelson	20	44.6
Nicholas	<5	Suppressed
Ohio	0	0.0
Oldham	17	24.7
Owen	<5	Suppressed
Owsley	5	Suppressed
Pendleton	7	Suppressed

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table 10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Perry	24	93.3
Pike	40	74.5
Powell	16	121.1
Pulaski	21	35.6
Robertson	0	0.0
Rockcastle	15	91.8
Rowan	20	94.9
Russell	6	Suppressed
Scott	17	28.3
Shelby	12	24.0
Simpson	8	Suppressed
Spencer	<5	Suppressed
Taylor	13	50.1
Todd	<5	Suppressed
Trigg	0	0.0
Trimble	0	0.0

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

Table10, cont.: Counts of Drug Overdose Deaths and Age-Adjusted Drug Overdose Mortality Rates, by Kentucky County of Residence, 2023

County	Count of Drug Overdoses	Age-Adjusted Drug Overdose Mortality Rate
Kentucky	1,984	45.9
Union	<5	Suppressed
Warren	29	23.1
Washington	7	Suppressed
Wayne	10	59.8
Webster	<5	Suppressed
Whitley	19	59.3
Wolfe	6	Suppressed
Woodford	9	Suppressed

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 were suppressed in accordance with state data release policy. Rates based on counts less than 20 are unstable and should be interpreted with caution. Data are provisional and subject to change.

About the Annual Overdose Fatality Report:

House Bill 1, from the 2012 Special Session, mandates that the Office of Drug Control Policy, in cooperation with the Office of the State Medical Examiner, prepare and publish an annual report for the Secretary of the Justice and Public Safety Cabinet that includes:

1. The number of drug-related deaths;
2. The decedent's age, race, and gender, but not their last name or address;
3. The counties in which those deaths occurred;
4. The scientific, trade, or generic names of the drugs involved; and
5. The method by which the drugs were obtained, when available.

The report is compiled utilizing data from OSME, KIPRC and the Kentucky Office of Vital Statistics. KIPRC, with support from the CDC, launched the **Drug Overdose Technical Assistance Core (DOTAC)** to support local health departments, community coalitions, and state and local agencies in their efforts to address substance misuse, abuse, and overdose. DOTAC's goal is to support and enhance local agencies' and community organizations' access to timely local data and analytical results on controlled substance prescribing, drug-related morbidity, and mortality trends. More information on the available data, analytical and community services is available at <https://kiprc.uky.edu/injury-focus-areas/drug-overdose-prevention>.

Definitions

Drug overdose deaths include events with an underlying cause of death code of X40–X44, X60–X64, X85, or Y10–Y14. Drug overdose deaths involving specific drug types are from toxicology testing of blood, urine, and/or vitreous fluids.

Data Sources

Drug overdose deaths were from the Kentucky Death Certificate Database, Kentucky Office of Vital Statistics, Kentucky Cabinet for Health and Family Services.

Toxicology testing results were accessed through the Drug Overdose Fatality Surveillance System, which utilizes post-mortem toxicology reports, coroner investigations, medical examiner autopsy reports, and data from the Kentucky All-Schedule Prescription Electronic Reporting records paired with death certificate data.

Disclaimers

The U.S. Centers for Disease Control and Prevention includes both the deaths of Kentucky residents and non-residents in their reporting. Kentucky's overdose report includes only the deaths of Kentucky residents, which has been the standard since the Kentucky General Assembly first required this annual report. The Kentucky Office of Drug Control Policy includes resident deaths only to better target harm reduction and prevention activities for Kentuckians.

Counts greater than zero but less than five and rates based on counts greater than zero but less than 10 are suppressed in accordance with state data management policy. Data are provisional and subject to change.

Produced by the Kentucky Injury Prevention and Research Center as bona fide agent for the Kentucky Department for Public Health, May 2024. This project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of cooperative agreement 1 NU17CE010186 totaling \$5.4 million with 0% financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC, HHS, or the U.S. government. For more information, please visit [CDC.gov](https://www.cdc.gov).

Special thanks to the following agencies for their contribution to the 2023 Kentucky Overdose Fatality Report: University of Kentucky College of Public Health, the Kentucky Injury Prevention and Research Center, and the Kentucky Department of Public Health.



Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your state's needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the [National Survey on Drug Use and Health \(NSDUH\)](#), [Treatment Episode Data Set \(TEDS\)](#), [National Substance Use and Mental Health Services Survey \(N-SUMHSS\)](#), the [Behavioral Health Barometer](#), [Behavioral Risk Factor Surveillance System \(BRFSS\)](#), [Youth Risk Behavior Surveillance System \(YRBSS\)](#), the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

To identify unmet needs and critical gaps in Kentucky's publicly funded behavioral health system, the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) conducts ongoing, data-informed, and partner-engaged needs assessments. This includes qualitative and quantitative data, incorporating community and provider perspectives to ensure relevance to the local context.

Kentucky's coordinated assessment activities include:

- Utilization of performance and contract data from CMHCs and other contracted providers/entities
- Provider feedback collected through statewide technical assistance calls and branch-led regional meetings (e.g., SUD Services Directors meetings; Children's Services Directors meetings)
- Consumer input from projects like the Statewide Housing Survey and Peer Listening Sessions
- Community-level primary prevention assessments
- Findings from the Kentucky Incentives for Prevention (KIP) Surveys
- Landscape analyses conducted through State Opioid Response, Partnership for Success, 988 implementation, Zero Suicide, Garrett Lee Smith Suicide Prevention, and workforce initiatives
- Behavioral health workforce surveys conducted in partnership with the Kentucky Injury Prevention and Research Center (KIPRC)
- Implementation process measures and qualitative data
- Analysis of Medicaid and CMHC data
- Support from federal partners including the National Council, JBS International, SSI/SSDI Outreach, Access, and Recovery (SOAR),

Kentucky also leverages the State Epidemiological and Outcomes Workgroup (SEOW) and integrates feedback from service participants such as adults and youth with behavioral health disorders, persons with disabilities, and military-connected families. Intersectional analyses—such as identifying the overlap between suicide, self-harm, and substance use—has deepened understanding of risk and service gaps.

The Kentucky Behavioral Health Planning and Advisory Council (BHPAC) consisting of 20 membership slots for individuals with lived experience from across the state as well as statewide advocacy organizations and relevant state department representation, also provides feedback regarding service gaps and challenges.

The Kentucky Behavioral Health Planning and Advisory Council (BHPAC) identified the following gaps and priorities during the April 2025 Finance and Data Committee meeting and then with further input of the full Council at the May 2025 quarterly meeting:

- Housing services;
- Support, mentoring and continuing education for peer support specialists (PSS), including support to become certified and information about Medicaid billing for the evidence-based practice of peer support;
- Transportation services;
- Reentry services/transition support specific to young people with behavioral health issues leaving prison/jails;
- Behavioral health services for people without insurance/Medicaid or for the Medicaid expansion population that may lose benefits;
- Crisis stabilization services for individuals with SMI and co-occurring SUD;
- Creating paths of career sustainability/upward mobility for employed PSS;
- Services for youth with high acuity needs;
- Reentry services/transition support for individuals with behavioral health disorders leaving local jails;
- Telehealth behavioral health services;
- More options for mental health civil commitment evaluations for the Louisville area;
- Curriculum/training regarding life skills for individuals with behavioral health disorders;
- Support for Consumer Operated Services Programs as evidence-based peer support service;
- Trauma-informed care training; and
- Neurodivergent-inclusive training.

Additional overarching DBHDID gaps identified include:

- Limited access to higher levels of care (e.g., adolescent residential, adult partial hospitalization, intensive outpatient)
- Behavioral health provider shortages, particularly in rural and frontier counties
- Increased mental health and substance use concerns among youth, exacerbated by the pandemic, with elevated rates of suicidal ideation, vaping, and co-occurring diagnoses
- Underutilization of evidence-based services with fidelity to the implementation model like supportive housing, supported employment and supported education
- Challenges with some reimbursement mechanisms (e.g., Early and Periodic Screening, Diagnosis, and Treatment), leading to utilization barriers
- Lack of culturally responsive providers and services for historically underserved groups
- Insufficient housing supports for individuals with SMI, SUD, transitioning from incarceration, or living with co-occurring disorders
- Fragmented reentry supports, with few behavioral health connections for adults exiting carceral settings
- Limited crisis services in some counties despite 988 and mobile crisis expansion

Kentucky continues to align federal and state resources to address these challenges. Strategic infrastructure supported by MHBG and SUPTRS Block Grants includes:

- Implementation of the 1115 Reentry Demonstration, expanding Medicaid access to justice-involved individuals pre-release
- Rollout of the 1915(i) SPA for adults with SMI and/or co-occurring SUD, offering new Medicaid-billable services
- Use of MHBG to build a statewide forensic coordinator network to broadly coordinate reentry for individuals with mental health issues
- Community readiness work for crisis response and stabilization services
- Cross-agency alignment with the Kentucky Olmstead Plan, prioritizing integrated care, housing, and employment.

These actions are embedded in DBHDID's SFY 24-25 Strategic Agenda, which focuses on six domains: equity, quality, workforce, financing, trauma/resilience, and system navigation.

Findings from these sources drive DBHDID's funding strategies, legislative recommendations, provider guidance, and ongoing system transformation efforts. The state remains committed to advancing equity, improving access, and ensuring high-quality care across its behavioral health continuum.

Data Sources:

National Survey on Drug Use and Health (NSDUH)

Treatment Episode Data Set (TEDS)

National Substance Use and Mental Health Services Survey (N-SUMHSS)
Youth Risk Behavior Surveillance System (YRBSS)
Behavioral Risk Factor Surveillance System (BRFSS)
Medicaid and CMHC encounter data
Kentucky specific workforce studies (e.g., KIPRC; KY TRAIN)
Reports from the State Epidemiological and Outcomes Workgroup (SEOW)

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

The following provides required prevalence data and unmet needs and critical services gaps for each of SAMHSA's identified priority populations. Kentucky includes Service Members, Veterans and Family Members (SMVF) as an additional priority population. Please note that additional detail about these priority populations can be found in other areas of this application as required in block grant application instructions, particularly in the Environmental Factors and Plan federal criterion for both block grants (Environmental Factors numbered 2, 5, 6, 7 and 9). Also please note that the data sources utilized for all priority population prevalence data and unmet needs and gaps can be found as an attachment uploaded to this section of the application. Additional attachments uploaded to this section of the application include data charts, state maps, and other supporting documentation.

Adults with SMI

Prevalence Data for this population:

Kentucky's Community Mental Health Centers (CMHCs) use the state's 2.6% SMI prevalence estimate, derived from U.S. Census 2020 data, as a baseline to inform service planning, identify unmet needs, and guide regional resource allocation. This awareness allows CMHCs to compare local service delivery data against estimated need and adjust outreach, staffing, and service priorities accordingly.

In addition to prevalence modeling, CMHCs actively engage with local communities, consumer and family advocacy groups, and the Behavioral Health Planning and Advisory Council (BHPAC). These partners provide real-time insights on service gaps, population-level trends, and emerging needs that may not be captured through traditional utilization data alone. This feedback loop is essential for shaping responsive, community-driven mental health services.

Kentucky's statutory definition of Serious Mental Illness (SMI) is aligned with the federal Serious and Persistent Mental Illness (SPMI) definition. The following data represent the adult population in Kentucky and the estimated number of adults with a serious mental illness (SMI), as well as the percentage of adults served.

Adult Population in Kentucky. Census (2020) – 3,045,985

Estimated Number of Adults with SMI (2.6% of Kentucky's adult population) – 79,196

Kentucky SMI Adults Served by CMHCs in SFY 2024 – 42,986 or 54.28% (of the 2.6% estimated SMI population)

Trend data shows that the CMHCs served slightly fewer adults with SMI in SFY 2024 compared to SFY 2022 (44,178 or 55.78%). While the overall percentage remains relatively consistent, this means that an estimated 45% of adults with SMI statewide remain unserved through the CMHC system. This gap underscores the need for continued system improvements in outreach, engagement, and service accessibility. CMHCs report ongoing efforts to expand telehealth, strengthen mobile outreach, and develop alternative care models — particularly in rural and underserved areas — to reach individuals not currently connected to care. However, formal evaluation of these efforts is still in development, and unmet needs remain a central priority in Kentucky's behavioral health planning and capacity-building strategies.

Unmet Needs and Critical Service Gaps:

Several unmet needs persist for individuals with SMI living in Kentucky. Housing needs remain paramount and multi-faceted, especially in rural areas. Additionally, there remains a significant demand for various levels of community-based residential support and crisis stabilization services. There is a persistent shortage of safe, affordable housing for individuals with SMI, particularly in rural areas, alongside an unmet need for multiple levels of community housing support.

Kentucky owns/operates four state psychiatric hospitals across the state. There are also many personal care homes in the state, with eligibility criteria that are less stringent than those for nursing home level of care but more restrictive than those for community housing. An additional level of community residential housing care was created for individuals with SMI who did not require a personal care home level of care but needed more intensive supports and supervision to live in the community. This level of housing allows up to three adults with SMI to have their own space in a community house or apartment, with 24/7 staffed supervision and access to behavioral health services available around the clock. There remains limited availability of community

residential support services to assist individuals with SMI who have complex and intensive service needs. In addition, although CMHCs are required to have housing specialists and provide supportive housing services, the needs continue to outweigh the amount of available support. DBHDID also contracts with additional housing providers for adults with SMI in the most populated areas. In addition, utilization of available crisis stabilization units and other crisis support services needs to be enhanced as a potential diversion from psychiatric hospitalization.

The Cabinet for Health and Family Services (CHFS) has been involved in a Settlement Agreement with Kentucky Protection and Advocacy since 2013, focusing on transitioning adults with SMI living in personal care homes to communities of their choice. As a result of this agreement, additional funding enhanced the community-based continuum of care for adults with SMI, adding services such as Assertive Community Treatment (ACT), Individual Placement and Support (IPS), Supported Employment, Permanent Supportive Housing, and Peer Support. Every CMHC, which is the safety net provider for this population, has at least one ACT team and can provide each of these evidence-based practices to those individuals with SMI in their communities. Although each CMHC offers this service, it is not always available in all counties within a region.

Peer Support

In SFY 2024, 42,986 adults with SMI received services through CMHCs, yet only 8.86% received adult peer support. While this reflects a steady upward trend from 7.54% in SFY 2022, overall penetration remains limited, given the scope of need. This growth corresponds with targeted investments in peer workforce expansion, certification infrastructure, and regional technical assistance, but persistent service gaps remain, especially in rural and under-resourced regions. These data demonstrate that access to evidence-based peer support services remains below optimal levels.

Table 1, in the attached document uploaded to this section of the application outlines CMHC service data for the number of adults with SMI receiving Adult Peer Support services per fiscal year.

In addition to individual peer support, 1,635 adults with SMI participated in group peer support in SFY 2024 (compared to 1,295 in SFY 2023 and 1,340 in SFY 2022). These figures suggest ongoing value and utilization of peer-led group models. However, group services are not available across all CMHC regions and are not a replacement for individualized recovery engagement.

Parent and family peer support services remain highly limited, with only 150 individuals with SMI receiving this service statewide in SFY 2024. The availability of family-focused peer roles varies significantly by region, with many areas lacking a sustainable infrastructure to support these services. This gap is especially concerning given the growing needs of caregivers supporting adults with SMI, including young adults transitioning out of child-serving systems. Additionally, during the same time period, 55 individuals with SMI received youth peer support services. It appears that some young adults are being identified earlier as meeting criteria for SMI. As Early Serious Mental Illness (ESMI) programming, such as treatment for First Episode Psychosis (FEP), becomes more fully implemented in Kentucky, more individuals will be identified sooner in their progression of illness and receive the peer support that is most appropriate for their developmental level.

These data points underscore the ongoing need for the expansion of both adult, family, and youth peer support services to ensure equitable access to recovery-oriented care statewide.

IPS Supported Employment

Table 2, in the attached document uploaded to this section of the application outlines CMHC service data for the number of adults with SMI receiving IPS Supported Employment services per fiscal year.

Access to IPS Supported Employment services remains critically limited for adults with Serious Mental Illness (SMI) in Kentucky. In SFY 2024, only 536 individuals with SMI received Supported Employment services through CMHCs, representing just 1.13% of the adults with SMI who received services that year. This reflects only a modest increase from SFY 2022 and SFY 2023, during which 480 individuals (approximately 0.99% each year) accessed these services.

Despite every CMHC offering Supported Employment as an evidence-based practice under the IPS model, implementation challenges persist. Barriers include limited availability of trained staff, difficulty sustaining fidelity to the IPS model, and the lack of embedded employment specialists in many rural and frontier counties. Additionally, inconsistent coordination with the Office of Vocational Rehabilitation, transportation challenges, and employer stigma continue to hinder workforce participation for individuals with SMI.

The ongoing shortfall in service access highlights a significant unmet need and a lost opportunity to support recovery, independence, and community inclusion through competitive, integrated employment. To close this gap, targeted investment in IPS workforce expansion, cross-system collaboration, and rural service adaptation strategies is urgently needed.

Targeted Case Management

Table 3, in the attached document uploaded to this section of the application outlines CMHC service data for the number of adults with SMI receiving targeted case management services per fiscal year.

Access to Targeted Case Management (TCM) services for adults with SMI has fluctuated significantly over the past three fiscal years, with a sharp decline of over 40% in SFY 2023 compared to SFY 2022. Although the number of individuals served partially

rebounded in SFY 2024, access remains well below previous levels, highlighting persistent structural vulnerabilities in the TCM system.

This volatility appears to be tied to a sudden loss of workforce capacity, as many experienced case managers have exited the CMHC system for higher-paying roles in education, health systems, and even non-health sectors. Providers report that economic pressures, limited career advancement opportunities, and post-pandemic burnout contributed to elevated turnover across the state. The challenges inhibiting CMHCs in offering more competitive wages have significantly impacted their ability to recruit and retain qualified TCM staff.

One of the key drivers of this compensation issue is that Medicaid reimbursement rates for TCM have remained stagnant for over a decade, despite rising labor costs and service complexity and growing expectations for coordination across complex systems. This static funding structure has placed mounting pressure on CMHCs, limiting their ability to recruit and retain qualified staff or expand capacity to meet demand.

Compounding this issue is the increased pressure at both the federal and state levels to contain or reduce Medicaid spending. As Kentucky navigates shifting fiscal priorities and budget constraints, there is significant concern that further cost-control measures, such as service carve-outs, administrative burdens, or rate reductions, could jeopardize the stability of TCM and other foundational community-based services. Without targeted investment or strategic rate modernization, the system risks erosion of access, continuity, and quality for individuals with serious mental illness.

Additional barriers include complex documentation and billing requirements, which can deter service provision or result in administrative denials. Frequent audits from Managed Care Organizations (MCOs) have further strained the system, as staff are routinely pulled from service delivery to manage audit responses and rework clinical documentation. These compounding pressures, low pay, high caseloads, administrative burden, and regulatory friction have destabilized the TCM workforce in many regions.

TCM remains a cornerstone service in the behavioral health continuum. It plays a critical role in helping individuals with SMI navigate complex systems and access essential services such as housing support, Assertive Community Treatment (ACT), IPS Supported Employment, Peer Support, and crisis intervention. Gaps in TCM availability compromise the state's ability to deliver timely, person-centered care, particularly for individuals at elevated risk of hospitalization, homelessness, or justice involvement.

Addressing the TCM service gap is essential to advancing recovery outcomes and ensuring continuity of care. Strategies are needed to modernize the reimbursement structure, stabilize the workforce, reduce administrative burden, and improve integration with other service systems to better support individuals with complex and intensive needs.

Assertive Community Treatment (ACT)

Table 4, in the attached document uploaded to this section of the application outlines CMHC service data for the number of adults with SMI receiving Assertive Community Treatment (ACT) services per fiscal year.

Access to Assertive Community Treatment (ACT) remains a significant unmet need for adults with Serious Mental Illness (SMI) in Kentucky. In SFY 2024, only 1.39% of adults with SMI receiving services through CMHCs were enrolled in ACT, a slight decrease from 1.53% in SFY 2023. Despite being a high-intensity, evidence-based model designed for individuals with the most complex and disabling forms of SMI, ACT services continue to reach only a small fraction of the eligible population.

While not all individuals with SMI require ACT-level care, national estimates (Moser, 2019) suggest that approximately 5–7% of adults with SMI meet the clinical and functional criteria for this level of service intensity. Applying this range to Kentucky's estimated SMI population (~79,000 adults) suggests that between 3,950 and 5,530 individuals could benefit from ACT. However, in SFY 2024, only about 660 adults were enrolled in ACT statewide, representing less than 20 percent of those who may qualify. This substantial gap underscores the need to align program capacity, referral practices, and eligibility interpretation with the population-level need for high-intensity, evidence-based services.

Service capacity remains constrained, and many individuals who meet clinical criteria for ACT, particularly those with co-occurring substance use disorders, forensic involvement, or histories of institutionalization, are not enrolled. Contributing factors include staffing shortages, narrow admission practices, and persistent hesitancy to serve individuals with complex or nontraditional diagnostic profiles. In practice, individuals with personality disorders, neurocognitive challenges, or chronic substance use histories are often excluded, despite national fidelity guidance confirming that these co-occurring conditions, when present with SMI, fall squarely within the ACT model's intended population.

This persistent underutilization compromises Kentucky's broader goals for community integration, reduced hospitalization, and supportive diversion from incarceration or homelessness. It also highlights the need for strengthened fidelity oversight, expanded workforce pipelines, and support for teams navigating complex case presentations.

Table 5, in the attached document uploaded to this section of the application outlines CMHC service data for the number of adults with SMI served in Consumer Operated Service Programs (COSP) per fiscal year.

Consumer Operated Service Programs (COSPs) provide peer-led, recovery-oriented services that support empowerment, self-determination, and social connection for adults with Serious Mental Illness (SMI). Despite their alignment with person-centered and recovery-based care, access to COSP services across Kentucky remains limited and uneven.

In SFY 2024, only 2,578 adults with SMI, representing 3.3% of the estimated SMI population (79,196), received COSP services. This reflects a modest increase from SFY 2023 (2,065; 2.6%) and a slight rebound toward SFY 2022 levels (2,365; 3.0%). These rates highlight persistent unmet needs and gaps in availability, especially in rural and frontier regions.

The Kentucky Division of Mental Health (DMH) contracts with the National Alliance on Mental Illness, Lexington affiliate (NAMI-Lex), to implement and oversee the state's COSP programming. NAMI-Lex conducts annual fidelity reviews and provides technical assistance focused on six key domains of effective COSP implementation:

- Structure
- Environment
- Belief systems
- Peer support
- Education
- Advocacy

Fidelity reviews have identified several recurring challenges across COSP sites, including staff turnover, inconsistent understanding of the fidelity domains, and limited capacity to operationalize recovery principles in daily program practices. These issues restrict the effectiveness and reach of COSP services, especially for individuals who may not be connected to traditional CMHC programming but still seek peer-led recovery and engagement opportunities.

Enhancing COSP access with fidelity is essential to building a truly person-centered system of care. Without expanded support and investment, individuals who could benefit from these services remain isolated from critical pathways to recovery and empowerment.

Adults with SMI who live in rural areas
Prevalence Data:

The 2020 Census data show 66,300,254 individuals in the United States living in rural areas. This represents 20% of the total population. The US Census delineates rural and urban geographical areas. An urban area is designated as being comprised of a densely settled population that meets minimum housing unit density and/or population density requirements. The "rural" designation refers to areas not classified as urban.

Kentucky's 2020 Census data show that 1,860,980 individuals, or 41.3% of the total population, live in rural areas.

DBHDID monitors individuals with SMI who live in areas designated as rural in Kentucky. The total estimated number of adults with SMI living in rural Kentucky counties, based on 2020 Census numbers, is 26,993. (2.6% of the total adult rural population). During SFY 2024, the CMHCs served 17,249 of these individuals, or 63% of those with SMI living in a rural portion of the Commonwealth.

Unmet Needs and Critical Service Gaps:

As a predominantly rural state, Kentucky faces unique challenges in meeting the needs of adults with SMI living in rural communities. While general service gaps, such as access to housing and evidence-based practices, apply statewide, rural areas experience additional barriers. Affordable housing is particularly scarce, and the lack of reliable public transportation often hinders individual access to care. Long travel distances, rugged terrain, and limited public transportation infrastructure contribute to service gaps that disproportionately affect this population.

Adults with SMI experiencing homelessness:
Prevalence Data:

According to Housing and Urban Development: The 2024 Annual Homelessness Assessment Report to Congress, on one single night in January of 2024, there were 771,480 people experiencing homelessness across the nation, or 23 in every 10,000 people. Overall, all the number of people experiencing homelessness increased by 18%.

DBHDID monitors the number of adults with SMI who are experiencing homelessness in Kentucky. During SFY 2024, CMHCs served 4,123 adults with SMI experiencing homelessness, which is 5.21% of the state's estimated SMI population. This is an increase from SFY 2023, when CMHCs served 3,876 individuals (4.96%).

The preliminary annual point-in-time street count in Kentucky (known as the K-Count) for 2024 has shown that the number of unsheltered individuals experiencing homelessness was 5,231, of whom 1,716 were unsheltered and 2,923 were in emergency shelters. This reflects an increase from the 2023 count, which identified 4,766 individuals (1,533 unsheltered; 2,768 sheltered)—an overall rise of 6.7%. The K-Count also identified 921 of those individuals who self-identified as having SMI. The Louisville Metro area continues to report the highest number of individuals experiencing homelessness in the state, with 606 unsheltered

individuals and 884 in emergency shelters in 2024, compared to 575 unsheltered and 839 sheltered in 2023.

These year-over-year increases at both the national and state levels highlight the growing need for focused interventions and housing supports for individuals with SMI.

Unmet Needs and Critical Service Gaps:

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

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

Older Adults with SMI

Prevalence Data:

According to the Centers for Disease Control and Prevention (CDC), as of 2019, 54.1 million adults in the United States are 65 years old or older, representing 16% of the population. By the year 2040, the number of older adults is expected to reach 80.8 million. Approximately 20% of people aged 55 and older will experience a mental health concern, such as a mood disorder, that is not a normal part of the aging process. (2008 – American Association for Geriatric Psychiatry).

Kentucky DBHDID captures data on older adults aged 60 and above who meet the criteria for SMI. Utilizing 2020 Census data, the total population aged 60 and above in Kentucky, estimated to have SMI, is 26,493. (2.6% of the aged 60 and above population). Of this identified population, the CMHCs served 7,226 older adults with SMI (27.28%) during SFY 2024. Table 6, in the attached document uploaded to this section of the application outlines the number of adults with SMI aged 60 and above served in each CMHC region of the state, along with each region's estimated population.

Many of the CMHCs that serve rural populations serve a much larger portion of their estimated population than some of the most populous regions. This could partially be due to the fact that larger populated areas have more resources, in addition to the CMHCs, and other agencies may be serving a portion of these individuals.

Unmet Needs and Critical Services Gaps:

Kentucky faces growing challenges in meeting the behavioral health needs of its aging population, particularly adults aged 60 and over who experience Serious Mental Illness (SMI) and co-occurring Substance Use Disorders (SUD). This population is at increased risk for poor health outcomes, institutional cycling, and premature mortality due to the intersection of physical health decline, behavioral health challenges, and social vulnerability.

Kentucky's older adult population is steadily growing. According to the 2023 American Community Survey, the proportion of Kentuckians aged 65 and older increased from 17.0% to 17.8% between 2010 and 2023, while the proportions of residents under 18 and between 18 and 64 declined or remained steady. This demographic shift reflects national trends and signals an urgent need to expand aging-competent behavioral health services.

Based on 2020 Census data, an estimated 26,493 Kentuckians aged 60 and over meet the criteria for SMI. During SFY 2024, Community Mental Health Centers (CMHCs) served 7,226 individuals in this group, representing only 27.28% of the estimated population. Service utilization is especially concentrated in some of the most rural areas of the state, where CMHCs often represent the primary behavioral health provider. However, substantial unmet needs remain, particularly for those with co-occurring SUD, cognitive decline, and limited access to natural supports or transportation.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is working to revitalize its Kentucky Mental Health and Aging Coalition (KMHAC), in partnership with the Department for Aging and Independent Living (DAIL) and the Division of Substance Use Disorder Services (DSUD). The goal is to promote cross-system collaboration and build a more responsive, coordinated system of care for older adults.

Key areas of need for this population include:

1. Integrated Medical and Behavioral Health Services

Older adults with SMI and SUD often manage multiple chronic conditions. There is a critical need to expand access to integrated care models that coordinate primary care, mental health, and substance use treatment. Services must also address polypharmacy risks and support appropriate medication management across specialties.

2. Age-Responsive Substance Use Disorder Treatment

Older adults face unique patterns of substance use, including alcohol misuse and prescription drug dependency. Most treatment programs are not designed with age-related considerations in mind. Kentucky lacks sufficient capacity for SUD treatment models that are trauma-informed, culturally competent, and tailored to the recovery needs of older adults.

3. Cognitive and Neuropsychiatric Screening

Aging adults with SMI are at elevated risk for cognitive impairment, including Alzheimer's disease and other dementias. The lack of standardized cognitive screening within behavioral health settings can lead to misdiagnosis, inappropriate treatment plans, and worsening functional outcomes. Increased training and implementation of cognitive assessment tools are needed.

4. Supportive Housing with Behavioral Health Services

There are insufficient housing options that accommodate both the physical accessibility and behavioral health needs of older adults. Many individuals with SMI and SUD experience homelessness, reside in personal care homes, or transition between institutional settings without adequate supports. Investment in supportive housing models with on-site or embedded behavioral health care is essential.

5. Transportation and Mobility Support

Loss of mobility and transportation access significantly limits older adults' ability to engage in behavioral health treatment and social support. Non-emergency medical transportation (NEMT) and community-based outreach services are often insufficient or unavailable in rural and frontier counties.

6. Social Isolation and Community Disconnection

Many older adults with SMI and SUD experience profound social isolation, compounded by stigma, grief, and limited family support. Kentucky must invest in peer support models and social engagement initiatives that reduce isolation, promote recovery, and enhance quality of life for this population.

7. Cross-System Navigation and Case Management

Older adults often interact with multiple systems—behavioral health, aging and disability services, housing, criminal justice, and medical care—without clear coordination. Targeted case management and interdisciplinary team models are necessary to ensure continuity of care, particularly for individuals transitioning between levels of care or housing settings.

8. Age-Competent Crisis Response Services

Traditional crisis response systems may not be equipped to manage the medical complexity and cognitive limitations of older adults with SMI and SUD. Enhancements to mobile crisis teams, peer crisis engagement, and post-crisis stabilization must include training and protocols that are specific to aging.

Additional gaps that need addressing for this population include:

- Expanding geriatric behavioral health provider training and workforce development.
- Piloting integrated care models that combine behavioral health, primary care, and aging services.
- Funding age-responsive SMI/SUD programs in both urban and rural areas.
- Supporting development of supportive housing models for aging adults with behavioral health needs.
- Incorporating standardized cognitive screening protocols for providers.
- Strengthening aging-informed crisis response and mobile outreach programs.

There are several unmet needs within this population in Kentucky. There is a critical need to expand housing options that address both the physical and behavioral health needs of individuals. There is also a critical gap in provider understanding and expertise related to the mental health needs of Kentucky's aging population, especially for those with SMI. More collaboration between agencies that serve this fragile and expanding population group is also a capacity gap.

Children with SED and Their Families

Prevalence Data for this population:

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

According to 2020 Census data, there are 995,111 children ages 0-18 in Kentucky. Applying a 5% prevalence estimate, 49,756 estimated Kentucky children meet criteria for having a serious emotional disturbance (SED). According to the Kentucky MIS Client and Event data set, the CMHCs served 21,079 children with SED in SFY 23 and 19,940 in SFY 24 (42% and 40% of Kentucky's children who meet criteria for having a SED, respectively). Please see SED Table 1, in the attached document uploaded to this section of the application.

Children with SED who experience homelessness:

For the 2023-2024 school year, the Kentucky Department of Education reported that 22,362 unduplicated children and youth, aged 3-21, enrolled in public schools met the definition of being homeless. Using a 5% prevalence rate, an estimated 1,118 children and youth experiencing homelessness and served by Kentucky public schools met criteria for a serious emotional disturbance (SED). However, this likely underestimates the true need, as children with unstable housing face significantly higher risk factors for mental health challenges. Further limitations of these data are that only children enrolled in public school are included. Children under age 5 who do not qualify for public preschool and youth who drop out of school (who may be at higher risk for mental health challenges), are not included. In addition, there are nearly 65,000 students in private schools in Kentucky, bringing the total to 3,250 more children and youth who meet the criteria for SED. Finally, children and youth who are homeschooled are also not included in the count. More than 38,000 school-age children in Kentucky are homeschooled,

increasing the potential prevalence of serious emotional disorders among this population by 1,900. While homeschooling can be a deliberate choice for some families, for others, especially those facing housing instability, it may be a necessity due to barriers in accessing public education. Challenges such as a lack of transportation, documentation, or a stable address can make public school enrollment difficult, leading some families experiencing homelessness to opt for homeschooling.

The Kentucky MIS Client/Event data show that in SFY 23 the CMHCs served 285 youth with SED who experienced homelessness and 268 in SFY 24, indicating that approximately 1% of youth with SED that were served by the CMHCs reported experiencing homelessness. This is likely an underestimate, as information about housing stability is updated infrequently and may be underreported by families.

Children with SED who live in rural areas:

Kentucky is a primarily rural state. According to the 2020 Decennial Census, 93 of Kentucky's 120 counties are predominantly (more than 50 percent) rural, with 54 of these counties classified as entirely rural, having no designated urban areas within their boundaries. Rural counties are disproportionately impacted by poverty. According to the 2024 Kentucky Kids Count data, 21% of Kentucky's children are living in poverty, and 44% in households with low income (below 200% of the federal poverty level). An added risk for becoming unhoused is the large number of children (44%) in Kentucky households with a high rental cost burden. Transportation in rural areas poses a considerable challenge, as families often lack access to reliable transportation, and with few exceptions, public transportation is non-existent. As a result, many children are unable to travel to service providers, and service reimbursement rates do not account for travel time, resulting in inconsistent availability of home-based services across the state. Finally, 105 of Kentucky's 120 counties are designated Health Professional Shortage Areas by the Health Resources and Services Administration, and 111 counties are identified explicitly as Mental Health Shortage Areas by the Rural Health Information Hub. These workforce shortages create further barriers to families seeking mental health services for their children. The Kentucky MIS Client and Event data set block grant report indicates that in SFY23 and SFY24, the Regional Community Mental Health Centers served 49% and 44%, respectively, of youth with SED living in rural areas, despite identified challenges. This is higher than the percentages of those served across the entire state (43% and 40%), as stated above.

Kentucky Families:

A primarily rural state, Kentucky's population is 4.5 million, according to the 2020 Census numbers, and ranks 48th for overall poverty rate. SED Table 2, in the attached document uploaded to this section of the application provides additional data from the 2020 Census, the Center for American Progress, the Center for Disease Control, and Spotlight on Poverty & Opportunity that indicate challenges faced by Kentucky families. Each of the indicators shown increase the risk for mental health challenges among families and their children. This highlights the importance of focusing on the whole family to improve health and well-being and mitigate risk factors.

Unmet Needs and Critical Service Gaps for Children with SED; Children with SED experiencing homelessness; Children with SED in rural areas; and Families:

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

Based on 2020 Census numbers and Kentucky's certified MIS Client/Event data, approximately 43% of children with SED were served by Regional Boards statewide in SFY23 and 40% in SFY24, and approximately 7% received targeted case management services in SFYs 23 and 24.

Fewer children and youth with SED received the evidence-based service, High Fidelity Wraparound (HFW). The Kentucky MIS Client and Event data indicate that 324 in SFY23 and 283 in SFY24 children and youth received this more intensive approach to care coordination (less than 1% of Kentucky's SED population). According to the National Wraparound Initiative's review of multiple studies, when wraparound is implemented with fidelity (i.e., HFW), "young people with complex needs are more likely to be able to stay in their homes and communities, or, should a crisis occur, to be in out-of-home placements only for short periods of time." DBHDID believes that targeted case management services for this population are crucial for ensuring that children and youth can remain in their own homes, schools, and communities. Notably, there is a very large gap between the children with SED being served and those receiving targeted case management, including HFW. While DBHDID has supported HFW implementation within the CMHCs, funding has been insufficient for consistent implementation, expansion, or to scale or to achieve sustainability.

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

system of care partners (CMHCs; child welfare; juvenile justice; education; families) as gaps.

All of the noted service gaps are further impacted by the severe behavioral workforce shortage that was exacerbated since the onset of the COVID-19 pandemic and has not yet fully recovered.

Early Serious Mental Illness/First Episode Psychosis Prevalence Data:

Table 1 in the attached ESMI/FEP document uploaded to this section of the application presents targeted demographics for youth and young adults in Kentucky aged 15–30 years:

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

The Recovery After an Initial Schizophrenia Episode (RAISE) study, conducted by the National Institute of Mental Health (NIMH), concluded that compared to typical care, people with early psychosis who received the evidence-based practice of Coordinated Specialty Care (CSC) experienced greater improvement in symptoms, relationships, and quality of life, are more involved in work or school, and stay in treatment longer. This research also shows that the sooner people receive CSC, in the progression of their illness, the greater the improvements.

Using the formula for estimating the incidence rate of First Episode Psychosis (FEP), derived from the OnTrack NY FEP study (Humensky, et. al. September 2013), the estimated incidence rate of FEP in Kentucky is approximately 1,352 individuals per year.

Kentucky is divided into 14 CMHC geographical regions. Table 2 in the attached ESMI/FEP document uploaded to this section of the application outlines the estimated incidence rate of FEP per CMHC region.

Kentucky's programming for FEP includes services for individuals aged 15 to 30, who are experiencing first episode psychosis. Some of those individuals enter the system through the children's system of care and meet criteria for serious emotional disturbance (SED) and some enter the system through the adult system of care and meet criteria for serious mental illness (SMI).

The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) 2022 report to Congress indicated that in 2022, 6.0% of individuals between the ages of 15 and 30 meet the criteria for an SMI. For children meeting the criteria for SED, this prevalence varied between 5% and 13%.

Table 3 in the attached ESMI/FEP document uploaded to this section of the application shows the data used for the following analysis. During SFY 2024, a total of 45,423 youth between the ages of 15 and 30 were served by CMHCs in Kentucky. Of those, 8,085 met the criteria for serious emotional disturbance (SED, ages 15-17), and 10,658 met the criteria for serious mental illness (SMI, over the age of 18). It should be noted that in Kentucky's client data set, the SED marker captures only those up to age 18 and the SMI marker captures only those 18 years old and above.

When compared to Kentucky's total population for individuals between the ages of 15 and 30 (903,847), 1.2% of the CMHC service population in that age group fits criteria for SMI, and 1% of the CMHC service population in that age group fits criteria for SED. It appears that Kentucky serves fewer people in that age group that meet SMI/SED criteria than national averages as identified in the ISMICC report, highlighting a potential access or service gap.

Kentucky contracts with 14 CMHCs for services, eight of those CMHCs currently have CSC teams. When the SFY 2024 service data for CMHCs is further analyzed, the eight CMHCs with CSC teams are serving approximately 76% (34,497) of the total population aged 15 to 30 identified with mental health issues, 76% (6,174) of those meeting SED criteria and 73% (7,769) of those meeting SMI criteria. This highlights the increased access available in areas utilizing the CSC programming.

Unmet Needs and Critical Gaps:

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

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

An additional complication for calculating the numbers served is that a large portion of this age group utilizes private insurance through their parents, and many of the services captured in Coordinated Specialty Care (CSC) are not billable through traditional insurance. (i.e., case management, peer support, supported employment/education). Kentucky Medicaid does not cover some CSC

services as well (i.e., supported employment/education), or may not cover for the length of time needed for this population (e.g., targeted case management). CSC is a relatively expensive service to provide, and the national average for caseload on each CSC team is 30 – 40 individuals. Although these services are effective and vital, federal block grant funds have been necessary to ensure the sustainability of this critical service. Kentucky is in the early stages of implementation of a 1915(i) State Plan Amendment (SPA) that will provide Medicaid reimbursement for some services for individuals with SMI that have not traditionally been covered. (e.g., supported employment/education).

Workforce issues have been improving across the state, but remain deficient in some geographic areas, and some teams have experienced challenges in filling vacancies. The Division of Mental Health (DMH) state FEP team has worked to support and assist these local teams in strengthening staffing and enhancing staff competency and capacity to identify and serve these young people in their areas.

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

- Support for implementation of multi-family group therapy (MFG), the evidence-based family psychoeducation/therapy model embedded in Kentucky's CSC programs;
- Additional support and empowerment for CSC team leaders;
- Support in making occupational therapy available for CSC participants who needed it;
- Enhancing clinical expertise on CSC teams;
- Guidance in hiring and retaining youth peer specialists on the CSC teams; and
- Guidance on best practices regarding outreach and education efforts

Individuals in Need of Behavioral Health Crisis Services

Prevalence data:

Kentucky Total Population: 4,461,952

Kentucky Adult Population: 3,045,985

Adult SMI Estimate (2.6%): 79,196

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

Child SED Estimate (5%): 49,756

Adults Served by CMHC Crisis Programs

According to the 2020 Census, Kentucky is home to over three million adults. In 2024, more than 19,000 adults—approximately one in every 156—received a crisis service through a Kentucky Community Mental Health Center (CMHC). Many of those were individuals with Substance Use Disorders (SUD), Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI). These services include walk-in crisis support at CMHC offices, mobile crisis response, and residential stays in crisis stabilization units. Of these, mobile crisis services were provided to approximately one in every 589 adults, again, many of whom are SED or SMI.

Kentucky state general funds also support additional crisis services through partnerships with Wellspring Kentucky (residential crisis services), the University of Louisville and Seven Counties Services (crisis evaluations), and Baptist Health Hardin and Communicare (psychiatric services). However, these services are not included in the figures shown in Table 1. Table 1 in the attached BHCS document uploaded to this section of the application provides 2020-2024 data on the number of adults served by CMHC crisis programs.

Adults with SMI Served by a CMHC Crisis Program

Approximately 2.6% (almost 80,000) of Kentucky's adults are estimated to have a serious mental illness (SMI). In SFY 2024, CMHCs provided crisis services to 8,692 adults with SMI and mobile crisis services to 2,028 adults with SMI. Over 44% of adults who received a CMHC crisis service in SFY 2024 had a SMI. Table 2 in the attached BHCS document uploaded to this section of the application provides 2020-2024 data for adults with SMI served by CMHC crisis programs.

Children Served by CMHC Crisis Programs

Kentucky is home to almost a million children and teens. In SFY 2024, CMHCs provided a crisis service to 5,393 youth, or approximately 1 of every 185 children. These services included mobile crisis services, walk-in crisis services at a CMHC office, and residential care in a crisis stabilization unit. Almost 1,000 youth were provided with mobile crisis services. Table 3 in the attached BHCS document uploaded to this section of the application provides 2020-2024 data for children served by CMHC Crisis Programs.

Children with SED Served by CMHC Crisis Programs

Approximately 5% (almost 50,000) of Kentucky children are estimated to have a serious emotional disturbance (SED). In SFY 2024, CMHCs provided crisis services to 3,630 children with SED (approximately 7.3%) and mobile crisis services to 557 children with SED (approximately 1.1%). Sixty-seven percent of children provided a crisis service were identified as having SED. Table 4 in the attached BHCS document uploaded to this section of the application provides 2020-2024 data for children with SED served by CMHC crisis programs.

Individuals with a Substance Use Disorder Served by CMHC Crisis Programs

In SFY 2024, 6,898 adolescents and adults with a substance use disorder (SUD) received a crisis service by a CMHC crisis program. These services include walk-in crisis support at CMHC offices, mobile crisis response, and residential care in crisis stabilization units. More than 25% of individuals who received a crisis service from a CMHC crisis program had a substance use disorder diagnosis. Mobile crisis services were provided to 1,773 individuals with SUD. Table 5 in the attached BHCS document uploaded to this section of the application provides 2020-2024 data for adolescents and adults with SUD served by CMHC crisis programs.

CMHC 988 and Call Center Services

CMHC call centers offer a range of services to individuals, including those with SMI, SED, and SUD, in crisis. These services include responding to callers, texters, and chatters on regional crisis lines, warmlines, and the 988 Suicide and Crisis Lifeline (988). They also coordinate services with jail triage teams, emergency evaluators, quick response teams, mobile crisis teams, and emergency services personnel. Kentucky's fourteen CMHCs are members of the 988 network. In SFY 2024, CMHCs provided 230,699 responses to callers, texters, and chatters (inclusive of calls, chats, and texts to 988 as well as local crisis numbers). Table 6 in the attached BHCS document uploaded to this section of the application provides 2021-2024 data on the number of responses provided by CMHC call centers.

Unmet Service Needs/Critical Gaps

- Increase capacity to answer Kentucky calls, texts, and chats in-state.
- Increase capacity to reduce the amount of time it takes calls, texts, and chats to be answered in the state.
- Increase capacity to reduce the number of calls, texts and chats that the caller abandons before they access a call center staff member.
- Increase crisis capacity, especially for mobile crisis services, for all populations, including those with SED/SMI/SUD.
- Increase capacity to serve Kentucky's youth with SED, SUD, and complex needs.
- Enhance crisis data reporting.

Adolescents with Substance Use Disorders or Co-occurring Substance Use and Mental Health Disorders Prevalence Data/Unmet Needs and Service Gaps:

Analysis of 2023 Youth Risk Behavior Surveillance Survey (YRBSS) data shows that substance use among Kentucky middle and high school students generally declined from 2021 to 2023. However, heroin use remained unchanged, alcohol use increased among middle schoolers, and marijuana use rose among high school students. Table 1 in the attached Adolescent M/SUD document uploaded to this section of the application provides detailed data for Kentucky students.

It is important to note that opioids combined with fentanyl remain one of the most lethal and sought out substances for many individuals across the nation and Kentucky. Although alcohol, marijuana, and nicotine are still the top three substances used by adolescents, results from the 2021 and 2023 YRBSS show that 2% of Kentucky high school students have tried heroin; 9% of middle school students and 13% of high school students have taken prescription pain medicine without a prescription or differently than prescribed, which is higher than national averages (CDC, YRBS, 2023). Tobacco/nicotine use remains higher in Kentucky than nationally; vaping is especially problematic in Kentucky schools.

The use of vaping devices by middle and high school students is exacerbated by adult uncertainty in handling students who vape, with teachers and other school staff often managing the issue by suspending students or by school staff/parents who refer the youth to a court designated worker instead of to the youth treatment coordinator, or other knowledgeable staff, located within their CMHC. Additional concerns include the ongoing perception that vaping is less harmful than combustible cigarettes, and the perceived acceptance of student vaping from adults who also use vape pens.

Nationally, the Centers for Disease Control and Prevention (CDC, 2025) estimates a 24 percent decrease in drug overdose deaths from October 2023 to September 2024; while this is encouraging news, the CDC reports that overdose is still the leading cause of death for Americans 18 – 44. Kentucky also continues to see a decrease in drug overdose deaths, with the number of Kentuckians dying from an overdose falling by 2.5% from 2021 to 2022, 9.8% from 2022 – 2023, and 30% in 2024. However, the leading cause of drug fatalities is still tied back to substances laced with fentanyl (KIPRC, 2023). This data shows the success of harm reduction efforts such as Narcan distribution, but highlights the need for continuing efforts, including ongoing individual and community education on how fentanyl can and does show up in unexpected places, such as laced with other substances used in vapes.

Results of the 2023 National Survey on Drug Use and Health (NSDUH) reveal further distressing statistics for Kentucky's youth. As noted in Table 2 in the attached Adolescent M/SUD document uploaded to this section of the application, past month marijuana and alcohol use are slightly lower than national averages. However, both cigarette smoking and use of tobacco products by Kentucky's youth are elevated compared to national averages; reports of at least one major depressive disorder episode has decreased nationally since 2021, while similar reports in Kentucky have increased. Kentucky youth also report plans for suicide in the past year at a higher percentage than their peers nationally, further demonstrating the need to focus on co-occurring mental health and substance use instead of treating these concerns as separate, unrelated issues.

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

the data to produce a state and regional data report showing regional Alcohol Tobacco and Other Drug (ATOD) trends for the state. In prior years the Kentucky Incentives for Prevention (KIP, 2021) survey used passive consent to administer the survey in school districts statewide. Recent legislation mandated that parents give their active consent before the school can administer a survey assessing the extent of alcohol, drug, and tobacco use among those who are 11 to 18 years old across Kentucky. The change in consent requirements prevented administration of the survey in 2023 but permitted it to proceed in 2024. However, results from the 2024 survey were not available at the time of writing.

In 2021, questions were added to the KIP survey focusing on military connectedness to help 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. Kentucky is home to two major military bases: Fort Campbell, with a daytime population of 90,194, and Fort Knox, with 26,260. These populations include active-duty service members, their families, and civilian and contracted personnel. In addition to these two bases, Kentucky is also home to approximately 7,353 Kentucky Army and Kentucky Air National Guard, and 267,611 military veterans. In 2021 when the question was introduced on the KIP, 40.7% of youth taking the survey identified as being military connected.

Tables 3a and 3b in the attached Adolescent M/SUD document uploaded to this section of the application depicts the prevalence of drug use and mental health correlates among 10th graders from military-connected families for any drug use as well as prescription drugs. Tenth graders from military-connected families consistently had higher 30-day rates of prescription drug use. Military-connected youth also had higher rates of mental distress as indicated by self-harm, suicidal ideation, suicide plans, and suicide attempts. Recognizing the needs of this special population, BHDID continues to work with regional youth treatment coordinators to implement outreach and engagement strategies specific to this population.

These data, along with reports from regional youth treatment coordinators, indicate that co-occurring mental health needs and substance use among Kentucky youth who report they are military connected remain higher than national averages. Furthermore, given the ongoing workforce shortages exacerbated by the pandemic, already limited service capacity has decreased. Data from the CMHC plan and budget documents indicate that the primary service available for youth with substance use and co-occurring mental health concerns is outpatient therapy, with very few programs offering higher levels of care such as intensive outpatient, partial hospitalization, and residential services. Many of the programs put into place in the last decade have been unsustainable due to lack of community referrals, workforce shortages, and Medicaid reimbursement rates that do not cover costs.

Kentucky has historically allocated the majority of substance use block grant funds to support services for adults with substance use disorder (SUD). Prior to the updated Medicaid State Plan Amendment (SPA) in 2014, Kentucky Medicaid did not reimburse for substance use treatment services. That year, a new SPA included reimbursement for substance use treatment with eligible recipients of all ages, thereby allowing young people to obtain substance use treatment services.

In addition to more covered behavioral health services, Kentucky Medicaid opened the behavioral health provider network to new provider types, making a wider variety of geographically accessible treatment options available. The above changes coupled with Kentucky having been the recipient of several SAMHSA grants focused on adolescents and young adults, including the most recent System of Care Grant locally titled Kentucky's System and Infrastructure eXpansion (KY SIX), have enabled Kentucky to build services as well as improve the quality of those services available for youth in the Commonwealth. However, activities supported with these discretionary grants have been difficult to sustain. Kentucky has leveraged funding from various sources, including pharmaceutical settlement awards and SAMHSA State Opioid Response funding, to enhance the availability and access to high-quality substance use treatment services for adolescents.

Using available funds, Kentucky has prioritized workforce development in evidence-based practices by supporting intensive learning collaboratives. As a result, clinicians across public and private settings statewide are now trained to deliver evidence-based adolescent substance use treatment. In addition to these learning collaboratives, statewide training has been provided to behavioral health clinicians and other youth-serving staff through partnerships with the Kentucky School for Alcohol and Other Drug Studies and the System of Care Academy. Clinicians and other youth-serving staff have been offered professional development in the following EBPs: Adolescent Community Reinforcement Approach, Motivational Interviewing, Seven Challenges, and Functional Family Therapy, as well as general adolescent provider competency-building such as group skills, trauma-informed care, and brain development.

Identified barriers in Kentucky to adequate adolescent substance use services include a lack of training on co-occurring mental health and substance use disorder treatment for providers, a lack of higher levels of care for young people such as intensive outpatient and partial hospitalization programs, a lack of community awareness and understanding about youth SUD, and an overall decline in the behavioral health workforce capacity. Anecdotal reports indicate that many clinicians are often hesitant to work with younger adolescents regarding substance use concerns. They report feeling knowledgeable working with adults, not youth, with SUD, or they report feeling knowledgeable working with youth, but not with SUD.

Data continue to reveal low numbers of youth who have a diagnosed substance use disorder and providers across the state express concerns of a trending decrease in youth and family seeking services as well as a decrease in referrals for youth substance use assessment and treatment from agencies such as education, justice, and the courts. This lack of parental awareness and community partner referrals has contributed to a gap in services for youth.

An estimated 17.1% of the population age 12 and older in the U.S. met diagnostic criteria for alcohol or drug use disorder in 2023 (Substance Abuse & Mental Health National Survey on Drug Use and Health, 2023). Based on the 2020 census data estimate for 2021, the state population age 12 and older was 3,851,676. Using this formula, 589,306 of Kentucky's population age 12 and older met criteria for a substance use disorder (SUD). (U.S. Census Bureau, Kentucky State Data Center). During SFY 2024, Kentucky's 14 Community Mental Health Centers (CMHCs) provided substance use specific treatment for 30,925 unique individuals ages 12 and older, 896 of whom were under age 18 (Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set, 2024). The number of unique individuals served across the CMHCs in SFY 2024 was 127,165, and 30,937 were identified as having co-occurring mental health and substance use disorders.

Nationally, the Centers for Disease Control and Prevention (CDC) recently published provisional data that drug overdose deaths decreased by 24% from October 2023 to September 2024. According to the CDC, drug overdose deaths in Kentucky increased from 2,083 in 2021 to 2,271 in 2022. The 2024 Justice and Public Safety Cabinet Drug Overdose Fatality Report, prepared by the Kentucky Office for Drug Control Policy, illustrated that drug overdose deaths decreased in 2024. This was a 30.2% decrease from 2023 and a third consecutive year in which overdose deaths decreased in Kentucky. Historically, Kentucky experienced the first drop in overdose deaths in nearly a decade in 2018 before the rate of fatal overdoses began to rise slowly in October 2019. In 2020, fatal overdose rates began to increase rapidly, beginning in mid-March, reaching their peak in October 2021 (Ahmad et al., 2023). Overdose deaths occurring in Kentucky also decreased from 2023 from 2,131 to 1,510 in 2024. The number of Kentuckians who died outside of Kentucky also decreased for this same time frame from 51 to 19.

The majority of drug overdose deaths in Kentucky residents involve opioids: 98% in 2024 (Steel & Daniels, 2024). Opioid overdoses are primarily attributed to fentanyl and fentanyl analogs. Fentanyl was involved in 62.3% of drug overdose deaths in 2024, which was a decrease of 39.4% from the 1,450 individuals who died from an overdose involving fentanyl in 2023. (Steel & Daniels, 2024). Methamphetamine was involved in 38.1% of the overdose deaths in 2021, which was an increase of 48.2% over the methamphetamine-involved overdose deaths in 2020 (Steel & Daniels, 2024).

According to the Kentucky Housing Corporation (KHC, 2023), of the 4,766 individuals experiencing homelessness in the commonwealth, 835 individuals self-reported having a SUD in the 2023 annual point-in-time count. Although this statistic does not necessarily reflect the number of individuals who meet diagnostic criteria for or who have been diagnosed with a SUD, rates of substance use are high among individuals who experience homelessness. Approximately 80% of those who experience chronic homelessness report lifetime substance use, and more than one-third (34.7%) of individuals experiencing homelessness report engaging in chronic substance use (SAMHSA, 2011). In a systematic review of 39 articles on homelessness of adults in high-income countries, the most common diagnostic category was alcohol use disorders (a random effects pooled prevalence of 36.7%), followed by drug use disorders (21.7% random effects pooled prevalence; Gutwinski, Schreiter, Deutscher, & Fazel, 2021).

According to the 2023 Neonatal Abstinence Syndrome (NAS) Reporting Registry Annual Report, there were 849 unduplicated cases of newborns with signs and symptoms of NAS in 2022, which was a decrease from 2021 (Kentucky Cabinet for Health and Family Services [KY CHFS], 2023). This represents 18.4 of every 1,000 live births among Kentucky residents. NAS prevalence rates are highest in Appalachian regions of the state, with the rate in Kentucky River ADD at 57.2 cases per 1,000 live births. These data indicate that rates of NAS in rural counties are nearly double the rate observed in urban counties in Kentucky. The state's rate of NAS remains far above the national average, with some areas reaching more than ten times the most recent national estimate (HCUP Fast Stats, 2020). Unspecified opioids (21.8%), heroin (13.2%), and methadone (10.5%) were the most frequently reported opioids. Other commonly used substances reported were amphetamines, including methamphetamine (56.3%), cannabinoids (32.6%), and benzodiazepines (11.5%) (KY CHFS, 2021). All other substances were used by less than 20% of women in the registry. A majority of cases (58%) were exposed to more than one substance during pregnancy, with an average of being exposed to two or more substances (KY CHFS, 2023).

In addition, infants with NAS are twice as likely to have a low birth weight and almost three times as likely to be admitted to a neonatal intensive care unit (KY CHFS, 2023). Tobacco use co-occurs with substance use at high rates, which could further affect the health and development of these infants. Kentucky Office of Vital Statistics data show that 14% of women whose babies did not have NAS reported they had smoked during pregnancy, which was significantly lower than the percent of women whose babies have NAS (65%) (KY CHFS, 2023). Infants with NAS are three times more likely to require longer hospitalization for longer than newborns without NAS. Pharmacological treatment was provided to 34% of infants with NAS (KY CHFS, 2023). Among infants who received pharmacological treatment in 2022, the most common pharmacological treatments were morphine (87.4%) and clonidine (28.3%), with approximately 32.4% of infants with NAS receiving multiple medications (KY CHFS, 2023).

Unmet needs and critical service gaps:

Current unmet service needs for individuals with substance use disorder in Kentucky include, but are not limited to, the following:

- Recovery Housing Supports;
- SUD Services to support individuals experiencing homelessness;
- Reentry services and programs to support justice-involved individuals;

- Transportation to access substance use disorder treatment services in rural areas;
- Systematic screening of pregnant persons for SUD;
- Housing support services for pregnant and parenting persons;
- Treatment systems where SUD treatment is fully integrated with primary care;
- Opioid overdose prevention and reversal;
- Low-barrier access to Medications for opioid use disorder, Harm reduction resources and outreach;
- Crisis response services;
- Access to naloxone among all individuals who use drugs and
- Limited access to Wi-Fi services.

As noted earlier, approximately 80% of those who experience chronic homelessness report lifetime substance use, and more than one-third (34.7%) of individuals experiencing homelessness report engaging in chronic substance use. Services to identify and engage this population remain limited. For those individuals who enter into treatment, there remains a need for housing supports both during and after treatment. The Kentucky Injury Prevention and Research Center (KIPRC, 2020) found specific needs and gaps regarding the capacity of recovery housing. There is a greater need for housing support in rural areas, and there is a lack of appropriate and available treatment and recovery housing for families.

In addition, during SFY 2021, DBHDID analyzed current and potential inequities in accessibility to programming for SUD. It was discovered during this data analysis that the pandemic had reduced reentry efforts in correctional institutions due to public health pandemic restrictions, resulting in negative impacts on accessing services for those experiencing reentry. During SFY 2022, COVID restrictions were eased, and reentry services were restored. However, due to lingering workforce issues, staffing these programs remains a challenge, and available services for those experiencing reentry remain limited. The goal for DBHDID is to provide an array of services and supports for justice-involved individuals returning to their communities. Reentry Coordinators assess and identify individual needs prior to release from custody. Appropriate wraparound services, including substance use, mental and physical health treatment, harm reduction, and peer support, are coordinated.

Although opioid overdoses remain the leading cause of overdose deaths in Kentucky, overdose deaths related to stimulants and other drugs have also been on the rise. In Kentucky, methamphetamine was involved in 716 overdose deaths in 2024, which was 50.8% of overdose deaths, a 28.6% decrease from the 1,007 deaths in 2023 (Steel & Daniels, 2024). Because resources have been primarily allocated to address OUD, Kentuckians with stimulant use disorders and other SUDs have limited options and resources for treatment and recovery. The increase of fentanyl and methamphetamine, coupled with the high prevalence of adulterated substances, highlights the need for increased harm reduction outreach, improved crisis response services, and access to naloxone among all people who use drugs.

Individuals with SUD Experiencing Homelessness Prevalence data:

Homelessness remains a persistent and complex public health challenge across the United States. According to the 2024 Annual Homelessness Assessment Report (AHAR) to Congress, uploaded to this section of the application, 771,480 people experienced homelessness on a single night in 2024. This point-in-time assessment revealed the highest number of individuals experiencing homelessness ever documented in the U.S.: approximately 23 of every 10,000 people, or an overall 18% increase. Homelessness increased in every population studied, with families with children increasing the most ever in one single year, a 39% increase from 2023 to 2024 (U.S. DHUD, 2024).

A point-in-time assessment in 2024 by the Kentucky Housing Corporation (KHC) revealed that there were approximately 5,231 unsheltered Kentuckians on any given night, a 9% increase from 2023. In addition, there is an extreme shortage of affordable rental units for Kentuckians with extremely low incomes, including approximately 165,000 Kentuckians (Kentucky Housing Corporation, 2024).

Risk factors for homelessness identified within the U.S. overall hold true for Kentucky. These include, but are not limited to, the following (Kentucky Housing Corporation, 2024):

- Percent of households with 50% or more income going to rent;
- Persons without health insurance coverage;
- Percent of households at or below the poverty line;
- Percent of households using public assistance;
- Percent of persons reporting extensive physical and mental distress;
- Unemployment, or other economic factors;
- Shortage of affordable rental homes;
- Low-income families struggling to make ends meet;
- Young adults who have aged out of the foster care system and have no real place to go; and
- Individuals who experience untreated, chronic mental health and/or substance use disorder(s).

SUD remains a significant concern among individuals experiencing homelessness. Individuals without stable housing are substantially more likely to struggle with SUD compared to the general population (SAMHSA, 2017)—high rates of co-occurring mental health disorders and limited access to consistent care compound this vulnerability. The 2023 point-in-time (PIT) count

found that one in every three people experiencing homelessness (152,585) met the criteria for chronic homelessness, marking the highest number recorded to date (U.S. DHUD, 2024). Chronic homelessness is often closely linked with untreated behavioral health needs, including long-standing substance use and trauma (SAMHSA, 2021).

For many in recovery, securing stable housing is one of the most critical steps and most difficult on the path to wellness. Unfortunately, individuals with past justice involvement often face legal and systemic barriers that prevent access to traditional housing programs (U.S. Department of Justice, 2022). This reality disproportionately impacts people in recovery who have worked hard to turn their lives around yet remain shut out of housing opportunities due to past records.

In Kentucky, efforts are underway to address this gap through recovery housing initiatives designed to support individuals rebuilding their lives. The Kentucky Recovery Housing Network (KRHN) and its KYARR (Kentucky Alliance of Recovery Residences) certification process ensure that homes meet established standards for safety, peer support, and accountability. These certified residences provide more than just a roof; they offer a structured, recovery-supportive environment designed to promote safety, accountability, and long-term stability.

However, housing alone is insufficient to support long-term recovery. Sustainable recovery also requires the development of recovery capital—the personal, social, and economic resources that promote individual wellness, stability, and reintegration into the community. Workforce development plays a pivotal role in this process. Programs that provide job training, resume development, and employment placement empower individuals to regain a sense of independence and purpose, both of which are essential for reducing the risk of relapse and enhancing resilience (U.S. DHUD, n.d.). When these services are integrated into recovery housing models, they offer a comprehensive approach that enables individuals not only to achieve stability but to thrive in their recovery journey.

Unmet Needs and Critical Gaps:

According to SAMHSA's Behavioral Health Services for People Who Are Homeless, individuals without stable housing face disproportionately high rates of substance use disorders. Estimates show that 17-33% of people experiencing homelessness struggle with SUDs, substantially higher than in the general population.

SAMHSA and the Department of Housing and Urban Development (DHUD) report that over half of adults in permanent supportive housing have mental or co-occurring mental and substance use disorders. Those without stable housing are at elevated risk of substance-related overdose.

Individuals in recovery, particularly those with prior justice involvement, often face systemic obstacles to accessing housing:

- Criminal records and past convictions, even minor or unrelated to the offense, routinely disqualify them from traditional housing programs.
- any who are sober, yet probation-involved are unable to benefit from stable housing, increasing their risk of relapse and recidivism.

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

Prevalence Data:

Substance use among women in the United States remains a significant public health concern. According to the 2023 National Survey on Drug Use and Health (NSDUH), approximately 28.6 million women aged 12 and older reported using illicit substances in the past year, with 17.7 million reporting use in the past month.

In terms of prescription drug misuse, the 2023 NSDUH data indicate that 4.4 million women aged 12 and older reported non-medical use of prescription pain relievers in the past year. Among these, a significant proportion met criteria for a pain reliever use disorder, with 32.7% of female misusers classified as having a severe disorder.

These statistics underscore the ongoing challenges related to substance use among women and highlight the need for focused interventions and support services.

People who are pregnant and use substances face tremendous stigma from their family, social networks, and society. This stigma creates barriers to seeking and accessing treatment. Due to Kentucky being a predominantly rural state, consistent access to care presents a challenge. In rural areas of the state, Kentuckians have limited access to behavioral and medical health providers, resulting in pregnant persons seeking services in areas away from their residency and seeking services later in their pregnancies. According to the Kentucky Maternal Mortality Review (MMR), 88% of Kentucky's maternal deaths that were reviewed from 2017-2020 cohorts were considered preventable.

According to the 2023 National Survey on Drug Use and Health, 59% or 167.2 million people aged 12 or older in 2023 used an addictive substance within the past month. Approximately 47.5% drank alcohol, 17.6% used a tobacco product, 9.4% vaped nicotine, and 16.8% used an illicit substance in the past month.

According to the same survey, around 5% of pregnant women, aged 15-44, used one or more addictive substances, 8.4% reported using alcohol, and 13.7% smoked cigarettes in the past month. Pregnant women who chronically misuse prescription medications

also have a greater risk of medical complications.

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

In 2021, the rate of drug-induced deaths among women residents of Kentucky was 34.7 per 100,000 residents (Steel & Mirzaian, 2022a). In 2023, the number of drug overdoses among female Kentuckians was 653, which represents a 13.3% decrease compared to 2022. From 2021 (1,299) to 2023 (1,026), there was a 21% decrease in overdose deaths involving people of typical childbearing age (ages 15-45).

According to the 2023 Maternal Mortality Report, 58% of all maternal deaths in Kentucky had substance use as a contributing factor. Many death certificates have causes of death consistent with substance use. Deaths that met the classification of being accidental and related to substance overdose are noted within Figure 3 which is included in the SUD data tables document uploaded to this section of the application. According to the 2023 Child Maltreatment report, Kentucky has the eighth highest rate of caregivers with a substance use disorder, nearly 40% compared with the national average of about 25%.

Pregnancy-related mortality rates for Kentuckians decreased in 2018 and 2019 but increased to 21.2 deaths per 100,000 live births in 2020. This was lower than the 2020 U.S. rate of 23.8 deaths per 100,000 live births. See Figure 6, which is included in the SUD data tables document uploaded to this section of the application.

Substance use, including opioid use, during pregnancy has emerged as a notable public health concern that impacts both maternal and child health. Opioid use during pregnancy could result in maternal, fetal, and infant complications, such as neural tube defects, congenital heart defects, gastroschisis, microcephaly, and deficits in motor, language, and cognitive domains, along with low birthweight and preterm birth. The increase in maternal opioid use disorder has led to an increase in NAS (Asad et al, 2024).

Between 2019 and 2023, there was a dramatic decrease in the number of Kentucky infants hospitalized with NAS. In 2019, there were 1,102 babies with NAS hospitalized in the state. This decreased to 792 in 2023. (2019 NAS Annual Report).

Since then, Kentucky's NAS rate has been far higher than the national average, with some areas of Kentucky reaching more than ten times the most recent national estimate. In 2019, the Kentucky NAS Registry showed 1,102 unduplicated cases of NAS, which was an increase from 2018 (n = 907). In 2023, the Kentucky NAS Registry documented 792 unduplicated cases of NAS, which was a decrease from 2019. The most recent data available shows a 2023 rate of NAS/neonatal opioid withdrawal syndrome (NOWS) in Kentucky as 15.22 cases per 1,000 hospital births (KY CHFS, 2024). See Figure 1 and Table 4 which are included in the SUD data tables document uploaded to this section of the application.

Importantly, there are large discrepancies in NAS rates by Area Development Districts (ADD) across Kentucky. The rate of NAS in rural counties is nearly double the rate of urban counties, with the highest rates in rural Appalachia, ranging from 5.8 to 49.7 cases per 1,000 live births. See Figure 2 which is included in the SUD data tables document uploaded to this section of the application.

Unmet Needs and Critical Service Gaps:

Kentucky is primarily a rural state, which creates challenges in both identifying the need for services and providing access to services in many remote areas of the commonwealth. Excluding marijuana, rural Appalachian Kentucky has one of the highest occurrences of illicit substance use for persons aged 12 and older.

Stigma associated with pregnant persons and SUD continues to create barriers to the identification and treatment of this population. To reduce stigma, ongoing training and consultation with professionals and community partners continue to be crucial.

Kentucky has faced ongoing challenges with the development of comprehensive SUD treatment services in part due to the expansion of Medicaid enrollees and the subsequent growth of new behavioral health provider types across the state. While having substance use disorder treatment services included in the Medicaid State Plan Amendment in 2014 has been an important inclusion, the subsequent creation of new provider types, including Behavioral Health Service Organizations (BHSOs), has been challenging. BHSOs are private organizations that are licensed to provide behavioral health services, most of which serve individuals with SUD.

Despite a recent increase in the availability of services for pregnant and parenting women, the opioid epidemic has placed a burden on Kentucky's system of care. There is a continuous need to increase access and improve the quality of services for this population. According to the annual Public Health Maternal Mortality Review, KIPRC, 2022, substance use is a contributing factor in more deaths of women during their pregnancies and up to one year post-delivery than any other cause in Kentucky, and has led to an increase in newborns hospitalized for NAS.

Early identification and treatment of pregnant women who use substances can reduce the risks of substance-exposed infants

(SEI), fetal alcohol spectrum disorders (FASD), NOWS, and NAS. The Health Insurance Portability and Accountability Act (HIPAA) restrictions also make it difficult for the physician treating infants to gain access to the mother's medical record and may limit the ability of that physician to identify risk factors for SEI and/or NAS and screen the infant appropriately.

Women with a substance use disorder who have dependent children
Prevalence Data:

The U.S. Department of Health & Human Services Children's Bureau Child Maltreatment Report 2023 released in 2025 shows Kentucky had more than 39,000 screened in abuse referrals/reports with 14,484 child victims, meaning about 14.2 out of every 1,000 children in the commonwealth experienced some type of abuse, placing Kentucky as the state with the fourth highest child maltreatment victimization rates in the country. An overall decrease in child victims was observed between FFY 2022 and FFY 2023. Kentucky has worked over the past several years to implement a safety model and a thorough review and modification of the state's acceptance criteria to ensure a focus on children and families with true safety threats versus risk factors. Kentucky's rate is nearly double the U.S. average of 7.4. The report found that most child victims in Kentucky and nationally were younger than one year old. Experts were concerned that the COVID-19 pandemic would lead to a spike in child abuse numbers. The pandemic left families facing financial, emotional, and other stresses, combined with spending long periods isolated at home with a lack of structure and support. These stressors can lead to potentially dangerous situations.

In Kentucky, substance use/misuse has increasingly negative effects on child and family well-being, with increased misuse of prescription pain medications, heroin, and fentanyl, along with the resurgence of cocaine and methamphetamine, often laced with potent, synthetic opioids. According to the Kentucky Center for Economic Policy, approximately 70% of current foster cases in 2019 related to substance use either directly or indirectly. Within the last year (05/01/2024-04/30/2025), substance use as a risk factor was present and/or contributed (indirectly or directly) to 54.32% of the 51,035 intakes through the Department for Community Based Services (DCBS) that met acceptance criteria for abuse and/or neglect. Among young children who were involved in a report with child protective services in Kentucky, 3.54% or 667 infants were found at risk of neglect due to being identified as a substance-affected infant. Please see Table 5 which is included in the SUD data tables document uploaded to this section of the application.

With the continued rise in opioid use disorder (OUD), there continues to be an increase in reports of substance-exposed infants. In addition, Kentucky has seen a significant increase in infants hospitalized with neonatal abstinence syndrome (NAS) due to opioid use during pregnancy (KIPRC, 2022). Between 2000 and 2019, there was a dramatic increase in the number of Kentucky infants hospitalized with NAS. In 2019, the Kentucky NAS Registry reported that there were 1,102 babies with NAS hospitalized in the state. This decreased to 792 in 2023. Since then, Kentucky's NAS rate continues to be far higher than the national average. The most recent data available shows a 2023 rate of NAS/neonatal opioid withdrawal syndrome (NOWS) in Kentucky as 15.22 cases per 1,000 hospital births (KY CHFS, 2023).

Kentucky has been significantly impacted by the opioid and drug overdose crisis, but recent data indicates a positive trend with decreasing overdose deaths. This steady decline began in 2022 with the first marked decrease of 5% in overdose deaths since 2018. This trend continued with a 9.8% decrease from 2022 to 2023 and then to a 30.2% decrease from 2023 to 2024.

Per the 2024 Drug Overdose Fatality Report, 1,410 Kentucky residents died from a drug overdose in 2024, a decrease of 30.2% from the 2,020 resident deaths in 2023, resulting in a rate of 32.0 deaths per 100,000 residents. Data from the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics indicate there was a 34.16% decrease nationally in overdose deaths involving opioids from 83,140 in 2023 to 54,743 in 2024. While prescription opioids are not a primary driver of drug overdose in the United States, they do contribute to opioid-related deaths. CDC Overdose Prevention Data In 2023, Kentucky's opioid dispensing rates were 58.3 prescriptions dispensed per 100 persons, placing Kentucky 17th in the nation. Fentanyl was identified through Kentucky toxicology in 878 drug overdose deaths, representing 62.3% of the total drug overdose deaths in 2024, and a decrease of 39.4% from the 1,450 drug overdose deaths involving fentanyl in 2023, in Kentucky.

While opioids continue to be the primary contributing factor in drug overdose deaths, a growing percentage involve methamphetamine. Methamphetamine was identified in 716 drug overdose deaths, representing 50.8% of the total drug overdose deaths in 2024, and a decrease of 28.9% from the 1,007 drug overdose deaths involving methamphetamine in 2023. (2024 Drug Overdose Fatality Report).

There is variability in the rate of drug overdose deaths by county and region of Kentucky, 2024 Drug Overdose Fatality Report. For example, Estill County had the highest rate of fatal drug overdose deaths for the past several years, resulting in an increase from 201 in 2023, from 156.1 to 187.3 per 100,000 residents. However, in 2024, overdose death rates began to shift and decrease. Estill County saw a significant decrease (54.4%) from the year before. Even though Lee County saw a slight increase in their rates (0.06%), they were still 16.7% lower than the number one position the year before. In addition to Lee County, the highest rates of overdose deaths in 2024 continue to be found in Appalachian counties, Knott (134.6), Breathitt (129.6), Powell (109.8), and Estill (85.4) counties.

In Kentucky, the impact of substance use on individuals and families continues to be a significant concern, with increasing effects on child and family well-being. According to the 2023 Child Maltreatment Report, there were 323 screened-in reports regarding

infants with prenatal substance exposure. Of those 323 screened-in reports, 90 were found to have been referred to appropriate services, while only 67 were found to have a plan of safe care.

With regards to NAS in Kentucky, there are large discrepancies in NAS rates by area development districts (ADD) across Kentucky. The rate of NAS in rural counties is nearly double the rate than in urban counties, with the highest rates in rural Appalachia. These discrepancies range from 5.8 to 49.7 cases per 1,000 live births. (2024 Neonatal Abstinence Report).

The prevalence of OUD among pregnant women in Kentucky rose dramatically between 1999 and 2014, increasing nearly 48-fold to 19 cases per 1,000 deliveries (Haight, Ko, Tong, Bohm, & Callaghan, 2018). Despite this sharp rise, women diagnosed with OUD represent only a small portion of those using opioids during pregnancy, an estimated 1 in 15, most of whom report non-prescription use (Ko et al., 2020).

Kentucky designated NAS as a reportable condition in 2013 through Kentucky Revised Statutes KRS 211.676, with mandatory statewide reporting beginning on July 15, 2014. The state's NAS reporting registry collects data from hospitals on Kentucky resident infants diagnosed with NAS and known prenatal substance exposure. Notably, case identification for the registry is independent of International Classification of Diseases (ICD) coding (Kentucky Department for Public Health, 2023).

In 2023, 34 hospitals in Kentucky submitted NAS case reports to the state registry, with an average submission occurring 35 days post-discharge. Delays in reporting can negatively affect data quality. The data system does not distinguish the timing or intent of substance use, which impacts data on polysubstance use and medications for opioid use disorder (MOUD). Finally, out-of-state hospitals do not report to the NAS registry, which may lead to underreporting near state borders.

In comparison, the most recent national estimate for NAS was 5.4 cases per 1,000 live births (HCUP Fast Stats, 2020), placing Kentucky far above the national average with 15.22 KY NAS cases per 1,000 live births. Please see Figure 1 which is included in the SUD data tables document uploaded to this section of the application. Even though Kentucky rates are higher than the national average, the rate of NAS has continued to decrease over the last two years. Data from the NAS registry shows 792 unduplicated cases in 2023, which is a decrease from 2022.

Opioids continue to be an issue for Kentucky, with 87% of NAS cases reporting opioid use. The second most commonly reported substance in 2023 was methamphetamines, including amphetamines, which were reported in 42% of all NAS cases. Use of these substances has increased in recent years, from 35.55% in 2020 to 41.92% in 2023.

Buprenorphine (59.47%), unspecified opioids (28.28%), fentanyl (25.76%), heroin (17.3%), and methadone (10.5%) were the most frequently reported opioids at the time of birth. More than one-third of the cases in the NAS registry were exposed to cannabinoids. About 73% of all reported NAS cases presented with polysubstance use, which means the use of substances from more than one type or category, excluding tobacco and alcohol. Polysubstance use may contribute to prolonged or more severe NAS symptoms. When used with opioids, cocaine, benzodiazepines, and antidepressants can be associated with worsened NAS symptoms. Although buprenorphine and methadone can produce NAS, these drugs are forms of MOUD used under medical supervision for the treatment of OUD, which is preferable to untreated OUD during pregnancy. Increased access to and utilization of MOUD may explain why these medications are two of the most reported substances to the NAS registry. Nearly half (49%) of women on the NAS registry had a prescription for medications to treat substance use disorder (KY CHFS, 2024).

In addition, infants with NAS are twice as likely to have a low birth weight and three times as likely to be admitted to a neonatal intensive care unit (NICU) (KY CHFS, 2023). Tobacco use co-occurs with substance use at high rates, which could further affect the health and development of these infants and increase any present NAS symptoms. Kentucky Office of Vital Statistics data shows smoking during pregnancy is over seven times more common among women whose babies have NAS. Compared to babies without NAS, 14% of women reported they had smoked during pregnancy, which was significantly lower than the percent of women whose babies have NAS (67%) (KY CHFS, 2024). Infants with NAS can have difficulties feeding and gaining weight, which further increases the health risks and challenges associated with preterm and low birth weight. These conditions are associated with medical complications that result in a longer duration of hospitalization. In 2023, about 11% of newborns without NAS had NICU stays, compared to 30% of newborns with NAS, and there is a national trend of NICUs dedicating increasing resources to NAS (Tolia et al., 2015). Infants with NAS are hospitalized approximately 3.5 times longer than infants without NAS at delivery (12.6 days versus 3.6 days, respectively). Overall, 46% of infants with NAS receive one or more medications to treat NAS. Infants with NAS who received pharmacological treatment (46%) had average hospital stays of 20.6 days compared to 5.9 days for infants who received comfort care only (KY CHFS, 2024). Among infants who received pharmacological treatment in 2021, the most common pharmacological treatments were morphine (93.6%), which aligns with research on prescribing practices. About one-third were prescribed clonidine, with approximately 36.2% of infants with NAS receiving multiple medications, which would indicate babies with severe signs of withdrawal. (KY CHFS, 2024).

Unmet Needs and Service Gaps:

Kentucky had more than 39,000 abuse cases, meaning about 14 out of every 1,000 children in the commonwealth experienced some type of abuse. The U.S. average is 7.4. Additionally, the pandemic left families facing financial, emotional, and other stresses, combined with spending long periods isolated at home with a lack of structure and support. These stressors can lead to potentially dangerous situations.

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

Other areas of need include:

- Additional treatment programs that incorporate services for families with children.
- Support services specific to families with children, including childcare, parenting supports (including parenting programs specific to families affected by SUD), supportive housing services, supported employment, peer support, transportation, and life skills development.
- Enhanced communication, collaboration, and coordination of services between DCBS, CMHCs, and other community partners to support Kentuckians, their families, and children affected by substance use and misuse.
- More training focused on increasing the use of evidence-based practices in treatment programs to ensure the provision of effective and appropriate SUD treatment, particularly for individuals with opioid use disorders.
- Integration with primary care providers to identify, refer, and follow up individuals at risk of or misusing substances, including pregnant persons.

Persons who inject drugs (PWID):

Prevalence Data:

DBHDID utilizes block grant funds to contract with 14 Community Mental Health Centers (CMHCs) to provide behavioral health services. The CMHCs are statutorily required to provide comprehensive behavioral health services that collectively cover all 120 counties in Kentucky. They are considered a safety net of providers for individuals with mental health and substance use disorders in Kentucky.

Data shown in Figure 1- Persons who inject drugs, which is included in the SUD data tables document uploaded to this section of the application outlines the number of persons who inject drugs served by the CMHCs for the last three state fiscal years. These numbers have remained consistent over that period.

Since SUD services became Medicaid reimbursable in Kentucky (around 2014) and additional Medicaid provider types for behavioral health were added, additional treatment providers have emerged across the state that serve individuals with SUD. As of April of 2025, there are 204 Behavioral Health Services Organizations/Multi-Specialty Groups licensed to provide Medicaid reimbursable SUD services, in addition to the 14 CMHCs. Kentucky currently has 1,260 licensed Alcohol or Other Drug Entity (AODE) providers. This includes extension sites, residential, outpatient, DUI, and NTP providers.

As additional providers have emerged, the overall number of persons with substance use disorder served by the CMHCs has trended downward. However, the number of persons who inject drugs served by the CMHCs has remained steady.

Persons who inject drugs continue to be at high risk for overdose, infectious disease, and chronic medical conditions. An estimated 2.6% of Kentuckians currently inject drugs or have a history of injection drug use. An estimated 67% of persons who inject drugs also have Hepatitis C virus (HCV), half of whom do not know their HCV status. (Dearing et al., 2019). Among the 14,474 admissions for SUD treatment in Kentucky (Treatment Episode Data Set-Admission (TEDS-A) in the 2022 dataset, 22.4% (n = 3,243) reported current injection drug use at admission. (Substance Abuse and Mental Health Services Administration, 2023) Even though the vast majority of admissions had co-occurring mental health and substance use disorders noted in their admission record, a significantly higher percentage of persons who inject drugs (99.8%) had co-occurring mental health and substance use disorders compared to individuals who did not currently inject drugs (95.4%), (N = 14,474) = 142.599, p < .001). (Cole, 2025).

Data trends regarding individuals who inject drugs reveal that the percentage of adults receiving services from CMHCs in Kentucky report lifetime intravenous drug use as they entered treatment from fiscal years 2008 to 2023. See Figure 2- Persons who inject drugs, which is included in the SUD data tables document uploaded to this section of the application.

Misuse of prescription opioids is the greatest risk factor for progression to intravenous heroin use. (CDC 2015) Persons with an opioid use disorder who use prescription opioids are 40 times more likely to use heroin. (CDC, 2015) Dispensing rates for opioids vary widely across states and counties, but they remain highest among southern states. Kentucky had the fifth-highest rate of opioid prescribing in the U.S. in 2020, at 68.2 opioid painkiller prescriptions for every 100 people. (CDC, 2021) In 2023, Kentucky dropped to sixth in the U.S. for the highest rate of opioid prescribing at 58.3 per 100 persons. (CDC, 2024 Nov 7) This remains well over the national average of 37.5 opioid prescriptions dispensed per 100 persons in 2023. (CDC, 2024 Nov 7) See Figure 3- Opioid dispensing rates, which is included in the SUD data tables document uploaded to this section of the application.

In 2020, 51 Kentucky counties had opioid dispensing rates that were higher than the U.S. average rate of 43.3 prescriptions per 100 persons. (CDC, 2022) In 2023, 54 Kentucky counties had opioid dispensing rates higher than the national average of 37.5 opioid prescriptions dispensed per 100 persons. Opioids continued to drive the increase in drug overdose deaths. However, Kentucky has seen a decrease in drug overdose deaths for three years in a row:

- In 2024, there were 1,410 overdose deaths. This is a decrease of 30.2% from 2023.
- In 2023, there were 2,020 overdose deaths. This was a decrease of 8.2% from 2022.
- In 2022, there were 2,200 overdose deaths. This was a decrease of 2.5% from 2021 and was the first year Kentucky saw a decrease in overdose deaths since 2018. (KODCP, 2025)

In 2021, 79.6% of drug overdose deaths (unintentional and undetermined intent) in Kentucky involved any opioids, with the most frequently reported opioid being illicitly manufactured fentanyl. (Steel & Mirzaian, 2022) Fentanyl was identified through toxicology in 878 drug overdose deaths, representing 62.3% of the total drug overdose deaths in 2024 and a decrease of 39.4% from the 1,450 drug overdose deaths involving fentanyl in 2023. Other prevalent drugs found through toxicology are as follows:

- Methamphetamine was identified in 716 drug overdose deaths, representing 50.8% of the total drug overdose deaths in 2024, and a decrease of 28.9% from the 1,007 drug overdose deaths involving methamphetamine in 2023.
- Cocaine was identified in 284 drug overdose deaths, representing 20.1% of the total drug overdose deaths in 2024, and a decrease of 27.6% from the 392 drug overdose deaths involving cocaine in 2023.
- Acetylfentanyl was identified in 389 drug overdose deaths, representing a decrease of 46.1% from the 722 drug overdose deaths involving acetylfentanyl in 2023.
- Oxycodone was identified in 115 drug overdose deaths, representing a decrease of 24.3% from the 152 drug overdose deaths involving oxycodone in 2023.
- Heroin was identified in 38 drug overdose deaths, representing a decrease of 2.6% from the 39 drug overdose deaths involving heroin in 2023.
- Alprazolam was identified in 99 drug overdose deaths, representing a decrease of 34% from the 150 drug overdose deaths involving alprazolam in 2023. (KODCP, 2025)

Kentucky ranked third in the U.S. for drug overdose deaths (unintentional, intentional, undetermined) in 2020 at 49.2 per 100,000 (age-adjusted), fifth in the U.S. at 55.6 (age-adjusted) drug overdose deaths per 100,000 in 2021, and seventh in the U.S. at 53.2 drug overdose deaths per 100,000 in 2022. (CDC, 2023) In 2024, prevalence was reported in the following populations:

- 170 Black Kentucky residents died from a drug overdose in 2024, a 37.3% decrease from the 271 Black resident deaths in 2023. The rate of drug overdose deaths among Black residents in 2024 was 43.3 deaths per 100,000 Black residents, which was 37% greater than the rate of deaths among White residents and a decrease from the 69.2 deaths per 100,000 Black residents in 2023. The rate for White residents in 2024 was 31.6 deaths per 100,000 White residents, a decrease from the 45.7 deaths per 100,000 White residents in 2023.
- The age group of 35- to 44-year-olds had the highest number of drug overdose deaths in 2024 at 379, a decrease of 34.8% from the 581 deaths among that age group in 2023. The number of drug overdose deaths for residents who were four years old and younger decreased from nine deaths in 2023 to five deaths in 2024.

Unmet Needs and Critical Service Gaps:

Although MOUD services are more widely available across the state, there remains resistance and stigma in many communities regarding the use of medications to treat substance use disorder. This has limited some client access to person-centered services and a complete continuum of evidence-based care.

With the number of individuals experiencing overdose due to opioid use, there is a need to provide immediate, low-barrier access to SUD services. Even with Medicaid expansion and an enhanced network of behavioral health providers in the state, Kentucky remains a primarily rural and mountainous state, with many of the available services clustered in the urban and more populated areas. Access to services for many in the state remains difficult due to poverty, transportation barriers, location of services, and co-morbid, chronic medical conditions.

DBHDID is gathering information to improve understanding of the current barriers for individuals who inject drugs that need treatment for SUD, and who also have chronic health conditions, in an environment lacking in resources, especially among underserved populations.

DBHDID has identified one population at risk of negative outcomes, including death, due to a lack of resources that are capable of effectively treating their substance use disorder in a residential setting. These are individuals who fall within a 3.5 – 3.7 level of care, as determined by the American Society of Addiction Medicine (ASAM) Criteria Fourth Edition, who are released from hospitals and who require the use of a Peripheral Inserted Central Catheter (PICC) line due to chronic health conditions. Research suggests that individuals with substance use disorder who inject drugs are at higher risk of developing complications requiring PICC lines, such as infections and vascular damage. However, there is a notable lack of integrated care for people with both addiction and complex medical needs. While data on the exact number of individuals with both PICC lines and SUD remains limited, the need for integrated treatment programs that address both addiction recovery and medical management is growing, especially in light of the increasing number of people with opioid use disorder (OUD) and other injected drug use. (IDU)

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

of December 31, 2023, the cumulative number of Human Immunodeficiency Virus (HIV) disease cases in Kentucky was 12,418. Most cases have been diagnosed in white, non-Hispanic males between the ages of 30 and 39.

Over the ten years between 2013 and 2022, the rate of HIV in Kentucky has remained somewhat stable, with a slight reduction in prevalence in 2020 and an increase beginning in 2022. The decrease in the incidence rate that occurred in 2020, as compared to pre- and post-pandemic rates, could be attributed to the shutdown of social venues, coupled with masking and social distancing required in response to the COVID-19 Pandemic. Currently, there are approximately 8,132 individuals in Kentucky who are living with HIV disease (DPH, 2024). See Figure 1 – Annual HIV cases, which is included in the SUD data tables document uploaded to this section of the application.

Within the ten years between January 1, 2014, and December 31, 2023, there were 3,568 HIV disease cases diagnosed among Kentuckians, with 1,070 AIDS cases diagnosed. Most HIV cases that progressed to an AIDS diagnosis occurred within 30 days of HIV diagnosis. It is important to note that 2,498 HIV-only cases were diagnosed in the same timeframe, but they had not progressed to AIDS as of December 31, 2023 (DPH, 2024).

In 2022, an estimated 1.2 million people in the U.S. had HIV (CDC, Apr 22, 2024). The annual estimated national HIV diagnosis rate was 6.7 per 100,000 population. The diagnosis rates among the 50 states and Washington, D.C. ranged from 0.6 per 100,000 population (Vermont) to 31.4 per 100,000 (Washington, DC). In the United States, the rate of HIV infections decreased by 12% between 2018 and 2022 (CDC, Apr 22, 2024). In 2022, new infections numbered 31,800. The southern U.S. accounted for nearly half (49% or 15,700) of new HIV infections in 2022 (CDC, Apr 22, 2024).

Kentucky ranked 22nd with an estimated diagnosis rate of 9.0 per 100,000 (DPH, 2024). There were 405 and 365 cases of HIV diagnoses in 2022 and 2023, respectively (DPH, 2024). Kentucky's distribution of HIV cases closely parallels U.S. prevalence rates in sex, age of diagnosis, race/ethnicity, and transmission route (DPH, 2024).

People who inject drugs continue to be at high risk of contracting HIV. It is estimated that in 2022, nationwide, people who inject drugs accounted for 7% (2,300) of newly diagnosed HIV infections (31,800), with White individuals accounting for the highest number of people who inject drugs who were newly diagnosed with HIV. This represents an overall reduction of 5% in HIV diagnoses among people who inject drugs (CDC, Apr 22, 2024). Data from 2019 shows that the lowest percentages of treatment, remission, and survival rates after receiving an HIV diagnosis are persons aged 55 and over and persons with HIV attributed to injection drug use.

In Kentucky, between 2018 and 2022, the largest number of new female cases reported injection drug use (IDU) as their primary route of transmission. The number of new female cases reporting IDU decreased from 2018 to 2020, with an abrupt increase in 2021 (DPH, 2024), when business and social venues began to reopen following pandemic precautions. See Figure 2 – Female HIV cases by transmission route, which is included in the SUD data tables document uploaded to this section of the application.

In Kentucky, between 2018 and 2022, the largest number of reported cases of HIV were in White males. The number of males reporting IDU as a risk factor consistently increased between 2018 and 2022 (30 cases to 45 cases), with only a slight decrease in 2022 (39 cases) (DPH, 2024). See Figure 3 – Male HIV cases by transmission route, which is included in the SUD data tables document uploaded to this section of the application.

Of all individuals in Kentucky diagnosed with HIV between January 1, 2014, and December 31, 2023 (3,568), approximately 22% were diagnosed with concurrent HIV/AIDS, 9% of whom were people who inject drugs. (DPH, 2024)

As part of Kentucky's efforts to combat the substance use epidemic that affects many Kentuckians, in conjunction with DPH, DBHDID continues to monitor high-risk populations and treatment options. Working with providers to meet all the needs of individuals in treatment or in need of treatment for substance use disorders, many of whom have HIV/AIDS diagnoses, is a collaborative effort that directly impacts cases within the state.

Hepatitis C (HCV)

Kentucky has relatively low rates of HIV/AIDS compared to other southern states (CDC, 2024, April 22). However, data shows a much higher rate of Hepatitis C viral infection (HVC), with Kentucky ranked third in highest incidence rates of reported cases of acute HVC in 2023 (CDC, 2025 Apr 15, Fig. 3.2). Further, Kentucky saw consistent increases in incidence rates of reported cases, from 4.4 per 100,000 in 2021, 5.2 per 100,000 in 2022 (CDC, 2024 Oct 21, Fig. 3.2), to 5.9 per 100,000 in 2023, well above the national average of 1.5 per 100,000 (CDC, 2025 Apr 15, Fig. 3.2). However, in 2023, Kentucky saw a marked improvement in the mortality rate, with HCV listed as a cause of death, from 5.27 per 100,000 in 2022 (CDC, 2024, Oct 21, Tab. 3.7), to 4.16 per 100,000, going from third highest in HVC deaths in 2022 to eighth (CDC, 2025 Apr 15, Tab. 3.7). Based on the Hepatitis C Elimination Plan by the Kentucky DPH, elevated rates have been driven by increases in injection drug use with nonsterile equipment, particularly in rural Appalachia. Estimates of Kentuckians currently living with Hepatitis C range from 43,000 to a more recent, locally derived estimate of 78,000. (DPH, 2022 Jul 27)

There were 67,400 estimated acute HCV infections in the U.S. during 2022 (CDC, 2024 Oct 9), and 9,000 estimated acute HCV infections during 2023 (CDC, 2025 Apr 15). Also in 2023, rates of acute HCV were highest among males, persons aged 30–39 years, non-Hispanic American Indian/Alaska Native (AI/AN) persons, and those living in the Eastern and Southeastern states. Among

cases with risk information reported, the most common risk factor was injection drug use (CDC, 2025 Apr 15). In 2022, IDU was associated with more than half (52%) of HCV transmission in the U.S. (CDC, 2024 Oct 21), with only about half of persons who inject drugs knowing their HCV status (Kentucky Budget Review Subcommittee on Human Resources, 2019). Likewise in 2023, case reports with at least one risk behavior/exposure reported six weeks to six months prior to symptom onset or documented test conversion, if asymptomatic, most often reported IDU (CDC, 2025 Apr 15, Fig. 3.7). Historically, a large portion of young adults with HVC report IDU use as their principal risk factor. (Schillie et al., 2020)

Unmet Needs and Critical Gaps:

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

Many Kentuckians with HIV do not get tested before they become sick. As of June 30, 2017, 10,244 HIV infections had been diagnosed among Kentuckians, and 63 percent of those cases progressed to AIDS. Of the 3,600 AIDS cases diagnosed in the last ten years, 24% were unaware of their HIV infection until 30 days or fewer before their AIDS diagnosis. This means many had been infected and were infectious for ten or more years before ever testing.

Researchers point to an explosion of HIV's widely accepted harbinger: the potentially deadly liver disease Hepatitis C. Kentucky is one of nine states with the highest incidence rates of reported cases of acute Hepatitis C virus infection. Like HIV, HCV can be spread by sharing needles, and it is easier to contract. It is not uncommon for individuals to have both diseases. From 2013 to 2016, Kentucky's prevalence rate for HCV surpassed the southern U.S. and national HCV rates, as well as HCV mortality rates in 2022. See Figure 4 – Hepatitis Prevalence Rates, which is included in the SUD data tables document uploaded to this section of the application.

Individuals with or at risk of tuberculosis

Prevalence Rate:

Overall, over the last 20 years, 1993 to 2023, rates of tuberculosis (TB) have decreased gradually across the U.S., with little upward fluctuation. As of 2023, the rate of TB in the U.S. was 2.9 cases per 100,000 persons (CDC, Jul 2024). In 2020, a noticeable reduction in the incidence rate occurred compared to pre- and post-pandemic levels: 2.4 cases per 100,000 (CDC, Jul 2024). This significant reduction in cases can be attributed to the shutdown of businesses, schools, churches, and social venues, coupled with masking and social distancing, required in response to the COVID-19 Pandemic. However, beginning in 2022, a trend of increased cases began nationally. This could be attributed to a rebound effect, meaning that with the reopening of community settings and increased interpersonal interaction, there was more opportunity for the transmission of TB. See Figure 1 – TB Cases and Incidence Rates, which is included in the SUD data tables document uploaded to this section of the application.

As reported by the Kentucky Department of Public Health (DPH), 75 cases of tuberculosis were reported statewide for 2023, which is a rate of 2.4 per 100,000 population (DPH, 2025). Kentucky's total population for 2023 was estimated at 4,526,154 (U.S. Census Bureau, 2024). Kentucky's incidence rate is below the national incidence rate for the U.S. in 2023 of 2.9 per 100,000, based on the total national population of 331,501,080 (Census Bureau, 2024).

Preliminary reporting for 2024 shows 93 cases of tuberculosis statewide, which is a rate of 2.0 per 100,000. Kentucky's estimated population for 2024, per the U.S. Census Bureau, is 4,588,372. It is important to note that prior to 2022, Kentucky saw a nearly continual reduction of cases of tuberculosis since 2000, when the rate was 3.7 per 100,000. Similarly to what was seen nationally, with the reopening of businesses, churches, and social venues, Kentucky saw a rebound of cases, increasing gradually each year from 57 cases in 2021 to 93 cases in 2024. However, despite these slight increases, Kentucky remains under the national average for incidence rate and continues to be considered a low-incidence state.

Sources: Centers for Disease Control and Prevention (CDC). (Oct 2024). Reported Tuberculosis in the United States, 2023: TB by Reporting Areas: 2022 and 2023. Atlanta, GA: Centers for Disease Control and Prevention at <https://www.cdc.gov/tb-surveillance-report-2023/tables/table-2.html>.

Cabinet for Health and Family Services, Department for Public Health, Division of Epidemiology and Health Planning, Infectious Disease Branch. (Winter/Spring, 2025). The DOT: Discussion on Tuberculosis; Kentucky's 10-year tuberculosis confirmed case counts and incidence rates, 2015-2024. Frankfort, KY: Kentucky Tuberculosis Prevention and Control Program, retrieved 04/24/2025 at <https://content.govdelivery.com/accounts/KYCHFS/bulletins/3d1cac3?reqfrom=share>.

United States Census Bureau. (Dec 2024). State Population Totals and Components of Change: 2020-2024. Washington, D.C.: United States Census Bureau, retrieved 04/24/2025 at <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html>.

Unmet Needs and Critical Service Gaps:

Despite the relatively low rates of tuberculosis in Kentucky, the CDC (2025 Jan 17) advises that persons with weakened immune systems are at a higher risk of contracting tuberculosis. This includes individuals experiencing substance use disorders. In the U.S.

in 2023, the most common social risk factors reported were current or former tobacco smoking (31.2%), excess alcohol use (7.9%), and noninjectable drug use (7.8%) (CDC, Jul 2024). As of April 2021, Kentucky ranks among the highest states in the U.S. for drug use and addiction. In terms of the cost of opioid-use disorder and deaths from it, Kentucky ranked fourth out of the 38 states studied for per-resident costs of opioid-use disorder and deaths (Cross, 2021).

In addition, individuals who live in congregate settings, including correctional facilities, detention centers, residential facilities, and homeless shelters, have an increased risk of becoming infected with tuberculosis due to shared airspaces (CDC, Jan 31, 2025). The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), works to ensure that SUD treatment and recovery service providers who receive state and/or federal funding are utilizing appropriate and effective TB control policies.

Source: Centers for Disease Control and Prevention (CDC). (Jan 17, 2025). Tuberculosis: Causes and How It Spreads. Atlanta, GA: Centers for Disease Control and Prevention, retrieved 04/24/2025 at <https://www.cdc.gov/tb/causes/index.html>.

Centers for Disease Control and Prevention (CDC). (Jan 31, 2025). Health Disparities in Tuberculosis. Atlanta, GA: Centers for Disease Control and Prevention, retrieved 04/24/2025 at <https://www.cdc.gov/tb/health-equity/index.html>.

Cross, A. (2021). Kentucky Health News. Study: Kentucky ranks fourth, among 38 states studied, in per-resident costs of opioid-use disorder and deaths resulting from it. Retrieved 04/24/2025 at Kentucky Health News, Study: Kentucky ranks fourth, among 38 states studied

Persons in need of Recovery Support Services for Substance Use Disorder (PRSUD)
Prevalence Data:

Recovery support services, including prevention, early intervention, and treatment strategies, continue to play a vital role in empowering individuals to achieve and maintain sobriety while addressing the broader challenges associated with substance use disorders. This is particularly crucial given that the percentage of adults who reported using prescription drugs non-medically (including pain relievers, stimulants, and sedatives) or illicit drugs (excluding cannabis) in the last 12 months in Kentucky is 20.9%, highlighting the ongoing need for comprehensive support services. This statistic places Kentucky 45th out of 50 states in terms of substance use challenges, emphasizing the urgent demand for effective recovery resources. See Figure 1 – Non-Medical Drug Use, which is included in the SUD data tables document uploaded to this section of the application.

Substance use disorders (SUDs) are a significant public health concern in the United States, particularly among young adults aged 18-25. Nationally, approximately 13.5% of individuals aged 12 and older reported using drugs in the past month, with young adults exhibiting the highest rates of substance use.

In Kentucky, the situation is particularly alarming, with around 137,000 individuals aged 18-25 reporting drug use in the last month. The estimated prevalence of opioid use disorder (OUD) among adults in Kentucky was 5.9% in 2019, with some counties experiencing rates as high as 17.7%. Furthermore, Kentucky has one of the highest opioid overdose mortality rates in the nation, with 79.1% of overdose deaths in 2023 involving fentanyl.

Kentucky faces a significant need for recovery support services due to the ongoing substance use crisis affecting many of its communities. While exact numbers of people seeking or in recovery are unavailable, the combination of high SUD prevalence and robust treatment infrastructure suggests that a substantial number of Kentuckians are actively engaged in recovery efforts.

Recovery support services are essential due to the multifaceted challenges individuals face when overcoming SUD. While initial treatment addresses the immediate aspects of addiction, long-term recovery necessitates ongoing support to tackle underlying issues such as mental health conditions, social isolation, and the risk of relapse.

Social support plays a pivotal role in recovery by providing emotional encouragement, reducing feelings of loneliness, and fostering a sense of belonging. Engaging with peers who have shared experiences can offer practical advice and accountability, which are crucial for maintaining sobriety. Recovery community centers facilitate substance-free social activities, helping individuals build healthier lifestyles and coping strategies. With 15 recovery community centers in 13 counties, these centers have provided more than 179,000 engagements in SFY 2024, averaging 542 people per day. These centers also offer opportunities for individuals to support others, reinforcing their commitment to recovery.

Moreover, recovery support services help address the stigma associated with addiction, which often deters individuals from seeking help. By providing a supportive environment, these services empower individuals to rebuild their lives, restore relationships, and reintegrate into society. In Kentucky, where overdose rates remain a significant concern, enhancing access to comprehensive recovery support is vital for fostering long-term recovery and improving public health outcomes.

Unmet Needs and Service Gaps:

Across Kentucky, significant unmet needs remain in recovery support services for individuals of all age groups, with notable disparities in rural areas and among young adults. Many rural communities lack sufficient access to recovery community centers, peer support programs, and other critical recovery services, exacerbated by the absence of public transportation. This creates

barriers for individuals seeking support, particularly in counties with disproportionately high rates of substance use. Limited access to wraparound supports such as housing, employment assistance, and transportation further compounds the challenges faced by individuals in these areas.

For young adults (ages 18-25), there is a distinct lack of developmentally appropriate recovery support services tailored to their unique needs. Nationally, young adults report the highest rates of substance use, with 13.5% of individuals aged 12 and older reporting drug use in the past month, and substance use among young adults is disproportionately high (SAMHSA, 2021). However, in Kentucky, few programs focus on this age group's unique challenges, such as navigating major life transitions, peer influences, and identity development. Peer support programs and youth-focused recovery centers, which have been shown to improve long-term outcomes, remain limited across the state, particularly outside urban areas.

The lack of accessible and developmentally appropriate recovery support for young adults underscores the urgent need for expanded services, including youth-focused peer recovery programs, transitional housing, and developmentally informed recovery services. Addressing these gaps is critical to ensuring equitable access to recovery resources statewide and reducing barriers to sobriety for all individuals, especially young adults in rural and underserved communities.

Adults with Co-Occurring Mental Health and Substance Use Disorders Prevalence data:

According to the SAMHSA report, Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (July 2024), approximately 22.8 million adults (aged 18 or older) were diagnosed with any mental illness (AMI), with 5.7% or 14.6 million adults diagnosed with serious mental illness (SMI). Also in 2023, 48.5 million people aged 12 or older (17.1 percent of the population) were diagnosed with a substance use disorder (SUD), with 28.9 million people experiencing an alcohol use disorder and 27.2 million people experiencing a drug use disorder. Similarly, in 2023, approximately 20.4 million adults were diagnosed with co-occurring AMI and SUD (either with or without SMI), while 6.8 million adults had SUD and SMI. See Figure 1 – Any mental illness or substance use disorder, which is included in the SUD data tables document uploaded to this section of the application.

Further, the data reflect that 32.8%, or 84.5 million people, had either an AMI or SUD. Among the 58.7 million adults with AMI, approximately one-third (20.4 million people) also had a SUD. The number of individuals with co-occurring AMI and SUD represented less than half of the 46.3 million adults diagnosed with SUD in 2023.

With high rates of SUD statewide, co-occurring mental health disorders and SUD is a serious concern in Kentucky. According to the DBHDID data collected from the Community Mental Health Centers (CMHCs) across the state, the rates of individuals served by the CMHCs with diagnosed SUD (See Figure 2 – SA Clients Served, which is included in the SUD data tables document uploaded to this section of the application) has shown a slight decline, while those diagnosed with a mental health disorder with co-occurring SUD has increased in SFY 2024 (See Figure 3 – M/SUD Served 2024, and Figure 4 - M/SUD Served 2023, which is included in the SUD data tables document uploaded to this section of the application).

Age-Specific Profiles

Young adults ages 18 – 25 represent the highest co-occurrence of mental illness and SUD, with 14.1% diagnosed with AMI and SUD (approximately 4.8 million people) and 5.4% diagnosed with SMI and SUD (approximately 1.8 million people).

Adults, ages 26-49, made up 10.9% of individuals diagnosed with AMI and SUD, and 3.9% of individuals with SMI and SUD.

Much lower rates of older adults, ages 50 and older, were diagnosed with AMI and SUD (3.6%) and SMI and SUD (0.8%). The significant lack of specialized services for older adults in mental health and SUD treatment programs, and a high level of stigma among this age group, suggests that data regarding older adults with mental health and SUD is vastly underreported. (NSDUH, July 2024)

Unmet Needs and Critical Gaps:

Of adults (ages 18 and older) who needed treatment services in 2023, those individuals requiring treatment for co-occurring disorders, AMI and SUD, or SMI and SUD received the least amount of treatment services or received incomplete treatment services.

For individuals ages 18 and older:

- 62.4% (12.8 million people) received either mental health or SUD treatment,
- 37.6% (7.7 million people) received neither mental health nor SUD treatment,
- Among adults with AMI and SUD who received treatment:
 - o 64.4% received mental health treatment only (8.2 million people);
 - o 3.6% received SUD treatment only (0.74 million people); and
 - o 18.6% received both mental health and SUD treatment (3.8 million people).

Regarding adults (ages 18 and older) with SMI and SUD (approximately 6.8 million people), 75% received treatment (either mental health and/or SUD treatment). In contrast, 25% received neither mental health nor SUD treatment services. Among adults receiving treatment:

- o 47.3% received mental health treatment only;
- o 2.4% received SUD treatment only; and
- o 25.4% received both SMI and SUD treatment services (NSDUH, July 2024)

Barriers to effective and efficient treatment for individuals with co-occurring mental health and substance use disorders include, but are not limited to, the following:

- Failure to provide routine, comprehensive behavioral health screening and assessment to identify, diagnose, and connect individuals to appropriate services for co-occurring disorders;
- Lack of standardized training and credentialing for co-occurring service providers;
- Lack of integrated care and siloed service systems create gaps in services for individuals with co-occurring disorders; and
- Medicaid, Medicare, and private insurance billing practices and restrictions that may limit needed services for individuals with co-occurring mental health and SUD services. (SAMHSA, 2024)

Service Members, Veterans, and their Families in Kentucky
Prevalence Data:

Substance use disorder (SUD) continues to present significant challenges across the United States, particularly among service members, veterans, and their families (SMVF). National data from the National Institute on Drug Abuse (NIDA) indicate that more than one in ten veterans receiving care through the Department of Veterans Affairs (VA) meet the criteria for a substance use disorder, a slightly elevated rate compared to the general population. Veterans also face higher rates of co-occurring mental health conditions, highlighting the importance of integrated, trauma-informed, and recovery-oriented care.

In Kentucky, the landscape mirrors these national trends while also reflecting unique state-level challenges. The commonwealth has expanded access to behavioral health services, yet the SMVF population continues to face significant risk, particularly in terms of overdose mortality.

Current statewide initiatives are increasingly emphasizing whole-person, community-based recovery supports tailored to SMVF needs. However, ongoing work is essential to build recovery capital, reduce stigma, expand peer support services, and ensure access to evidence-based care. Kentucky's behavioral health system is poised to advance these goals through coordinated partnerships, data-informed planning, and culturally competent service delivery.

Kentucky has a strong military history and presence. Approximately 7.2% of the 4,588 million Kentuckians are veterans, compared to less than 1% of those who serve in the military nationwide. According to the VA Fiscal Year Benefits Report 2023, 267,611 military veterans reside in Kentucky, of which 26,573 are female and 241,038 are male. According to the report, the number of women veterans in Kentucky increased by 825. It is encouraging to see more women veterans seeking services and identifying themselves as veterans. However, many still hesitate to pursue benefits they've earned, often due to not viewing themselves as part of the veteran community. This disconnect can prevent them from accessing critical support services. Ongoing outreach efforts, including current awareness campaigns and events, aim to reshape perceptions and foster a culture of recognition and respect for women veterans. There is hope that all veterans will feel empowered to register with the VA and begin to receive the comprehensive care they deserve.

There are 53,661 Department of Defense (DOD) personnel assigned to Kentucky (42,914 military personnel and 10,747 DOD civilians), predominantly Army (including the Reserve and National Guard), with two large Army military installations - Ft. Campbell and Ft. Knox. Kentucky currently ranks 11th highest among the 50 states with 30,755 active-duty military personnel stationed in the commonwealth, and 16th in the number of total military personnel (including civilian workers, reservists, and National Guard). Kentucky continues to have the fourth-highest number of active-duty Army personnel following Texas, Georgia, and North Carolina. There are an additional 217 members of the U.S. Coast Guard Sector Ohio Valley, under the U.S. Department of Homeland Security, assigned to Louisville and Paducah.

The Kentucky National Guard is comprised of 7,353 soldiers and airmen in the Army National Guard and the Air National Guard. The Kentucky National Guard has mobilized and deployed more than 18,000 soldiers and airmen in support of the global war on terror. More than two-thirds of those military-connected individuals live within our communities and access community resources for behavioral health needs.

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 an undiagnosed traumatic brain injury (TBI) and Post Traumatic Stress Disorder (PTSD).

Kentucky has demonstrated a strong commitment to identifying and addressing the behavioral health needs of the SMVF population through active participation in national policy academies led by SAMHSA. By engaging in SAMHSA's SMVF policy academies, Kentucky has worked collaboratively with other states, territories, and tribes to develop sustainable strategic plans aimed at strengthening behavioral health care systems and services for the SMVF population. These academies focus on goals such as increasing access to appropriate care, closing gaps in the system, building system capacity, enhancing interagency communication and collaboration, and incorporating evidence-based and best practices.

Kentucky's efforts are further supported by the dedication of leaders from various organizations who prioritize the well-being of the SMVF community. Through collaborative endeavors like the Kentucky Governor's SMVF Challenge Team, the state continues to enhance its behavioral health service systems, ensuring that the unique needs of service members, veterans, and their families are met with effective and coordinated care.

VA medical centers and community-based outpatient clinics (CBOCs) play a critical role in delivering accessible care across both urban and rural regions. Service members and veterans from the Kentucky National Guard are scattered across Kentucky's 120 counties, resulting in difficulty in obtaining behavioral health treatment when and where they need it. Most individuals are typically not located near a military base or a Veterans Health Administration (VHA) facility. However, there are 14 VHA CBOCs and one VHA outpatient clinic in Kentucky that provide mental health services, in addition to two VHA regional medical centers in Lexington and Louisville. These clinics have continued to face challenges with workforce capacity to support the delivery of services. Service members and veterans in Kentucky are also seeking services at the community mental health centers (CMHCs) and private behavioral health providers, sometimes as an effort to keep their diagnosis and treatment information out of their military records.

Service members or veterans living near a bordering state may leave the state for treatment 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 the career advancement of the service member. This may result in the service member paying out of pocket in cash for services to protect their confidentiality.

As people become more aware of the resources, it is reasonable to expect an increase in demand for resources and treatment services. Resources can become more fragmented, which can decrease service quality. Without new funding, resources, and additional behavioral health staff in place to assist service members and veterans as they return home, heroes and their families will suffer.

Additional Kentucky-specific prevalence data for this population is included in the SUD data tables document uploaded to this section of the application including Veteran and Active Duty Personnel Served by CMHCs; Active Duty Personnel Served by CMHCs; and Veterans Served by CMHCs.

Unmet Needs/Critical Service Gaps:

- Increased access to effective evidence-based behavioral health services for the SMVF population
- Increase help-seeking behavior for the SMVF population
- Reduce access to potentially lethal means for suicide for the SMVF population

Substance Use Primary Prevention

Prevalence Data for Kentucky's Selected Substances:

Substance 1: Alcohol

The Kentucky prevention system has made substantial gains in reducing underage drinking over time. According to the 2023 Youth Risk Behavior Survey (YRBS), high school past 30-day alcohol use dropped 61% (45.1% to 17.4%) from 2003 to 2023, but alcohol use by adolescents remains problematic in the commonwealth.

The 2024 Kentucky Incentives for Prevention* (KIP) survey data reveals that 8.7% of tenth graders drank alcohol in the past 30 days, and 5.8% also report they have been drunk on at least one occasion in the past 30 days. Youth are not just drinking to drink but drinking to get drunk. Furthermore, 4.2% of tenth 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 24 tenth graders surveyed, or 887, 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 2.8% in 2024), the number of Kentucky youth who engage in past 30-day drinking and binge drinking is still unacceptably high. (The KIP Survey required active parental consent for the first time in 2024. Differences between 2024 and previous years may be due to changes in the composition of the sample, i.e., which students completed the survey rather than true shifts in student behavior. KIP 2024 data is similar to national data, such as the YRBS).

Research shows that increased sales of alcohol correlate with increased youth access to alcohol. Increased youth access to alcohol is correlated with increased 30-day use and binge drinking. According to revenue data from February 2025, wine consumption taxes increased by 5.89% and taxes from distilled spirits rose by almost 38.68%, when compared to data collected for the same month in 2020. The 2023 National Survey on Drug Use and Health (NSDUH) survey showed that Kentucky's alcohol use is below the national average in every age category. 46.26% of Kentucky adults reported past 30-day use of alcohol, compared to a national rate of 52.28%. That rate climbs to nearly 43.35% for those ages 18-25, compared to 49.91% nationwide. About 46.7% of adults over the age of 26 reported using alcohol in the past 30 days, compared to 52.65% nationwide. Past 30-day alcohol use in the U.S. decreased from 51.37% in 2017-2018 to 47.5% in 2023 (NSDUH), while it increased in Kentucky, 39.97% vs. 42.41%.

Binge drinking in Kentucky is lower than the national rate in every category. Across all populations, 18.62% of Kentuckians over the age of 12 reported binge drinking in the past month, according to the 2023 NSDUH. Comparatively, the rate was 21.68% nationally. Kentucky youth binged at a rate of 7.23%, compared to 8.39% nationally. Among those over the age of 26, 19.37% of

Kentuckians reported binge drinking in the past 30-days, compared to 22.63% nationwide. Across all age groups, binge drinking decreased from 2017–2018 to 2023: US 24.49% to 21.7%, and Kentucky 20.47% to 18.62%. (NSDUH)

The cost of excessive alcohol use has been well documented. A 2010 study found that binge drinking is responsible for 77% of the total excessive drinking costs in all states and is responsible for some of the serious health problems, including alcohol poisoning, fetal alcohol spectrum disorder, sexually transmitted diseases, and unintended pregnancy. Binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers, making them likely to cause driving-related injuries, which could result in mortalities. In Kentucky, at that time, the cost per person was \$736, with a societal cost of more than \$3.1 M, roughly equal to the block grant allocation for prevention services.

Because of the significant cost and impact of alcohol use among Kentucky residents, initiatives implemented will focus on reducing the early initiation of alcohol use and decreasing youth and adult binge drinking.

Substance 2: Nicotine Products

The Kentucky prevention system has made significant progress in reducing underage nicotine use. According to the 2023 YRBS, past 30-day use of combustible cigarettes among high school students has continued to decline, reaching historic lows. Only 4% of Kentucky high school students reported smoking cigarettes at least once in the past 30 days, down from 21.7% in 2010 - a reduction of over 80%. The 2024 KIP Survey similarly reflects historic lows, with just 2% of high school students reporting past 30-day cigarette use.

Despite these gains, vaping remains a significant concern among Kentucky youth. The 2023 YRBS found that 41% of high school students in Kentucky reported ever using electronic vapor products, and nicotine vaping remains the most common form of substance use among Kentucky youth. Current use rates are declining. From 2021 to 2023, current (past 30-day) e-cigarette use among high school students declined by 10%, from 21.9% to 19.7%. Middle school students use also dropped, from 13.8% to 10.6% over the same period. Both rates remain about double the national average.

The 2024 KIP Survey shows further declines. In 2024, 2% of sixth graders and 11% of tenth graders reported using e-cigarettes in the past 30 days, down from 3% and 17%, respectively, in 2021.

Vaping and nicotine use concerns are also reflected in school discipline data. The Kentucky Department of Education's Safe Schools Annual Statistical Report for 2023–2024 found that nicotine/nicotine incidents made up 66.8% of all substance-related behavior events in schools, far outpacing cannabis (22.2%), other drugs (7.9%), and alcohol (2.1%). There has been a dramatic rise in drug, alcohol, and nicotine-related events in Kentucky schools between the 2017–2018 and 2022–2023 school years. This is largely attributed to nicotine-related incidents involving e-cigarette products. There is an urgent need for targeted prevention and intervention efforts focused on nicotine use, especially vaping, among Kentucky students.

The need for targeted prevention and intervention efforts has been partly addressed by Kentucky Revised Statutes KRS 158, revised in 2024 to require all Kentucky public schools to adopt vape-free campus policies and provide nicotine education to every student. For the first time in state history, all schools must implement a 100% nicotine-free campus policy. However, the law has limitations, including a lack of dedicated funding and limited enforcement mechanisms. Despite these challenges, regional prevention specialists, health departments, coalitions, and other prevention partners are working together to fill resource gaps and ensure students have access to the evidence-based, age-appropriate prevention and cessation resources mandated by the statute.

Youth preference for flavored e-cigarettes also remains a challenge. Regulatory loopholes have contributed to youth preference for flavored disposable e-cigarettes. While the Food and Drug Administration (FDA) banned flavored cartridges and pods in early 2020, disposables were not initially included. Although the FDA closed this loophole in March 2022 and increased enforcement, flavored disposables remain widely available due to slow regulatory processes and ongoing product innovation. Data from the 2024 National Youth Tobacco Survey (NYTS) show that over 60% of current youth e-cigarette users report using disposable products. Kentucky stores and online retailers continue to offer a variety of flavored disposable devices, highlighting persistent enforcement challenges despite strengthened federal oversight, recent Supreme Court support for FDA authority, and new state-level regulations legislation, such as KRS 438.305, which effectively bans flavored vapor products not authorized by the FDA. Focus group data and qualitative assessments gathered by the Kentucky prevention system indicate flavored disposables and other flavored e-cigarette devices are popular and perceived as easy to access among Kentucky youth.

The 2023 YRBS summary tables published by the Kentucky Department of Education do not include data on perceived risk for vaping. However, the KIP and the NYTS have consistently shown that youth perceive lower harm from vaping nicotine compared to other nicotine products. NYTS (2024) findings indicate that approximately 15% of students perceive little or no harm from occasional e-cigarette use, while the rate for cigarettes remains significantly lower, at around 8%. On the KIP, perceived risk among tenth graders has improved over recent years. In 2018, 57% perceived no or slight risk from vaping, dropping to 38% in 2021, and further to 25% in 2024. While this is a positive trend, the rates remain notably low, indicating that Kentucky students still tend to view vaping as a relatively low-risk behavior.

Both national and Kentucky data suggest social sources remain the primary way youth access e-cigarettes, with retail purchases

representing a meaningful but smaller proportion. Nearly half of youth e-cigarette users nationally report getting their products by borrowing or receiving them from someone else (NYTS), and 47% of Kentucky youth reported the same in the KIP survey. About 21% of Kentucky tenth graders reported buying e-cigarettes in a store such as a convenience store, supermarket, discount store, gas station, or vape store (KIP, 2024).

In 2025, Kentucky amended KRS 438 to require all nicotine product retailers to obtain a license, thereby making Kentucky no longer one of the ten states without a comprehensive nicotine licensing law. The law grants the Department of Alcoholic Beverage Control inspection and enforcement powers, establishes penalties for selling to minors, and permits license revocation. Additionally, it allocates a portion of fines collected from violations to youth prevention programs. Enhanced penalties and the threat of license revocation are expected to heighten retailer vigilance in age verification and compliance with sales laws, aiming to reduce the percentage of Kentucky youth reporting the purchase of e-cigarettes from retail sources. This is a hard-won victory, achievable only through the education and mobilization efforts of Kentucky's Synar program coordinator, along with the tireless contributions of the prevention system and partners statewide. The mobilization and empowerment of youth were particularly essential.

Adult cigarette use has continued to decline significantly in Kentucky. However, cigarette use remains a major public health issue. As of 2023, 20.5% of Kentucky adults smoked cigarettes, down from previous years, but still leaving Kentucky tied for the fourth highest adult smoking rate in the nation, well above the national average of 14%, according to the Behavioral Risk Factor Surveillance System (BRFSS).

Kentucky Adults also report a higher use of other nicotine products compared to national rates (BRFSS, 2022):

- E-cigarettes: 10.5% of Kentucky adults used e-cigarettes, versus 7.7% nationally.
- Smokeless nicotine: 7.4% of Kentucky adults used smokeless nicotine, more than double the national average of 3.4%.

Kentucky continues to have the highest rate of lung cancer in the nation, and nicotine use, including cigarettes, e-cigarettes, and smokeless nicotine, remains a significant contributor to the state's health burden (American Lung Association).

While the adult smoking rate in the state has dropped from nearly 25% five years ago to 20.5% in 2023, this decline is somewhat offset by persistently high rates of alternative nicotine product use, which keeps overall nicotine use among Kentuckians above the national average. Each year, 8,900 people in Kentucky die from smoking-related illnesses, and the annual health care costs directly attributed to smoking in the state are estimated at \$1.92 billion (Kentucky Department for Public Health).

Substance 3: Illicit Drugs and Non-medical Use of Prescription Drugs

Cannabis

As of January 1, 2025, medical cannabis is legal in Kentucky. Although a recent development, the use of cannabis among residents has been climbing exponentially over the last several years. Since the 2015-2016 NSDUH report, Kentucky's past 30-day cannabis use among those over the age of 12 has climbed 41%, from 7.02% to 11.52%. (2023 NSDUH) The majority of those increases are among Kentucky residents over the age of 26. In 2023, the past 30-day use rate among that age group was 31% higher than in 2018, from 6.98% to 11.16%. Residents aged 18-25 use cannabis at significantly greater rates than other age groups, with nearly 19% reporting past 30-day use in 2023 (NSDUH).

Overall, nearly 12% of Kentuckians report 30-day use of cannabis, with 2.07% of Kentucky's residents reporting first use of cannabis in the last year. Increases are noted in all age groups but are significant within those who are aged 12-17 and those who are aged 18-25. Cannabis use has also been attributed to a 40% to 60% increase in suicidal ideation, planning, and attempts among those aged 18-34 over the past decade, with the greatest increases noted among women and those with major depressive episodes (NSDUH).

According to the 2023 YRBS, past 30-day use of cannabis among high school students has been declining since 2003, and at 12.4% is slightly lower than the national average of 17% for this age group.

Cannabis remains the most widely used illicit substance by young people in Kentucky (YRBS) despite the fact that 30-day use of cannabis by 12-17-year-olds in Kentucky (5.27%, 2023 NSDUH) is slightly lower than the national rate (6.22%) for this age group. Kentucky has not mirrored these trends, with usage rates among Kentucky tenth graders falling steadily from 2010 through 2021. (2021 KIP KY Trend Data). Six percent (6%) of tenth graders reported past 30-day use in 2024. (KIP) Since this is a new cohort of students and fewer students participated, survey evaluators recommend viewing this as a snapshot in time rather than a definite continuation of the trend.

Past year cannabis use rates, as measured on the KIP survey, steadily increase from sixth through 12th grades, with 1% of sixth graders reporting use within the last year compared to 13.2% of 12th graders. For this age group, however, use rates have been declining since 2010, falling from a high of 30.3%. For eighth and tenth graders in Kentucky, 7% report they first smoked cannabis by the age of 12. (KIP 2024)

While the percentage of students reporting that access to cannabis has been decreasing since 2004, 37% of twelfth graders and

nearly 29% of tenth graders reported that it would be “sort of easy” or “very easy” for them to access the illicit substance. Personal disapproval of cannabis use decreases significantly from the sixth grade, where 98% of students said it was “wrong” or “very wrong” for someone to smoke cannabis, to 12th graders, where only 77% answered in the same manner. Generally, personal disapproval of cannabis use is decreasing in Kentucky overall. This indicates that youth perceive it to be more acceptable for them to smoke cannabis. Perception of parental disapproval of smoking cannabis has also been decreasing over the same time frame, with 4.5% of 12th graders perceiving their parents would not disapprove of cannabis use. Additionally, the perception of peer disapproval of cannabis use has also decreased since 2012 (the first year the question was added to the KIP survey). The older the student, the less peer disapproval they feel about cannabis use. Between 2012 and 2016, peer disapproval for sixth graders was 96%. It fell to 95% in 2018 and held steady in 2021. In 2024, 68% of 12th graders reported that their friends would say it was “wrong” or “very wrong” for them to smoke cannabis. (2024 KIP).

Just as disapproval ratings for cannabis use have fallen over the past decade, so have risk perceptions. The perception of harm decreases significantly from the sixth grade to the 12th grade. The perception of harm among sixth graders was nearly 70%, compared to less than 47% for 12th graders.

According to NSDUH data, past year cannabis use for all age groups is trending upward, with significant gaps between use rates of the 18–25-year-olds and the rest of the population. For the 18-25 age range, NSDUH data shows that since 2010, the rate of past year cannabis use has climbed from a rate of 17.35% to 36.5%. Data from the Treatment Episode Data Set (TEDS) shows that admissions for cannabis use decreased by 22.6% in Kentucky between 2021 and 2023, the latest data available. Prevention efforts will focus on continuing the decrease in use among middle and high school students while also addressing the increasing use among 18–25-year-olds, as well as increased consequences of use requiring hospitalization.

Stimulants (Methamphetamines, Cocaine, Prescription Drugs)

As Kentucky continued to address the opioid crisis, a fourth wave in the nation’s substance use disorder epidemic began – stimulant use. Use of prescription drugs, such as Adderall, Ritalin, and Adipex, and illicit substances, including methamphetamine and cocaine, began increasing around 2015. Methamphetamine use rates are higher in Kentucky than in the U.S. as a whole. (1.32% and .91%, respectively). Rates are highest for those 26 and older at 1.1%. Use of methamphetamine in Kentucky is above the national average, and use of cocaine is below it. Among youth in Kentucky, cocaine, methamphetamine, and stimulant use are small compared to the use of alcohol, nicotine, and cannabis. According to the 2024 KIP survey, 30-day cocaine use among tenth graders is less than 0.5%. Methamphetamine use among this same age group is about the same, while stimulant use is about 0.7%.

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

Methamphetamines

According to the KIP Survey, past year methamphetamine use has declined among tenth and 12th graders since 2012 from an average of 1% of youth to approximately .5%. Personal disapproval of methamphetamine use is high across the grades, ranging from 98% among seniors to approximately 99% among sixth graders. Perception of parental disapproval of methamphetamine use is also high, at approximately 99% across all grades. Tenth graders who report that at least one of their four best friends used methamphetamine in the last year have fallen from 6% in 2012 to 1.6% in 2024. The drop is similar in other grades. The Comprehend CMHC region in northeastern Kentucky has the highest rates of tenth-grade methamphetamine use at 1.8% (compared with a statewide tenth-grade rate of .7%). Methamphetamine was identified in 716 drug overdose deaths, representing 50.8% of drug overdose deaths in 2024 and a decrease of 28.9% from the 1,007 drug overdose deaths involving methamphetamine in 2023. The top five counties for methamphetamine related overdose deaths were Jefferson (169), Fayette (38), Boyd (19), Madison (20), and Pike (17).

Cocaine

Over the last 12 years, cocaine use has been steady or decreasing among middle and high school students, with a gradual increase by grade level as measured by the KIP. KIP data shows that about 0.7% of 12th graders report past-year cocaine use. NSDUH data shows that 3.13% of 18-25-year-olds in Kentucky reported cocaine use in 2023, down from 5.09% in 2015. Personal disapproval of cocaine – i.e., the percentage of students answering “wrong” or “very wrong” to the question, “How wrong do you think it is for someone your age to use cocaine?” ranged from 98% for 12th graders to 99.4% for sixth graders. The percentage of parental disapproval of cocaine use ranged from 98.4% for 12th graders to 99.4% for sixth graders. Two percent (2%) of 12th graders said at least one of their four best friends had used cocaine in the last year. That percentage was 2.6% for tenth graders, 3% for eighth graders, and 2.1% for sixth graders. The Four Rivers CMHC region in far western Kentucky had the highest rate of tenth graders reporting cocaine use (1.6%) in the past 30 days, while the Communicare CMHC region in central Kentucky had the lowest at 0.1%. The overall tenth-grade rate was .5%. NSDUH data indicate that cocaine use rose slowly across all age groups from

2010 to 2018/19, fell slightly in 2021, and increased again in 2023.

Opioids/Heroin/Non-Medical Use of Prescription Drugs

Substance use/misuse, particularly the use of prescription drugs along with heroin and illicit fentanyl, continues to be a major public health concern for Kentucky. According to the Overdose Fatality Report released by the Kentucky Office of Drug Control Policy, there were 2,250 overdose deaths in Kentucky in 2021, which was the highest number since data from this report was introduced in 1999. In 2024, 1,410 Kentucky residents died from a drug overdose, a decrease of 30.2% from the 2,020 resident deaths in 2023 and a rate of 32.0 deaths per 100,000 residents. The largest number of overdose deaths in Kentucky in 2024 was among those aged 35-44. (Latest data disaggregated by age group.) At least 70 youth under the age of 25 died by overdose (all drugs) in 2024. The top five counties for opioid involved overdose deaths per 100,000 population in 2024 were Lee (156), Knott (134.6), Breathitt (129.6), Powell (109.8), and Estill (85.4).

Fentanyl was identified through toxicology in 878 drug overdose deaths, representing 62.3% of the total drug overdose deaths in 2024 and a decrease of 39.4% from the 1,450 drug overdose deaths involving fentanyl in 2023. Methamphetamine was identified in 716 drug overdose deaths, representing 50.8% of the total drug overdose deaths in 2024 and a decrease of 28.9% from the 1,007 drug overdose deaths involving methamphetamine in 2023. Acetylfentanyl was involved in 27.5% of all overdose deaths for the year. This was a decrease of 46.1% from 2023. Jefferson (292), Fayette (86), Kenton (32), Madison (24), and Boyd (24) counties had the highest number of fentanyl-related deaths.

According to the CDC Opioid Dispensing Rate Maps, the most recent data indicates that in 2023, Kentucky healthcare providers dispensed opioids at a rate of 58.3 prescriptions per 100 people. With Kentucky's estimated population of approximately 4.5 million, this translates to roughly 2,623,500 opioid prescriptions dispensed statewide in 2023. For context, Kentucky's opioid prescription rate has been steadily declining over the past decade. In 2020, the rate was 68.2 prescriptions per 100 people, and in 2017, it was 86.8 per 100 people. Kentucky remains above the national average for opioid prescribing, but the gap has narrowed as prescription rates have fallen.

The Kentucky Controlled Substance Prescribing Council Annual Report 2024 showed that overall, the greatest percentage of controlled substances prescribed in Kentucky is for Gabapentin, representing 27% of all controlled substances dispensed in the state. Gabapentin, or Neurontin, is followed by hydrocodone (Lortab, Vicodin) at 24%, and Oxycodone (OxyContin and Percocet) at 13%. Additional prescribed controlled substances include Tramadol (6%), Alprazolam (5%), Amphetamine/Dextroamphetamine (8%), Buprenorphine/Naloxone (6%), Clonazepam (5%), Pregabalin (4%), and Lorazepam (2%). The highest number of doses of prescribed controlled substances was found in Louisville and Fayette counties, both of which represent Kentucky's population centers and metropolitan areas. The highest dosage rates per 1,000 residents by patient address, however, were located in 15 counties in southeastern Kentucky, each with between 50,298 and 81,854 doses per 1,000 residents.

Five counties spread across Kentucky had the highest opioid morphine equivalent doses per 1,000 residents at 3-5 doses. Use of Benzodiazepines and Opioids is especially problematic in the state, with three southeastern counties of the total 120 counties in Kentucky reporting a rate of 15-22 per 1,000 residents of seven-day overlap by patient addresses.

The Kentucky opioid overdose emergency department visit rate was 113.4 visits/100,000 population in 2023. Individuals aged 35-44 comprised the largest percentage of individuals treated for opioid overdoses in Kentucky emergency departments (EDs) in 2023. TEDS data shows a steady downward trend, from a high of 4,872 in 2016 to 1,145 in 2023, highlighting the work that has been done across Kentucky to stop access to and use of heroin. Admissions for other opioids decreased as well, falling from 6,245 admissions in 2010 to 1,546 in 2023. Males are more likely to be admitted for both heroin and other opioid use than females. Those aged 31-35 are most likely to be admitted for heroin use as well as other opioid use.

2024 KIP results also show that 2.8% of tenth graders report they first used a prescription drug (such as OxyContin, Percocet, Vicodin, etc.) without a doctor's prescription before the age of 12. This is the highest rate for tenth graders since 2012, when the question was added to the KIP survey. The results for 12th graders have also been steady since 2012, but in 2018, they dropped from 1.7% to 1.3%. It rose to 1.7% again in 2021, and in 2024, it stayed at the same level. However, this same question has shown significant increases for sixth and eighth graders in that time frame, rising from 2% to 4.7% for eighth graders (135% increase), and from 1.3% to 3.9% for sixth graders (200% increase). In 2024, these numbers decreased to 0.3% for sixth graders and 1.6% for eighth graders.

Past year prescription pain killer use, as reported on the KIP, has shown a slight increase for sixth (.2% to .9%) and eighth (1% to 1.6%) graders from 2012 to 2024. There was an increase of 1.7% to 2.0 % for tenth graders, and a decrease from 1.8% to 1.5% for 12th graders. Thirty (30)-day use of prescription pain killers has decreased slightly from 0.7% to 0.4% for sixth graders, 1.2% to 0.7% for eighth graders, 1.3% to 1.0% for tenth graders, and 1.4% to 0.8% for 12th graders. These declines speak to the significant prevention efforts that have been in place across the state over this time frame and serve as effectiveness indicators of strategies implemented to address the non-medical use of prescription drugs in that time frame.

Personal disapproval of prescription drug use without a doctor's prescription was high across the grades, with 97% of sixth graders and 97% 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 98% of sixth and 12th graders reporting they thought their parents felt it was "wrong" or "very wrong" for them to use prescription drugs without a doctor's prescription. Perception of peer disapproval rose from 2012 to 2024, for 12th graders (78.8% to 94%), tenth graders (81.8% to 94%), and eighth graders (89.7% to 93%) who reported they felt their friends would think it "wrong" or "very wrong" to use prescription drugs without a doctor's order. It fell slightly for sixth graders from 96.4% to 96%. The number of tenth and 12th-graders reporting that at least one of their four best friends took a prescription drug without specific direction from a doctor was 5.2%. Risk perception increased among all students in the 2012-2024 timeframe. Students reporting that using a prescription drug without a doctor's orders was a "moderate" or "great risk" was 84% for sixth graders, 86% for eighth graders, 88% for tenth graders, and 87% for 12th graders.

Unmet Service Needs and Critical Gaps:

Alcohol

A long-recognized critical gap in 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 regional data, it is difficult from an epidemiological standpoint to identify areas of the state where the need for alcohol prevention services is greatest. Additionally, addressing early alcohol use as a gateway to later increased substance use, substance use disorder, and related consequences to substance use is vital in developing healthy, thriving adults and communities in which they live.

Nicotine Products

As e-cigarette use continues to grow in Kentucky, prevention efforts must target youth who do not perceive the use of e-cigarettes as harmful. Efforts will focus on educating youth, parents, and educators about the harmful effects of electronic vaping products, providing training and technical assistance to schools and community organizations to update school and community smoke-free policies to address electronic vaping devices, providing retailers of vaping products with information on the Nicotine (formerly Tobacco) Retailer Underage Sales Training (TRUST) for retailers to reduce sales to minors, and providing training and technical assistance to schools to support and enhance early prevention, screening, and assessment of adolescents. Because Kentucky had made so much progress in the reduction of cigarette use, prevention providers had turned their attention to other substances, such as opioids, letting some of the focus on e-cigarette use lapse.

Illicit Drugs and Non-medical Use of Prescription Drugs

The needs assessment process conducted for prevention services indicates that a focus on addressing illicit drug use, especially among 18- to 25-year-olds, is imperative if the state is to reduce the impacts of this drug use among its residents. Even with limited data available for this age group, it is evident that there is an increasing risk and use leading to more severe consequences, including death, in subsequent age groups. Prevention efforts should begin with middle and high school students, since there is a general trend of increased use and decreased perception of risk as students get older, leading to an even greater increase when those students graduate and transition into college or work life in their young adult years. Illicit substances of focus identified in the assessment include opioids/heroin/fentanyl/non-medical use of prescription drugs (since a significant percentage of the prescription drugs used/misused are opioids), cannabis, methamphetamine, and cocaine. These illicit drug categories have increasing use with age, increasing hospital admissions, increasing long-term consequences because of use, and decreasing risk factors, including perception of harm. In addition to focusing prevention efforts on those in the 18 to 25-year age group, strategies will also be targeted to those geographic hotspots with the greatest use. This will vary by substance used, and prevention efforts will need to be tailored to the specific circumstances occurring at the community level that support the use of the illicit drug.

Cannabis prevention efforts will focus on increasing the perception of risk of use and decreasing the perceived access to 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. Now that medical cannabis is legal, emphasis on reducing access to youth or others without a prescription will also be an area of focus.

Efforts focused on cocaine must address the significant increase in use by those in the 18-25-age-group and should include continuing to decrease the perception of peer use among middle and high schools, as well as finding additional ways to measure the impact of use in the young adult group.

Prevention strategies focused on methamphetamine use must first 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 of this substance is low, but young adult use represents a significant increase.

Prevention efforts to address Kentucky's opioid crisis will be multi-pronged and collaborative, leveraging all available resources to continue to assess the hot spots and target prevention capacities in those areas, either geographically or among target populations, such as pregnant and parenting women, those who are military-connected, and those in the middle years. Prevention efforts will be coupled with treatment and recovery efforts to reduce the use and consequences of use and reduce deaths.

Workforce

Kentucky's prevention system, anchored by 14 regional prevention centers (RPCs), has made significant strides in recent years to address workforce issues, including building workforce capacity and implementing the Strategic Prevention Framework (SPF). Since 2016, with a more focused approach in recent years, RPCs have expanded staffing and engaged in extensive technical assistance and training through national experts and the Prevention Technology Transfer Centers (PTTC). A core emphasis of this capacity-building effort has been the implementation of evidence-based programs, practices, and policies (EBPPPs) tailored to address shared risk and protective factors across diverse communities.

Despite this progress, workforce instability remains a significant challenge, with many of the RPCs under new leadership and staff with less than two years' experience. Prevention salaries remain low, especially compared to similarly credentialed treatment staff co-located within community mental health centers (CMHCs), where revenue-generating services are prioritized. This structural disparity leaves prevention staff underfunded, professionally isolated, and vulnerable to burnout and turnover.

RPCs often struggle to assert their value within their host agencies, and staff who obtain licensure are frequently drawn into treatment roles offering higher pay and perceived job security. These challenges hinder the stability and effectiveness of prevention programming and threaten long-term outcomes, including the consistent implementation of EBPPPs.

To address these issues, Kentucky's Substance Use Disorder Prevention and Promotion Branch will continue to prioritize workforce development over the next two years. This includes delivering targeted technical assistance to strengthen leadership, improve staff retention, and help prevention professionals communicate the long-term value of their work, including the measurable impact of EBPPPs on substance use trends and community well-being. Continued investment in workforce training, support, and sustainability is critical to advancing evidence-based prevention strategies, strengthening community coalitions, and reducing substance use across the Commonwealth.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

The following provides the required planning information for each of SAMHSA's identified priority populations. Kentucky includes Service Members, Veterans, and Family Members (SMVF) as an additional priority population. Please note that additional detail about these priority populations can be found in other areas of this application as required in block grant application instructions, particularly in the Environmental Factors and Plan federal criterion for both block grants (Environmental Factors numbered 2, 5, 6, 7, and 9).

Adults with SMI Addressing the Need:

DBHDID continues its work toward full implementation of community-based, evidence-based practices for adults with SMI in Kentucky. This includes ongoing collaboration with MCOs and the Kentucky Department for Medicaid Services on system alignment, most notably through a legislatively driven 1915(i) State Plan Amendment, which will authorize reimbursement for several previously non-billable services for eligible adults with SMI. This amendment enables direct Medicaid reimbursement for several crucial community-based services: Supervised Residential Care, In-Home Independent Living Supports, Supported Employment, Supported Education, Tenancy Supports, Planned Respite for Caregivers, and Non-Medical Transportation. These were previously ineligible for billing under the existing state plan. This expansion reflects a strategic shift toward value-based, recovery-oriented supports for adults with SMI, aligning with evidence-based practice.

To address instability in Targeted Case Management (TCM) access, DBHDID is collaborating with the Department for Medicaid Services to evaluate reimbursement rate modernization for the first time in over a decade, with the goal of supporting Community Mental Health Centers (CMHCs) in rebuilding a sustainable workforce. DBHDID is also collaborating with providers to streamline documentation practices and address concerns regarding the intensity of MCO audits, which have disrupted service delivery. Technical assistance is being tailored to improve retention strategies and strengthen the role of TCM in housing transitions, crisis response, and diversion from institutional care.

The Division of Mental Health (DMH) provides statewide training, technical assistance, and fidelity monitoring to support the delivery of evidence-based services. For ACT, DMH supports implementation through a dedicated program administrator and a statewide ACT implementation team, which is contracted through the University of Kentucky. This team, comprising fidelity reviewers, trainers, and clinical coaches, partners with CMHCs to strengthen fidelity and identify opportunities for regional service expansion. These efforts are increasingly focused on improving access for individuals with complex co-occurring disorders, forensic involvement, or extensive institutional histories, populations historically underserved despite meeting ACT criteria.

A parallel structure supports the Individual Placement and Support (IPS) model for Supported Employment, including the DMH IPS

Program Administrator, the Kentucky Office of Vocational Rehabilitation, and fidelity reviewers, trainers, and coaches from the University of Kentucky. As with ACT, fidelity scores across IPS sites vary considerably, highlighting the need for focused investment in regions with lower performance. DMH continues to apply principles of implementation science to enhance service fidelity and sustainability, with tailored coaching and peer learning strategies for frontline teams. The integration of Supported Education into IPS, scheduled to launch in July 2025 under the 1915(i) SPA, represents a significant step forward in supporting dual goals of employment and education for adults with SMI.

To address the persistent housing gap, DBHDID administers the Olmstead Housing Initiative (OHI), which uses state general funds to support individuals with SMI who are institutionalized or at risk of institutionalization in transitioning to safe, affordable community housing. These funds create flexible options to help individuals cover rent and related housing costs and are coordinated through CMHC-based housing specialists.

In response to the need for more intensive residential supports in the community, the forthcoming 1915(i) State Plan Amendment includes coverage for 24/7 supervised housing models for eligible individuals with SMI who do not meet the criteria for a personal care home but require structured, round-the-clock support to maintain stability in the community. This service option will provide individuals with their own space in small community-based homes or apartments, with access to behavioral health services and staff support available at all times.

Additionally, DBHDID contracts with a network of housing providers beyond the CMHC system to serve adults with SMI in high-density urban areas, ensuring broader geographic coverage where CMHC housing capacity may be limited. These partnerships help bridge the persistent gap between housing need and availability, especially in regions where rental costs or housing stock present barriers to recovery-focused placement.

DMH continues to advance peer-delivered services as a core part of the recovery continuum. Through a longstanding partnership with NAMI-Lexington, DMH supports the implementation of Kentucky's Consumer Operated Service Programs (COSPs). NAMI-Lex conducts annual fidelity reviews across six core domains: Structure, Environment, Belief Systems, Peer Support, Education, and Advocacy, and uses this data to guide training and coaching priorities. COSP needs, such as staff retention, understanding fidelity expectations, and translating recovery values into daily practice, are addressed through the annual Kentucky System Transformation Advocating Recovery Supports (KYSTARS) Conference, which includes specialized tracks for COSP peer support specialists and their supervisors.

In addition, DMH partners with Bridgehaven to support the Center for Peer Excellence, a peer-run initiative that provides consultation, statewide training events, resource development, and ongoing support to Kentucky's certified peer support workforce. This effort complements broader system reforms focused on expanding the role of lived experience in service delivery and supervision.

To strengthen transitions from institutional care and reduce readmission risk, DBHDID launched a discovery phase in partnership with the Alliance for Rights and Recovery (ARR) to explore the implementation of the Peer Bridger Model. Through this initiative, an analysis of strengths, weaknesses, opportunities, and threats (SWOT) for Kentucky's four state psychiatric hospitals and their affiliated Community Mental Health Centers (CMHCs) is informing the design of a recovery-oriented framework that connects individuals with peer support before discharge, builds trust, and reinforces engagement with community-based services.

To enhance alternatives to psychiatric hospitalization, DBHDID continues to promote the use of crisis stabilization units (CSUs) as community-based, short-term care options for individuals in psychiatric crisis. The utilization of CSUs is closely monitored to identify opportunities for expansion and alignment with broader crisis response initiatives.

Additionally, Kentucky's implementation of the 988 Behavioral Health Crisis System has enhanced the state's capacity for real-time response, triage, and linkage to appropriate services. This includes the recent launch of the Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Unit at Eastern State Hospital, which offers a crisis care model centered on rapid stabilization, peer engagement, and timely transition to outpatient or residential follow-up care. These efforts reflect Kentucky's commitment to diverting individuals from unnecessary hospitalization through integrated, recovery-oriented crisis systems.

Finally, Kentucky continues its statewide emphasis on person-centered recovery planning for all adults with serious mental illness (SMI) receiving services at Community Mental Health Centers (CMHCs). This initiative, launched several years ago, includes shared decision-making and a stagewise planning framework that aligns medical necessity criteria with individual recovery goals.

Adults with SMI who live in rural areas:
Addressing the Needs:

Telehealth has emerged as a valuable tool for improving access to care in rural Kentucky. While Kentucky offered limited telehealth options prior to 2020, primarily for prescribers, expanded regulations and Medicaid rules now enable a broader range of behavioral health services to be delivered remotely. This policy shift enabled many rural residents with SMI to engage in treatment despite transportation or geographic barriers. However, disparities persist, particularly in areas with limited broadband coverage or high poverty rates, where reliable virtual access remains a challenge.

The Kentucky Department for Medicaid Services provides non-emergency medical transportation (NEMT) through contracted vendors across the state. Additionally, the Kentucky Department of Transportation administers the Non-Emergency Transportation Network (NETN), which coordinates transportation for medical appointments, pharmacy visits, and other health-related needs. While these services help reduce barriers for some rural residents, coverage remains inconsistent and limited to strictly health-related purposes. Many individuals with SMI in rural areas still face unmet transportation needs that impact their ability to engage consistently in treatment and recovery supports.

Adults with SMI experiencing homelessness
Addressing the Needs:

The Division of Mental Health (DMH) within DBHDID has a program administrator who focuses on housing issues for individuals with SMI, including working with several statewide groups that address homelessness. DMH also provides funding (state general and block grant) for several agencies across the state, in addition to the CMHCs, to assist with services for this population, including two agencies in Louisville, a homeless shelter in Lexington, a drop-in center in western Kentucky, and others.

The CMHC based in Louisville also has a Homeless Outreach Team that works in the community to identify and provide services to this population, including transition-age individuals. This outreach team also partners with the University of Louisville to identify individuals who require assistance.

Additionally, there is a statewide recovery housing program administrator within the Division of Program Integrity and the Division of Substance Use Disorder (DSUD), has a program administrator who focuses on recovery supports, including recovery housing for individuals with Substance Use Disorder (SUD) across the state.

DBHDID maintains wraparound funds across the four state psychiatric hospital catchment areas, covering all 120 Kentucky counties, to support individuals who meet Olmstead criteria and need help obtaining or maintaining community housing. These funds are used by CMHCs to address specialized needs, and primarily housing-related support. These funds are in addition to the Olmstead Housing Initiative (OHI) voucher program mentioned in the section on adults with SMI.

In September 2024, DBHDID launched an initiative, TEAM SOAR (Treatment-Engaged Assertive Mechanics for SSI/SSDI Outreach, Access, and Recovery), through a 5-year SAMHSA Treatment for Individuals Experiencing Homelessness Grant. Implemented in partnership with Seven Counties Services and the University of Kentucky's Human Development Institute, TEAM SOAR operates as a street-based outreach and service-delivery model in the Louisville Metro area, which has the state's highest concentration of unsheltered individuals with serious mental illness (SMI). The program integrates evidence-based approaches, including trauma-informed care, harm reduction, motivational interviewing, and SOAR assistance, to directly link individuals to housing, mental health treatment, and income supports.

TEAM SOAR serves as a demonstration platform for scalable innovation. Its goals include building a replicable infrastructure for high-fidelity street outreach, expanding Kentucky's homeless services workforce, and implementing sustainable service models in high-need communities statewide. The initiative also includes a robust evaluation component that will inform data-driven expansion to additional regions. Through this investment, Kentucky is strengthening its capacity to reach and engage adults with SMI who are unsheltered, reducing barriers to stability, and advancing Olmstead-aligned community integration.

Older Adults with SMI:
Addressing the needs:

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

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

Children with SED; Children with SED experiencing homelessness; Children with SED in rural areas; Families:
Addressing the Need:

DBHDID staff met regularly with CMHC CEOs throughout SFYs 23 and 24 to identify barriers to service access and use, explore potential solutions, provide consultation and support on concerns identified by CMHCs, and share relevant resources. Additionally, Children's Branch staff met regularly with CMHC children's directors and quarterly with other key CMHC staff including; HFW staff; children's crisis program directors; early childhood staff; youth treatment coordinators; transition age youth

coordinators; local resource coordinators, and other regional leaders to provide technical assistance and support in implementation of evidence-based practices; workforce recruitment and retention; grant writing, and other identified areas of need.

DBHDID met regularly with Department for Medicaid Services (DMS) staff to discuss identified problems and potential solutions. DBHDID and DMS staff have reinstituted quarterly meetings with MCOs with the intent of increased communication, data review, and collaborative guidance toward continuous quality improvement. Furthermore, DBHDID staff meets monthly with DMS staff to identify services that will be added to upcoming Medicaid State Plan Amendments and waiver applications in an effort to meet the increasingly high acuity behavioral health needs of Kentucky's children, youth, and families.

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

Several state-level interagency workgroups focused on improving services and supports for children and youth with the highest acuity behavioral health needs continued to meet. Efforts focused on the individual children/youth level and those aimed at systemic changes to the infrastructure and service/support delivery system within the system of care convened regularly and made recommendations to the governing body of Kentucky's System of Care and the Cabinet for Health and Family Services.

Early Serious Mental Illness/First Episode Psychosis: Addressing the Need:

1. A full time FEP administrator is dedicated to coordinate this statewide program and is part of the Adult Mental Health and Recovery Services Branch within DMH. The FEP administrator leads the state FEP team, which currently includes staff from the Adult Mental Health and Recovery Services Branch and the Children's Behavioral Health and Recovery Services Branch. This state FEP team guides implementation efforts for CSC across the state. Efforts will continue to strengthen CSC implementation.
2. A Transition Age Youth Cross Branch Team within the DBHDID includes the following branches via Memorandums of Understanding (MOU): The Adult Mental Health and Recovery Services Branch; The Children's Behavioral Health and Recovery Services Branch; the Adult Substance Use Treatment and Recovery Services Branch; the Mental Health Promotion, Prevention and Preparedness Branch; and the Substance Use Prevention and Promotion Branch. This team crosses both Mental Health and Substance Use Disorder Divisions and includes the Division of Mental Health (DMH) state FEP team. This team is charged with enhancing the seamless coordination of transition age youth behavioral health services across child and adult services, as well as substance use prevention and treatment.
3. Each CMHC is required to identify two Key Contacts, one from adult services and one from children's services, to attend statewide FEP meetings and assist with implementation of FEP programming. CMHCs without CSC teams are also required to provide these Key Contacts and attend training events designed to build capacity for identifying and treating these young people in their communities.
4. Each CMHC is required to have a Youth Substance Use Disorder Treatment Coordinator position, which is located within their children's services. They are charged with coordinating supports for this age group who have or are at risk of having substance use disorders or co-occurring MH/SUD.
5. Each CMHC is required to have a Transition Age Youth Coordinator who is responsible for collaborating across local programming to enhance supports that are developmentally appropriate and evidence-informed for youth, young adults, and their families affected by serious behavioral health issues. These staff are charged with providing consultation, referral, education, training, technical assistance, coaching, outreach, and system development within their CMHC. These positions are funded through Mental Health Block Grant funds.
6. The DMH FEP team, in partnership with the Early Assessment and Support Alliance (EASA), hosts a monthly MFG consultation call to assist with implementation barriers and provide ongoing support for all CSC teams.
7. DMH FEP state program administrator hosts a monthly meeting with all CSC team leaders to build competencies, address implementation barriers, provide statewide information sharing regarding infrastructure support as well as evidence-based components of CSC, and to provide an additional feedback loop for communication from the field.
8. Kentucky has provided more structure and additional training opportunities regarding engagement and treatment needs for

young people with early psychosis. The Stepped Care Model (Sale, Tamara, et al., 2018) is currently under development in Kentucky, and in partnership with the Yale University Prime Clinic, DMH has provided training on the Stepped Care Model to all CSC teams, with ongoing consultation. This will help develop additional levels of care for these young people and better meet the needs that have been identified. Additionally, the Prime Clinic offers regular training and consultation to enhance the proficiency of CSC teams in the Structured Interview for Psychosis Risk Syndromes (SIPS) assessment tool.

9. Following a directive from Kentucky legislators, the Kentucky Department for Medicaid Services (DMS) has recently received approval for a Center for Medicare and Medicaid Services (CMS) 1915(i) State Plan Amendment that would include reimbursement for supportive housing services, supported employment, and supported education services for eligible individuals with serious mental illness (SMI). DBHDID is charged with implementing this in partnership with DMS. Work will continue to determine how this SPA will benefit programming for individuals on the early side of psychosis, and how these newly approved services can interface with CSC programs.

10. Beginning in late SFY 2023, DMH partnered with Mental Health America of Kentucky to provide a foundational First Episode Psychosis learning series, aiming to generate awareness and educate on the basic components of CSC. The scope and audience for this learning series were broad, with the goal of building capacity. This series was funded through Bipartisan Safer Communities Act (BSCA) funding. Training efforts for awareness and education about FEP, that reaches a broader community base, including for 988/call center personnel will continue.

11. Kentucky partners with the University of Kentucky Human Development Institute (HDI) to coordinate training, coaching and fidelity support across the state, as well as provide specific data collection for CSC programs. This partnership is essential for strengthening implementation of CSC programming for FEP.

Behavioral Health Crisis Services: Addressing the Needs:

- Increase capacity to:
 - o answer Kentucky 988 calls, texts, and chats in-state.
 - o reduce the amount of time it takes 988 calls, texts, and chats to be answered in the state.
 - o reduce the number of 988 calls, texts, and chats that the caller abandons before they access a call center staff member.

DBHDID has received and completed a 988 implementation planning grant, applied for and received a 988 Capacity grant and Supplement, and applied for and received a 2023 988 Capacity Expansion grant to ensure sufficient staffing capacity to address the current and expected increasing volume of calls, chats, and texts to Kentucky 988 centers.

DBHDID requested and received a \$19 million two-year 988 State General Fund line item in 2020 to support increased staffing and improved technology across the 14 Crisis Call Centers participating in 988. Those funds have remained in DBHDID's base budget in subsequent biennium cycles, and the agency has maintained the intent of the funding.

DBHDID received a \$5 million, two-year mobile crisis State General Fund line item to support a loan fund that would increase mobile crisis services. However, there were no applicants for those dollars due to repayment requirements. Those funds have been maintained in the agency's budget in subsequent funding cycles. Those funds are now being used to support improved crisis response infrastructure.

DBHDID requested and received two Technology Transfer Initiative (TTI) grants from NASMHPD in 2023 and 2024 that focuses on developing a job architecture for crisis call centers, standardizing education and experience expectations for staffing the call centers, as well as identifying the quality of outcomes based on levels of experience and education to devise a consistent model to be used across the state's 14 centers.

DBHDID is reviewing uniform platform models for a statewide Air Traffic Control model adoption that will allow 988 calls to ring first in the local region and then, as needed, bounce to the next available caller for a backup system. This will reduce the number of caller takers needed across the entire system and leverage the existing staff to respond to current and expected call volumes.

DBHDID is providing technical assistance to centers to review existing technology platforms and identify next steps to reduce, through technological advances, the number of staff needed.

DBHDID issued a Notice of Funding Opportunity (NOFO) to increase chat and text capacity. One grant was awarded to an existing Kentucky 988 call center to provide 24/7 statewide coverage of 988 chat and text services.

DBHDID is supporting training to crisis call center staff to support responsiveness for focus populations, including those with SED/SMI/SUD.

- Increase crisis capacity, especially for mobile crisis services, for all populations including those with SED/SMI/SUD.
 - o Kentucky has introduced a new career path website, Futuriti. DBHDID will explore ways Futuriti can be utilized to increase the crisis workforce.
 - o DBHDID has contracted with the University of Connecticut's Innovations Institute to assess the state's capacity to implement rapid response and stabilization services (RRSS) and to develop a state plan.
 - o The State Interagency Council for Services and Supports for Children and Transition-Age Youth (SIAC) has created a Kentucky

Rapid Response and Stabilization Services Workgroup (KRRSS). It began meeting in February 2025. It is co-chaired by leaders representing DBHDID and the Department for Medicaid Services. KRRSS's goal is to interrupt current pathways to residential and restrictive settings and ensure families (including children with SED) have access to the right services and supports at the right time and at the right intensity. RRSS standards of practice are being drafted. KRRSS meets monthly and provides updates to SIAC quarterly. Early exploration of the utilization of the KRRSS model for lifespan response is also underway.

- o DBHDID is currently reviewing options for RRSS technology supports to enhance communication, data collection, dispatch, and documentation.

- o DBHDID has created a full-time 988 Workforce Program Coordinator position. The Program Coordinator has implemented a monthly virtual training series that is focused on 988 and the crisis continuum. The training series invitations are shared widely with 988 staff, crisis staff, first responders, 911 dispatchers, and other agency and community stakeholders.

- o DBHDID has created a full-time 988/911 Program Coordinator position. The Program Coordinator is working to implement and enhance regional coalitions that support local coordination of 988 and crisis services. Some communities have co-responder or alternative responder programs. DBHDID will continue to explore ways to enhance collaboration with these programs.

- o CMHCs have enhanced crisis services for individuals experiencing a substance use crisis or who have co-occurring SMI/SED and substance use disorder. DBHDID will continue to blend funds and enhance collaboration with substance use treatment providers and Quick Response Teams.

- Increase capacity to serve Kentucky's youth with SED, SUD, and complex needs.

- o DBHDID staff continue to meet daily with child welfare and juvenile justice staff to ensure effective behavioral health services are provided to children with complex needs, including SED. RiverValley Hospital in Owensboro (western Kentucky) has developed specialized services for boys with SED in state's custody. The hospital's unit is capable of serving 10 boys. DBHDID's Medical Director participates in the daily meetings and serves on the unit's clinical team for admissions.

- o DBHDID's new 988 virtual learning series includes topics to support individuals with SMI/SED/SUD and their caregivers.

- o DBHDID has developed a strategic plan for enhancing and utilizing crisis and suicide data to inform crisis planning. Program staff are compiling a list of available data, identifying gaps, and will develop strategies to utilize existing data better and leverage partnerships for data sharing.

- o DBHDID has expanded and revised its web presence over the past three years. A new 988 webpage and 988 data dashboard have been developed. The crisis prevention and response webpage includes new information and resources.

- o Crisis staff are reviewing reports and working with university partners to ensure existing reports meet current needs. Staff are also looking at new data needs, which may include reports to examine accessibility for under-resourced communities.

- o Crisis staff will explore ways to utilize the CMHC human resources data set more effectively to inform crisis system planning.

- o Within the Kentucky Cabinet for Health and Family Services, the Departments for Medicaid Services; Behavioral Health, Developmental & Intellectual Disabilities, and Community Based Services are partnering with Myers & Stauffer to create a children's 1915(c) Waiver application. The waiver, named Community Health for Improved Lives and Development (CHILD) is intended to serve children with the highest acuity needs and require intensive behavioral health and residential services and supports. It will provide home and community-based waiver services to Kentucky children and youth ages birth through twenty-one who have a Serious Emotional Disability; Intellectual Disability; Developmental Disability, or Autism Spectrum Disorder and who meet level of care for Psychiatric Residential Treatment Facility or Intermediate Care Facility for Intellectual Disability. Priority enrollment will be granted to those children who are unhoused, are at risk of being unhoused, or transitioning out of an institution. The following services will be included in the 1915(c) application:

1. Case Management
2. Respite – Including in-home, community, and facility-based options.
3. Community Living Supports
4. Environmental and Minor Home Modifications
5. Step-Down and After Care Support (includes parental and family support)
6. Supervised Residential Care

Adolescents with Substance Use Disorders or Co-occurring Substance Use and Mental Health Disorders:
Infrastructure Needs and Plans to Address:

Starting with a SAMHSA Children's Mental Health Initiative (System of Care) grant in 2004, Kentucky began a steady track to building an infrastructure for agencies and communities to support youth who are struggling with substance use issues. Funding and the provision of high-quality services for youth have been a focus for Kentucky. However, as mentioned, many of the activities of these grants have not been sustainable. Through grant-supported professional development and collaboration with agencies across the Commonwealth, many providers and social service agencies have been trained to screen for youth substance use issues. Unfortunately, the practice has not been consistent over time and with staff turnover, implementation of EBPs is not standardized across the state. Continued work is needed to drive the implementation of a continuum of evidence-based screening, referral, assessment, and planning processes that support communication of results and recommendations across agencies so that youth, families, and providers have access to the most accurate information to inform treatment planning. It is hoped that current efforts related to such a process within the child welfare system will serve as a model for other populations of children, youth, and families.

To support growth and sustainability planning, the Division of Mental Health maintains a full-time position within the Children's Behavioral Health and Recovery Services Branch for a staff member who serves as the Youth Co-Occurring Program Administrator.

This position is charged with educating and re-energizing treatment providers, child-serving agencies, community partners, and the general public around creating developmentally appropriate, evidence-based approaches to screening, referral, assessment, treatment, and recovery for youth with co-occurring SUD and their families. Likewise, at the regional level, DBHDID provides funds to support a full-time Youth Substance Use Treatment Coordinator staff position within each of the Community Mental Health Centers. The DBHDID Program Administrator is responsible for supporting this statewide peer group of youth treatment coordinators. The coordinators are located within the CMHC's children's services division and are charged with serving as the regional subject matter expert in youth substance use and co-occurring substance use and mental health disorder treatment. The coordinators collaborate with and coordinate other CMHC programs that provide services to children, adolescents, and adults with or at risk of developing SUD, and are also responsible for providing community outreach and education. This position was created in response to information from CMHCs that they were not receiving referrals for youth with substance use issues, that there is a general lack of knowledge in communities regarding how to identify, screen for, and refer youth with substance use issues, as well as a lack of awareness of what services and supports are available for these young people. Beginning in SFY 2024, the coordinators began training CMHC staff, including both clinical and non-clinical staff, as well as their communities. The coordinators also keep an inventory of clinicians within their agency who are trained to serve youth with substance use disorders and coordinate training as necessary. Results from current plan and budget documentation from CMHC children's directors and substance use directors indicate that across the 14 CMHCs, there are currently 232 clinicians who are trained to and routinely serve youth with substance use disorders, a number consistent with the SFY 2023 total of 235. However, in previous years, prior to the pandemic, the number of clinicians serving youth with substance use disorders was much larger (57% more). This further supports the need for community education and engagement around identifying, screening, and appropriately referring youth with substance use issues.

To ensure continued progress, the following priorities are essential. Efforts should include policymakers and stakeholders:

- Increase public awareness about the dangers of fentanyl-laced substances, including counterfeit pills and contaminated vapes.
- Expand school-based and community prevention messaging focused on vaping, prescription drug misuse, and early mental health support.
- Strengthen screening and referral processes in schools, primary care, and juvenile justice systems to connect youth to appropriate care sooner.
- Rebuild the continuum of care by reinvesting in intermediate and higher levels of treatment for youth with complex needs.
- Elevate the role of Youth SUD Treatment Coordinators and ensure they are active participants in system-level coordination efforts.
- Sustain investments in training and workforce development and ensure access to evidence-based models such as Seven Challenges, A-CRA, and Motivational Interviewing.

As Kentucky continues to improve its behavioral health infrastructure, acknowledging and addressing the rise in adolescent co-occurring disorders is both a public health priority and a fiscal imperative. Ensuring youth access to timely, evidence-based care supports not only health and safety—but also educational outcomes, family stability, and future workforce capacity.

Individuals with Substance Use Disorders:

Addressing the Need:

During SFY 2024, the Adult Substance Use Treatment and Recovery Services Branch within DBHDID transitioned the certification for Recovery Housing to an agency outside of the Cabinet and incorporated the National Alliance for Recovery Residence standards to ensure best-practice standards for recovery housing. DBHDID will continue to provide technical assistance to the certifying organization and recovery residences. Kentucky currently has 331 Certified Recovery Housing programs with 4,613 beds. The program continues to grow at a consistent rate.

Additionally, the Adult Substance Use Treatment and Recovery Services Branch created supportive infrastructure and provided technical assistance to the Kentucky Oxford House Outreach staff and began to implement a strategic planning process to enhance equitable access to community-based recovery housing. In an effort to facilitate referrals for housing requests and to maximize a cooperative approach to services for at-risk populations, linkages were created with health care providers, substance use treatment and recovery programs, and criminal justice agencies. Kentucky Oxford House has opened houses throughout the state for men, women, men with children, and women with children. There are currently 132 houses across the state.

During SFY 2024, DBHDID provided grants to increase access to crisis and treatment services. Those grants supported innovative projects designed to identify and engage underserved populations experiencing crises, including individuals experiencing homelessness, justice-involved individuals, and individuals discharged from emergency rooms.

Kentucky's behavioral health system of care includes 14 CMHCs, licensed Alcohol and Other Drug Entities (AODE), Federally Qualified Health Center (FQHC) Behavioral Health Service Organizations (BHSO), and multiple licensed and credentialed private providers as specified in the DBHDID provider directory. These providers provide access within the state to a full continuum of services, including education, screening, brief intervention, assessment, outpatient, intensive outpatient, residential, withdrawal management, and peer and recovery supports. Kentucky is continuously identifying specific populations of need and works to provide focused services to those populations. Those populations include service members, veterans, and their families (SMVF), adolescents, pregnant and parenting persons, individuals experiencing homelessness, older individuals, individuals with co-occurring substance use and mental health disorders, and others as identified. Kentucky promotes the use of MOUD as the gold

standard for OUD treatment through the 48 state-certified Narcotic Treatment Programs (NTPs) that dispense methadone or buprenorphine in tandem with treatment services. Kentucky also supports low-barrier access to MOUD and the incorporation of this treatment service as part of primary care. Kentucky maintains comprehensive administrative regulations to support access to all buprenorphine formulations. For example, Kentucky has removed prior authorization requirements for extended-release buprenorphine, Sublocade. Additionally, Kentucky has established an online treatment locator platform called FindHelpNowky.org, which is a real-time SUD treatment availability locator and information center. The locator lists treatment openings and providers, including CMHCs, AODEs, FQHCs, BHSOs, private, non-profit, faith-based treatment providers, and providers of MOUD. Providers are encouraged to update their treatment availability and facility information daily. FindHelpNowky.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, recovery, and harm reduction resources. FindHelpNowky.org was created by the Kentucky Injury Prevention & Research Center (KIPRC) through a partnership with the Kentucky Department for Public Health, the Kentucky Office of Drug Control Policy, the DBHDID, and Operation UNITE (Unlawful Narcotics Investigations, Treatment, and Education).

To address NAS and the issues of families affected by substance use, the Kentucky Department for Public Health and the DBHDID continue to work on the following:

- Increase access to quality prenatal care;
- Increase low-barrier access to MOUD for pregnant and parenting persons;
- Implementing a plan of safe care initiative to enhance, at the community level, a coordinated system of care for pregnant and parenting persons, their infants, and families affected by SUD;
- Enrollment in services such as WIC, substance use prevention and treatment programs, substance use recovery support services; and
- Improving access to long-acting reversible contraception.

Mothers of infants with NAS tend to have less education, be unmarried, and have more children, which may suggest lower socioeconomic status, a lack of social support, and/or reduced access to services. Two key steps are to identify demographic patterns and address social determinants of health to reach these high-risk populations.

In response to the ongoing opioid crisis, DBHDID has worked to expand low-barrier access to MOUD and increase the number of Kentuckians linked to treatment, harm reduction, and recovery services. Key interventions include education and technical support, identifying and addressing MOUD access gaps, removing barriers, and expanding the MOUD delivery system. Focused implementation areas will consist of clinical and nonclinical settings: office-based opioid treatment (OBOT) and opioid treatment programs (OTPs); general healthcare; prehospital and hospital; mobile treatment units; correctional settings; and other community-based programs. Local interdisciplinary teams will be identified and assembled to carry out interventions at the community level. Kentucky currently has 48 full-service NTPs and three medication stations.

Through federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), Kentucky State Opioid Response (SOR) grants, and guided by the Recovery-Oriented System-of-Care framework, the Kentucky Overdose Response Effort (KORE) implements a robust array of evidence-based prevention, harm reduction, treatment, and recovery support services for individuals with opioid and/or stimulant use disorder. A needs assessment and strategic plan drive goals and annual objectives. From September 30th, 2021, to September 29, 2022, the number of unduplicated clients who received OUD treatment services through KORE was 13,150. This includes 3,991 who received services that included the use of a federally approved medication for the treatment of OUD. During the same period, 13,149 unduplicated clients received recovery support services that included access to recovery housing, coaching or peer support, and employment supports.

Work to address the needs of individuals with SUD in Kentucky continues. This includes concerted efforts to mitigate complications stemming from the COVID-19 pandemic, ensure service access and availability, and foster the continued development and data-driven implementation of a recovery-oriented system of care (ROSC) that provides seamless integration of readily accessible, high-quality, evidence-based services across systems.

Individuals with SUD experiencing homelessness:
Addressing the Need:

Kentucky's model, which pairs certified recovery housing with employment and life-skills programming, provides a powerful example of how states can address homelessness, addiction, and justice reintegration together. By removing outdated barriers, expanding access to accredited recovery homes, and investing in economic opportunity, we can create systems that support true, lasting recovery.

Women who are pregnant and have a substance use disorder/co-occurring mental health disorder:
Addressing the Need:

Over the last several years, state and federal policies have been enacted to address some gaps in the continuum of care for pregnant and postpartum persons and have resulted in strengthened plans of safe care for infants with prenatal substance exposure (Asad, et al, 2024).

including case management and prevention services. The Medicaid State Plan Amendment (SPA) approved by the Centers for Medicare and Medicaid Services (CMS) in 2014 included a wide variety of treatment services for individuals with SUD. In an effort to improve maternal and child health outcomes and increase access to life-saving health care services for pregnant and parenting Kentuckians, CMS expanded Medicaid coverage to a full 12-month postpartum period on May 25, 2022. This expansion was critical in addressing health concerns that can affect women and children in the period following childbirth. Through the Medicaid SPA, mothers who experience substance use risk factors and effects of substance use/misuse can participate in substance use prevention, treatment, and recovery support services up to 12 months postpartum.

Pregnant women are a priority population in accordance with the Center for Substance Abuse Treatment (CSAT) regulations. The 14 Community Mental Health Centers (CMHCs) in Kentucky screen for SUD at initial contact and provide care within 24 hours. If no such facility has the capacity to admit and provide treatment, interim services are to be made available within 48 hours. The CMHCs now have an established protocol to inquire about pregnancy at first contact with new female clients, including adolescents.

To help address concerns related to substance use during pregnancy and post-birth, the Kentucky Perinatal Quality Collaborative (KyPQC) was established in 2019. KyPQC has remained focused on the impact of substance use disorders during pregnancy and postpartum periods and implemented KyPQC First Initiatives. This program focuses on supporting universal screening for SUD in labor and delivery units and improving reporting of infants born with intrauterine substance exposure to the state's NAS Registry. (KIPRC, 2022)

In 2020, Kentucky enacted Kentucky Revised Statutes (KRS) 214.160, which developed a statewide criterion to screen pregnant persons for alcohol or substance dependency or misuse, including a comprehensive history. This statute permits any physician to administer a toxicology test to a pregnant person under the physician's care within eight hours after delivery to determine whether there is evidence, they have ingested alcohol, a controlled substance, a substance identified on the list provided by CHFS, or if there are any obstetrical complications that are a medical indication of possible use of any such substance for a nonmedical purpose. This important development is crucial to protect the health and well-being of both mothers and babies. Thorough screening for substance use following birth, early identification of substance use disorders can take place, enabling timely interventions and access to necessary treatment and support services, ultimately leading to healthier pregnancies, births, babies, and mothers.

Kentucky's statewide prevention and treatment infrastructure is growing. Kentucky has over 30 publicly funded and contracted programs that are explicitly designed to serve pregnant and parenting women affected by SUD. Of those programs, there are 11 residential treatment and 12 transitional housing locations that allow children to reside with their mothers while they are participating in SUD treatment and recovery support services. In addition to the residential and transitional housing programs, there are 14 intensive outpatient programs (IOPs) and 18 outpatient programs. The goals of these programs are to provide a warm, nurturing environment to support treatment services for women affected by SUD, their children, and their families.

Some of these programs are listed below:

KY-Moms: Maternal Assistance Towards Recovery (MATR) is a behavioral health prevention and case management program focused on risks and effects of substance use/misuse while providing education, information, resources, support, and hope to pregnant and postpartum women and their families and to the professionals who serve them. KY-Moms MATR helps moms provide their babies with a healthier start in life. KY-Moms MATR improves Kentucky birth outcomes by helping pregnant and postpartum women recover from substance use risk factors and substance use disorders by engaging them in prevention education services, intensive case management, recovery supports, and/or other needed services.

The KY-Moms MATR statewide team provides community outreach, community education, and training, along with early intervention techniques and services. At-risk pregnant and postpartum persons are engaged in universal, selective, and indicated levels of prevention education to assist in the reduction of substance use risk factors. Engaging pregnant and postpartum persons in intensive case management services provides an opportunity to enhance readiness for treatment, while providing support for women with a mild, moderate, or severe SUD. Evidence-based practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Motivational Interviewing, Prime for Life (PRI), Hope at Home, and contingency management. As part of the KIDS NOW Early Childhood Development Initiative, the Adult Substance Use Treatment and Recovery Services Branch in the Division of Substance Use Disorder has implemented this program as a statewide effort in all 14 CMHC regions that aims to increase the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other substances during pregnancy and up to 12-months postpartum. In SFY 2025, 139 pregnant and/or postpartum women participated in KY-Moms MATR case management services. In addition to case management services, 111,401 persons were reached with substance use prevention messaging through 3,895 prevention activities.

Independence House is supported by block grant funding and other braided funding streams. It provides residential substance use treatment, intensive outpatient treatment, medication for SUD, and targeted case management services for women during pregnancy and post-partum. Located in Southeastern Kentucky, it serves women from across the state and allows newborns and children under five years of age to reside with their mothers during treatment.

Chrysalis House is a residential and transitional housing treatment program located in Lexington, Kentucky, with three residential facilities, a 40-unit apartment complex, 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 University of Kentucky PATHways and Beyond Birth clinics to provide obstetrics services, medication assisted treatment, and healthcare referrals for pediatric services at UK hospital.

Freedom House I, II, and III offer holistic and comprehensive programs that provide evidence-based interventions and support for women affected by SUD. Their programs include residential, transitional housing, intensive outpatient, and Medications for Opioid Use Disorder (MOUD) for pregnant and parenting women. The program accommodates infants and other children who may reside with the mother during treatment. The third Freedom House in Eastern Kentucky opened last year.

Serenity House is supported by block grant funding and other braided funding streams. It is an eight-bed residential treatment program for pregnant and parenting women with SUD. Residents can stay at Serenity House for up to six months during pregnancy and up to three months post-partum with their infant. Residents of Serenity House receive counseling for SUD and co-occurring mental health disorders, including trauma-informed programming, parenting classes, peer support services, targeted case management, Hazelden Betty-Ford Foundation's Comprehensive Opioid Response and 12 Step (COR-12) facilitation, self-help groups, and other recovery support services. Residents receive prenatal care and access to MOUD through partnerships with local providers as an essential part of their comprehensive treatment for OUD. Serenity House offers an array of services that promote maternal bonding, recovery, health, and wellness of both the mother and the infant.

The Addiction Recovery Center (ARC) is a residential and intensive outpatient program for pregnant and parenting women in Louisville, Kentucky, operated by the CMHC in that area, Seven Counties Services. It is supported by block grant funding and other braided funding streams. ARC provides residential care for pregnant and parenting women at a 3.5 and 3.1 ASAM level of care. Multiple therapeutic modalities are utilized in this program, including the following evidence-based practices and programs:

- MOUD;
- Trauma-Informed Care;
- Child-Parent Psychotherapy (CPP), which aims to support and strengthen the caregiver-child relationship through interaction and observation for trauma-exposed children ages zero through five;
- Incredible Years, 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 and safe pregnancy for mother and child;
- Employment supports;
- Peer support services for pregnant and parenting women, which offer recovery-focused, person-centered support from individuals who are in recovery from a mental health or SUD, with specific training to address the needs of this population; and
- Transitional housing and supportive services as individuals and families move through the continuum of care.

The goal of this program is to provide a warm, nurturing environment to support treatment services for women affected by SUD, their children, and their families.

The Office of Drug Control Policy provided expansion grants that utilize a blend of state general and block grant funds to support services that address the needs of infants and families at risk for or suffering from NAS, including the following programs:

- Transitions, Inc. provides residential treatment and transitional housing services for pregnant and parenting women (PPW). The Recovery Treatment Center (RTC) has 30 treatment beds for PPW that include MOUD on-site healthcare and OB/GYN services, transportation, targeted case management, services promoting child/parent bonding, and recovery supports. Hope House, formerly Dayton Healthy Baby House, is a recovery center for women that provides a full complement of SUD services for women and children including residential treatment, MOUD, psychiatric services, recovery housing, outpatient clinical services, targeted case management, certified peer support, transportation assistance, and individual placement and support (IPS) supported employment;
- LifeSkills, Inc. Park Place Recovery Center for Women is a 16-bed residential facility specifically designed for pregnant and parenting women with SUD. It is supported by block grant funding and other braided funding streams. Infants remain with their mothers while receiving SUD treatment to promote bonding and attachment with one another. Comprehensive services are provided for the family, including family therapy, mutual aid groups, trauma services, person-centered treatment planning, group therapy, and aftercare services. MOUD is included in this treatment model. Transitional services are also provided to assist the family upon completion of residential treatment;
- Haven4Change is owned and operated by LifeSkills, Inc. and is a 24-bed transitional facility for parenting women and their children. Recovery support services include continuing education, job training and placement, skill building, and integration back into the community. Aftercare services include support meetings, outpatient services, qualified community mental health services, and recovery community support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Alanon, and several faith-based groups;
- Communicare, Inc. owns and operates The Elizabethtown Alcohol and Substance Treatment (EAST) Center, which is an eight-bed recovery residence and intensive outpatient program for pregnant, post-partum, and parenting women with OUD. Services include MOUD, individual and group therapy, peer support, case management, and other comprehensive services to assist

mothers and their families in recovery. EAST Center is supported by block grant funding and other braided funding streams;

- Eastern Care Center is an eight-bed transitional recovery residence (including children) that offers an IOP, Parent-Child Interactive Therapy (PCIT), MOUD, daily living skills, support for continuing education, job placement, childcare partnerships, and recovery supports;

- Kentucky River Community Care established the Hollyberry Houses that operate as transitional living apartments with intensive treatment options that provide 24-hour support with parenting, addiction recovery, counseling for trauma and co-occurring mental health needs, along with options for long-term linkage to effective recovery models. They also provide support from early childhood specialty programs for NAS and offer a holistic program that is sustainable with additional available resources. Hollyberry Houses is a modified treatment community approach designed to assist pregnant and parenting women with SUD, who lack the necessary support systems in their community to sustain long-term recovery. Residents can have two preschool children stay with them to support the family unit and to assist the resident in caring for her children while sustaining recovery;

- Pennyroyal Center's Pregnant and Parenting Women's Transitional Program offers four beds to serve women as they transition to recovery services. Peer support services (PSS) for pregnant and parenting women offer recovery-focused, person-centered support from individuals who are in recovery from a mental health or substance use disorder, with specific training to address the needs of this population. Transitional housing and supportive services are available for individuals and families as they move through the continuum of care. Their goal is to provide a warm, nurturing environment for women with an SUD, their children, and families. Pennyroyal Center is supported by block grant funding and other braided funding streams;

- RiverValley Amethyst House for Women is a six-bed residential facility specifically designed for pregnant and parenting women with SUD. It is supported by block grant funding and other braided funding streams. Infants remain with their mothers to promote bonding and attachment. Comprehensive services are provided for the family, including Medication Assisted Treatment, family therapy, mutual aid groups, trauma services, person-centered treatment planning, group therapy, and aftercare services;

- Pathways, Inc. provides services to pregnant and parenting women with SUD. Women receive services through the specialized program, The Journey. This program has 25 available residential treatment beds for women, their infants, and children under the age of two as they move through the continuum of care. Peer support services for pregnant and parenting women offer recovery-focused, person-centered support from individuals who are in recovery from a mental health or substance use disorder, with specific training to address the needs of this population. Life skills and parenting training assist families to re-enter their communities with skills and supports to help them maintain a healthy recovery. The Journey is supported by block grant funding and other braided funding streams;

- UK PATHways-Morehead is a specialized track for prenatal care for mothers with co-occurring mental illness and OUD that is supported by a psychiatric nurse practitioner and an MOUD prescriber. This program offers services through the University of Kentucky-operated Women's Healthcare clinic in Morehead, KY;

- The PATHways program at Polk Dalton Clinic in Lexington, KY (part of University of Kentucky Healthcare) provides evidence-based, comprehensive care for pregnant women with OUD in a structured, clinic setting in which prenatal care, substance use counseling (including MOUD), and neonatology consultation are provided. This program delivers essential, comprehensive, coordinated services for a population that often has difficulty obtaining prenatal services;

- New Vista is the CMHC located in Lexington, KY. Through the Schwartz Center, pregnant women are provided with specialized services. These services include counseling for SUD and co-occurring mental health disorders, trauma-informed programming, parenting classes, peer support services, targeted case management, Hazelden Betty-Ford Foundation's Comprehensive Opioid Response and 12-Step (COR-12) facilitation, mutual aid groups, and other recovery support services. Residents receive prenatal care and access to MOUD through partnerships with local providers as an essential part of their comprehensive treatment for OUD; and are supported by block grant funding and other braided funding streams;

- The Appalachian Restoration Project, located in Barbourville, KY, provides residential services for 12 pregnant and parenting women and their children under the age of two. Services include residential substance use treatment, counseling services, MOUD, and targeted case management services for women during pregnancy and postpartum. In addition, recovery housing for pregnant and parenting women with dependent children, a resource center, and recovery supports are also available.

Additional programming to support SUD treatment for pregnant women includes the following initiatives.

Recovery Housing:

In 2023, legislation was enacted in Kentucky requiring recovery residences to be certified to meet the best practice standards of the National Alliance for Recovery Residences (NARR). In response, the Kentucky Recovery Housing Network (KRHN) was established to implement a statewide certification process and to improve both the quality and availability of recovery housing across Kentucky. In 2024, KRHN partnered with the Virginia Alliance of Recovery Residences (VARR) to establish a new affiliate in Kentucky responsible for conducting NARR certifications for recovery residences. Through the partnership with VARR, the Kentucky Alliance for Recovery Residences (KYARR) was formed as the new affiliate that now evaluates recovery residences in Kentucky across four domains, ten principles, and 31 quality standards. Currently, Kentucky has 103 NARR certified recovery

residences, 21 of which serve pregnant or parenting women.

Plan of Safe Care Initiative:

The Child Abuse Prevention and Treatment Act (CAPTA) requires states to have policies to identify and provide services to infants and their families if the infant is affected by prenatal substance exposure. Nationally, in federal fiscal year (FFY) 2023, 44,453 infants in 49 states were referred to child protective service agencies, with parental drug abuse as a circumstance of referral. The majority (72.5%) of infants with prenatal substance exposure were screened into child protective services to receive either an investigation or an alternative response (2023 Child Maltreatment Report). The Child Fatality and Near Fatality External Review Panel ("the Panel") conducts comprehensive, multidisciplinary reviews to discover risk factors and systems issues and recommend prevention measures. Historically, a large proportion of cases, especially abusive head trauma cases, have had caregiver substance misuse as a risk factor. Programs are needed to provide coordinated and collaborative prevention, treatment, and recovery services to pregnant and/or postpartum individuals and their support person(s) to reduce the risk of harm associated with parental substance use/misuse.

Kentucky's Plan of Safe Care (POSC) initiative focuses on developing a coordinated system of care for pregnant and parenting women affected by SUD, their infants, and families. The focus of this effort is to develop a collaborative community response to address the needs of this population by promoting partnerships and linkages between service providers, stakeholders, community partners, individuals, and families to enhance services and improve outcomes. The initiative recognizes the relationship between trauma, adverse childhood experiences, SUD, and mental illness. It seeks to ensure that services and supports are collaborative, coordinated, widely available, and accessible to this population.

The regional CMHCs currently lead 11 DBHDID-funded POSC pilot sites in partnership with their local Department for Community Based Services (DCBS), other community partners and stakeholders. The sites hold monthly collaboration meetings to develop a system of care for pregnant and parenting women, their children, and families who have been affected by substance use. DBHDID is working to expand this project to all 14 CMHCs.

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

- Early identification, screening, and engagement of pregnant women who are using substances;
- Appropriate treatment for pregnant women, including timely access to MOUD;
- Best-practice guidelines and standards for treatment;
- Consistent hospital screening of pregnant and postpartum women and their infants;
- Consistent hospital notifications to DCBS;
- Memoranda of Agreement (MOA) for information sharing and monitoring infants and families across systems;
- Ongoing care plans for mothers and their infants;
- Collaboration and coordination of services across systems focused on the individual needs of families; and
- Provision of recovery support services.

Through a partnership with the POSC Community Connector Pathway, a DCBS plan of safe care and prevention initiative, KY-Moms MATR is assisting with connecting pregnant moms and their families to a variety of behavioral health, community, and recovery support services. The goal of this partnership is for families to experience a reduction in substance use risk factors and make connections to services earlier, to prevent and reduce future child abuse and neglect reports and substantiated cases.

Narcotic Treatment Programs/Opioid Treatment Programs:

Kentucky currently has 48 narcotic treatment programs/opioid treatment programs and three medication stations that accept pregnant persons. The Narcotic Treatment Program and the New Vista MOUD Recovery Program in Lexington, KY, receive block grant funding to assist in the treatment of this priority population. Pregnant women receive priority treatment at this program. Kentucky has several initiatives as part of a comprehensive approach among various stakeholders, government agencies, healthcare providers, community organizations, and law enforcement to address prescription drug misuse in Kentucky such as Partnership for Success 2015 grant (PFS 2015), Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, enactment of House Bill 1 (HB 1) and Senate Bill 192 (SB 192), Medicaid expansion, regional prevention centers (RPCs), KY Health Now, school-based prevention programs such as "Too Good For Drugs", recovery community centers, Naloxone saturation efforts, syringe service programs (SSPs), fentanyl test strip distributions, the Angel Initiative, drug court programs, reentry programs, and implementation of the Kentucky Agency for Substance Abuse Policy (KASAP). Kentucky has strived to move forward with prevention and treatment measures to help improve the quality of life for residents and to develop a recovery-oriented system of care.

Multiple trainings have been provided across the state for behavioral health professionals, health care professionals, community-based service providers, and other community agencies with specific training and information on opioid use disorder, NOWS, NAS, trauma informed care, American Society of Addiction Medicine (ASAM), Motivational Interviewing (MI), Naloxone use, training specific to peer support specialists working with pregnant and parenting persons, and other evidence-based practices.

To address NAS, DBHDID has worked in collaboration with the following agencies and organizations: The Kentucky Department for Public Health, DCBS, Kentucky Perinatal Association, Norton Healthcare, University of Louisville, University of Kentucky Division of Neonatology, Administrative Office of the Courts, National Alliance for Recovery Residence (NARR), and the Kentucky Chapter of the American College of Obstetrics and Gynecology (ACOG). DBHDID has participated in the Department for Public Health's KYPQC and the Kentucky Maternal Morbidity and Mortality Task Force (KyMMM), which serves to enhance networking and collaboration

with other statewide programs that work to improve maternal and infant health throughout the state of Kentucky, along with implementing and promoting best practices and to make birth safer. The overall mission and vision of KyPQC and KyMMM are to make Kentucky a great place for every woman to have a baby and a great place for every baby to be born.

Plans for the next two years for this population include the following:

- Provide technical assistance and support to providers regarding recovery housing for pregnant and parenting women with dependent children;
- Facilitate recurring meetings focused on pregnant and parenting women, NOWS, NAS, FASD, and children's treatment and support services to collaborate with other professionals with similar projects to share program challenges, successes, and resources and enhance implementation efforts;
- Advise on housing program policies and procedures in collaboration with the National Alliance for Recovery Residence (NARR) that better accommodate the needs of women with children, such as safe, child-friendly spaces;
- Provide technical assistance to agencies and community partners in establishing maternal health councils across the state.
- Continue to require providers to screen for pregnancy on the first contact;
- Continue partnerships and funding for services that support pregnant and postpartum women, including prevention, outpatient treatment services, residential treatment services, MOUD, case management, peer support, life skills, parenting, supported housing, employment assistance, and other specified needs;
- Expand capacity and improve quality of treatment services for pregnant and postpartum women, while strengthening the use of evidence-based practices in women's treatment programs;
- Coordinate the treatment and resource needs of infants and children with the services provided for the mother and family;
- Continue collaboration with the Department for Public Health toward addressing the issue of safe sleep practices for infants and the reduction of maternal smoking during pregnancy:
- In collaboration with the Kentucky Chapters of the ACOG and the American Medical Association (AMA), a statewide initiative to continue the expansion of universal substance use screening and provide brief intervention and referral to treatment services (SBIRT) as a routine part of prenatal care through promoting the use of a pregnancy specific SBIRT protocol by medical providers. The protocol should include specialized instruction on how to address the unique fears and barriers faced by pregnant women with substance use disorders. This initiative would increase the identification of substance use/misuse during pregnancy and permit earlier intervention, thus minimizing the adverse effects on the baby. As of April 2023, Kentucky has 26 DBHDID-approved SBIRT instructors across the state;
- Continue the collaborative work of the KyPQC, which serves to enhance networking and collaboration with other statewide programs that work to improve maternal and infant health throughout the state of Kentucky. The KyPQC is comprised of three workgroups: obstetrics (OB), neonatology (Neo), and data and analytics that develop goals and initiatives to improve maternal and infant health outcomes;
- Continue to collaborate with DCBS (child protective services) regarding pregnant and parenting mothers and improving access to SUD services;
- Continue to enhance KY-Moms MATR substance use prevention and case management services, focusing on the use of evidence-based and evidence-informed practices. Provide substance use prevention services to women of childbearing age, prior to, during, and after pregnancy through community engagement and outreach events. Focusing additional educational/prevention services on women prior to pregnancy creates the opportunity to educate them regarding the risks and complications associated with substance use, while providing tailored services and supports to the individual during the most critical time in a new parent's life;
- Continue to provide technical assistance to the KY-Moms MATR statewide team in providing substance use prevention, case management, and recovery support services to pregnant persons and persons up to 12-months postpartum;
- Enhance training, data collection efforts, and reporting methods for community mental health center staff who provide services to pregnant and parenting persons;
- Continue to promote the development of a coordinated and collaborative system of care to address the needs of families affected by substance use. Improving intervention services before, during, and after pregnancy can result in service provision that is coordinated and collaborative; and
- Continue to support and collaborate with community partners on a statewide plan of safe care initiative to enhance the ability of communities to provide evidence-based, collaborative, and coordinated services to families in need.

Women with a substance use disorder who have dependent children:

Addressing the Need:

DBHDID participated in the SAMHSA Policy Academy in 2014 on prescription drug misuse 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 childbearing age and pregnant women who are using substances. The core team involved in the project includes DCBS, family drug courts, Department for Public Health, Office of Drug Control Policy, Kentucky Medicaid, Office of the Inspector General, community partners including community mental health centers (CMHCs), narcotic treatment programs, Veterans of America Freedom House, Chrysalis House, and the University of Kentucky (UK) Polk Dalton Clinic.

As a result of the work associated with the policy academy, Kentucky was awarded the SAMHSA Medication-Assisted Treatment Prescription Drug and Opioid Abuse: (MAT-PDOA SMARTS) Grant. With this grant, Kentucky expanded treatment services and increased capacity for evidence-based medication-assisted treatment (MAT) and other recovery support services to pregnant and postpartum women with OUD, through a partnership with two CMHCs. Although the grant funding is no longer available, the

model developed through this opportunity created the blueprint for implementing comprehensive, coordinated, and collaborative SUD treatment services for parents with dependent children.

Prior to 2014, Kentucky Medicaid SUD treatment services were only available to pregnant and post-partum (up to 60 days) women, including case management and prevention services. The Medicaid State Plan Amendment (SPA) approved by the Centers for Medicare and Medicaid Services (CMS) in 2014 included a wide variety of treatment services for individuals with SUD. To improve maternal and child health outcomes and increase access to life-saving health care services for pregnant and parenting Kentuckians, CMS expanded Medicaid coverage to a full 12-month postpartum period on May 25, 2022. This expansion was critical in addressing health concerns that can affect women and children in the period following childbirth. Through the Medicaid SPA, mothers who experience substance use risk factors and effects of substance use/misuse will now have the opportunity to participate in substance use prevention, treatment, and recovery support services up to 12 months postpartum. Additionally, due to Medicaid expansion, fathers, husbands, boyfriends, and significant others can now more readily have access to substance use disorder treatment and recovery support services. Kentucky's statewide prevention and treatment infrastructure is growing due to these changes.

In state fiscal year 2024, funding was awarded to 12 CMHCs and multiple additional providers to address specific needs within each community related to SUD treatment services. Two CMHCs established mobile crisis units, two utilized the funds to open and operate a recovery community center, and four CMHC providers expanded treatment services through additional intensive outpatient services. Other providers utilized funds to expand services and increase recovery support services.

Through the Pregnancy Empowerment Project partnership with KY-Moms Maternal Assistance Towards Recovery (MATR), substance use prevention specialists and case managers positively impacted education and engagement for people who use substances and for people in recovery through the integration of pregnancy tests, prenatal vitamins, and other items into the organizational toolbox to engage program participants and enhance their ability to build recovery capital. A total of 1,669 pregnancy tests, 258 prenatal vitamins, and 268 additional items were distributed during SFY 2024 and SFY 2025.

Using the evidence-based Oxford House model, Kentucky has significantly increased the capacity of community-based recovery housing that can support parents with dependent children. While greater housing resources are needed, the commonwealth has established 132 Oxford Houses as of May 1, 2025, which are equipped to provide a stable and supportive living environment for persons in SUD recovery and persons in SUD recovery with dependent children. Of the 34 women's houses, 21 are houses for women with dependent children, and seven are houses for men with dependent children. Each home provides space for a parent to reside with their dependent(s), with rules regarding the age of the child and supervision. These houses provide around 275 beds for women, 179 beds for women with dependent children, and 56 beds for men with dependent children. Please see the Oxford House map in the SUD Data Tables document uploaded to this section of the application.

During SFY 2024, the Adult Substance Use Treatment and Recovery Services Branch within DBHDID transitioned the certification for recovery housing to an agency outside of the Cabinet and incorporated the National Alliance for Recovery Residences (NARR) National Alliance for Recovery Residences (NARR) standards to ensure best-practice standards for recovery housing. The Department will continue to provide technical assistance to the certifying organization and recovery residences. Kentucky currently has a total of 331 certified recovery housing programs with over 4,613 beds. The program continues to grow at a consistent rate. To date, there are 103 certified recovery residences for women, including 21 residences specifically certified to serve women with dependent children.

To increase access to recovery housing and the number of residences that support persons in recovery from SUD, in 2023 and 2024, the Adult Substance Use Treatment and Recovery Services Branch, in partnership with the Office of Drug Control Policy (ODCP), offered seven recovery housing expansion grants to expand capacity or establish new recovery housing. The grants established new or expanded services for men, women, and pregnant and parenting persons.

In addressing NAS and families affected by substance use, DBHDID, in partnership with ODCP in 2023 and 2024, provided 20 awards specific to treatment and supports to providers. These awards focused on the continued promotion of prenatal care by addressing the following:

- Promoting enrollment in MOUD programs;
- Implementing a plan of safe care (POSC), including educating parents and medical/childcare providers on safe sleep, abusive head trauma, the effects of substance use on pregnant and parenting families, along with child abuse and neglect;
- Enrollment in services such as Women, Infants and Children (WIC), substance use prevention and treatment programs, and substance use recovery support services; and
- Supporting technology to access treatment and recovery supports for families facing transportation barriers, access to recovery communities, and barrier support phone applications for instant support and resources.

A reorganization occurred in 2022 that created a new division within DCBS focused on prevention and community efforts. The Division of Prevention and Community Well Being (DPCW) houses three branches: Primary Prevention, Community Response and Well-Being, and Prevention Evidence-Based Practices. These three branches focus on primary, secondary, and tertiary prevention efforts. Through a partnership between DPCW and DBHDID, the POSC Community Connector Pathway was created, a DCBS POSC prevention initiative. This initiative engages the KY-Moms MATR statewide team in assisting DCBS with connecting moms with dependent children to a variety of behavioral health, community, and recovery support services. Through this partnership, it is

anticipated that families can experience a reduction in substance use risk factors and make connections to services and supports sooner, to prevent future child abuse and neglect reports and substantiated cases. This pathway is designed explicitly for reports that do not meet criteria for maltreatment and for families who can benefit from additional community supports.

In addition, Kentucky plans to:

- Continue to enhance the current system of care;
- Continue to increase the use of the kynect benefit and resources websites to connect qualifying Kentuckians to needed benefits and resources; Kentucky Benefits | kynect
- Increase and enhance data reporting related to substance use and pregnant persons and women with dependent children;
- Enhance the use of evidence-based practices (EBPs) across the system of care;
- Integrate substance use disorder and mental health disorder services with primary care services;
- Continue to promote the use of person-centered recovery Planning;
- Increase and enhance recovery support services;
- Expand the availability of aftercare and follow-up services for clients receiving behavioral health and recovery support services;
- Increase awareness of the availability of services and enhance the referral network;
- Encourage and facilitate collaboration and coordination of services among community partners;
- Increase universal screening by medical providers and other referring community partners using Screening, Brief Intervention and Referral to Treatment (SBIRT) principles;
- Enhance childcare and transportation services to increase accessibility of behavioral health and medical services;
- Continue to update and enhance Find Help Now KY, a web-based treatment, recovery housing, and naloxone locator website; Find Help Now - KY
- Provide ongoing education on substance use risk and protective factors, substance use during pregnancy and postpartum, NAS, POSC, and MOUD;
- Include injury prevention education and strategies as part of SUD treatment and NAS hospital discharge planning to prevent injuries and fatalities to substance-affected infants;
- Continue to provide technical assistance to support the 2026/2027 priorities; and
- Increase the availability of crisis response, including quick response teams (QRT) and mobile response services.

Persons who inject drugs:

Addressing the Need:

DBHDID will continue to ensure that all CMHCs screen for IDU on initial contact and refer clients to appropriate services. DBHDID will continue to work collaboratively with the Department for Public Health and other advocacy groups and recovery organizations to enhance harm reduction efforts statewide. In addition, DBHDID will work to enhance access to peer support and other recovery support services for these individuals, as well as evidence-based OUD services, including MOUD.

DBHDID will collaborate with department and division staff, as well as community partners, to develop a centralized listing of programs in Kentucky specifically equipped to treat individuals with SUD and PICC lines. DBHDID will gather information to develop an inventory of residential SUD treatment programs that serve individuals within the 3.5 – 3.7 ASAM level of care and are equipped to serve PWIDs with a PICC line. DBHDID will create and conduct a follow-up survey to review the impact of disseminated information on awareness of the need for these services.

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

Addressing the Need:

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

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

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

To combat growing concern over HIV and Hepatitis C outbreaks, Kentucky statute allows county health departments to provide syringe exchange programs, also known as syringe service programs. These programs have proven effective in reducing the spread of infections without increasing drug use. As of June 30, 2024, there are 83 syringe services programs in 64 counties across the state.

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

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

Specifically, VHP aims to achieve the following:

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

The Division of Substance Use Disorder will continue to work collaboratively with DPH to maintain the most current data on Kentucky's rates of newly diagnosed cases of HIV/AIDS so the most appropriate services may be coordinated. Kentucky recognizes that there is a need to address Hepatitis C more intensively in substance use services, as well as increase education about Hepatitis A and B.

Individuals with or at risk of tuberculosis:

Addressing the Need:

DBHDID works with the 14 Community Mental Health Centers (CMHCs) to ensure that individuals who receive substance use disorder (SUD) services and have or are at risk of contracting tuberculosis are screened appropriately and referred to needed services. Strategies to attain this objective include continuing partnerships with DPH and the CMHCs to improve data collection, definitions, and screening protocol for tuberculosis, ensuring that CMHCs are systematically screening for tuberculosis among individuals receiving services for SUD, and offering CMHCs technical assistance in updating and improving their policies and procedures regarding tuberculosis screening and referral.

The Division of Substance Use Disorder continues to monitor contractual and regulatory mandates regularly, the CMHC policies and procedures annually, and the licensed opioid treatment programs (OTP) recertification reviews. DBHDID continues to ensure appropriate training is available to substance use treatment staff and that continuing education is provided, offering the most current information on infectious diseases.

The Division of Substance Use Disorder requires that all CMHCs submit their written policies and protocols detailing the screening and referral process for all individuals seeking services for substance use disorders. To continue to enhance this process, CMHCs also submit their specific written procedures, training processes, and training curriculum to DBHDID as part of the annual reporting process. These written procedures include the CMHC's training curriculum, designed to ensure staff receive adequate instruction on effective and consistent implementation of the CMHC's tuberculosis protocols.

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

State employees, local health department employees, and private health care providers carry out TB control activities. State and federal funds are allocated to designated local health departments, which serve as local lead agencies for the TB Control Program. State-level public health personnel provide program planning, implementation, and evaluation, program performance standards, technical assistance, and consultation, including X-ray, nursing, medical, clerical, statistical, financial, and managerial support, and training and disease surveillance. DBHDID continues to work with DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of tuberculosis so the most appropriate services may be coordinated.

Persons in Need of Recovery Support Services for SUD:

Plans to Address the Unmet Needs:

Kentucky implemented recovery community centers (RCCs) as one avenue to bridge the gap for needed recovery support services. Efforts to strengthen and expand these programs will continue, including addressing access issues for rural areas. Telehealth can continue to bridge the gap in these areas for some recovery support services, such as peer support.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) plays a central role in certifying peer support specialists (PSS) across the state. DBHDID establishes regulatory standards, approves training curricula, and oversees the credentialing process to ensure that peer support services are delivered safely and effectively. This includes enforcing Kentucky Administrative Regulations (KAR) that define eligibility, training, supervision, and continuing education requirements for adult, family, and youth peer support specialists. DBHDID reviews and approves training curricula submitted by providers to ensure alignment with state standards and authorizes organizations to deliver peer support training. Upon successful completion of training and examination, DBHDID manages certification records through its Training Records Information System (TRIS), which tracks certifications and ensures compliance with continuing education requirements. Certified peer support specialists must complete ongoing continuing education to maintain their credentials, and DBHDID monitors compliance to uphold the quality and effectiveness of recovery support across the state.

Young adults face unique challenges, such as the need for education and job assistance, transitional housing, and programming capable of meeting these unique needs.

The Division of Substance Use Disorder (DSUD) will continue to work closely with the 14 community mental health centers across the state to enhance service delivery and provide comprehensive behavioral health care that includes recovery support services. This work will consist of training and technical assistance, specifically for the recovery support service workforce, but including supervisors. Social determinants of health, like housing issues and joblessness, will continue to be addressed. Continuing to build community partnerships and providing additional public education will assist in reducing stigma and creating more recovery-friendly environments. By working with providers and community members, including individuals seeking recovery, to implement recovery programming that is relevant, and then providing oversight for programming, DSUD will strive to improve access to recovery support services and empower individuals to achieve and sustain their recovery journeys.

Adults with Co-occurring M/SUD: Addressing the Need:

DBHDID collaborates with community mental health centers (CMHCs) across Kentucky to address the needs of individuals with co-occurring mental health and substance use disorders. DBHDID continues to collect service data and uses this information to identify integrated care opportunities. Additionally, Kentucky's Peer Support Implementation team is working to revise and enhance the training process for peer support specialists by developing a training rubric for peers with lived experience in co-occurring mental health and substance use disorders. Further, Kentucky will continue to provide technical assistance to community providers to ensure individuals with co-occurring mental health and substance use disorders receive the appropriate evidence-based services.

Kentucky has partnered with Zia Partners to assist the department in building a statewide, capable, co-occurring system of care. This collaboration will unfold in two phases:

1. Phase One focuses on designing a strategic plan that defines what a co-occurring capable system could look like in Kentucky.
2. Phase Two will support the implementation of this vision through a statewide change initiative, engaging selected external partners.

Service Members, Veterans, and their Families in Kentucky: Addressing the Needs:

Kentucky Governor's SMVF Challenge Team

DBHDID continues to participate in the Kentucky Governor's Challenge for Service Members, Veterans, and their Families. Representatives from SAMHSA's SMVF Technical Assistance Center, military, federal, state, veterans service organizations, and public and private providers meet quarterly to focus on lethal means safety relating to suicide prevention. The areas of focus are identified to include firearms safety training, safe storage of medication, and firearms. The task force is currently working on action plans and strategies to address access to lethal means, SMVF community outreach, and veteran suicide mortality reviews.

Military Behavioral Health Coordinators

Since 2013, the CMHC contracts have included a requirement for 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 (MBHCs) and function as a point of contact within their organization. They also help the client to navigate the system and identify additional resources/benefits. The coordinators have attended specialized training such as Operation Immersion and Operation Headed Home, events to enhance their knowledge and skills to meet the needs of the SMVF population.

Operation Headed Home Conferences

The Operation Headed Home (OHH) workgroup began in 2008 with a core group of three individuals and has grown to over 100 dedicated members who are connected and committed to providing counseling, information, resources, and support to service members, veterans, and their families.

Since 2010, the department has hosted four Operation Headed Home conferences and trained over 1,000 individuals for free.

Conference participants and presenters include past and present service members, veterans (all branches), and their

families/caregivers, local, state, and national leaders, subject matter experts, and those serving on the front lines of behavioral healthcare and supportive services. The conference addressed the following identified needs: TBI, PTSD, suicide prevention, reintegration, family and caregiver support, available resources and benefits, transitioning to work and school, polytrauma, polypharmacy, substance use prevention and treatment, and hearing loss and tinnitus from blast injuries. Normal attendance for this event is over 300 individuals.

For future conferences, a core group of individuals would be established within each region that would be led by the MBHC to bring awareness and develop support systems unique to that region for service members, veterans, and their families. The resources, partnerships, and funding opportunities gained after the previous conferences built relationships across the state and filled tremendous gaps. It has also laid the groundwork for future community collaboration around TBI, PTSD, and suicide prevention in Kentucky.

Operation Immersion

Operation Immersion is designed to remove barriers, ease soldier apprehension, and increase access to treatment. The department and the Kentucky National Guard collaborated 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 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, and combat missions; enjoy MREs (meals ready to eat); and network with military personnel and resource providers. In addition, workshops are provided on TBI, PTSD, combat stress, suicide prevention, substance use prevention and treatment, military sexual assault and prevention, comprehensive soldier and family fitness (CSF2), trauma-informed care, and other best practices to treat military clients and their families. Kentucky has held nine Operation Immersion events since its inception in 2012 at the Wendell H. Ford Regional Training Center. This site is one of the premier Kentucky National Guard training venues. Four hundred and ninety-six (496) behavioral health professionals/providers have attended this hands-on event to learn about military culture and focus on how to help the SMVF population in Kentucky. The next Operation Immersion is set for Spring of 2026.

Additional plans to address needs include the following:

1. Increase access to effective behavioral health services

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

Service Members, Veterans, and their Families - Peer Support Specialist (SMVF-PSS)

Program Description:

Four CMHCs were selected to hire and train peer support specialists (PSS) with lived experience of a substance use disorder, military experience, and status as a veteran as part of a pilot program. The peers were hired to provide PSS services to service members, veterans, and their families (SMVF) with opioid use disorder (OUD) in the CMHC crisis stabilization units. These SMVF-PSS provide additional support in community outreach and SMVF population identification and assist in safely transitioning the consumer to care in outpatient or inpatient follow-up programs. The SMVF-PSS works closely in collaboration with the CMHC military behavioral health coordinators, the regional prevention centers, crisis services, and all outpatient programs. The SMVF-PSS helps facilitate continuity of care by being a bridge to aftercare services and by monthly monitoring of consumers within the program post-discharge.

2. Increase Help-Seeking Behavior

- Provide technical assistance to CMHCs and managed care organizations (MCOs) regarding TRICARE and encourage agencies to accept and work with TRICARE for the SMVF population in Kentucky.
- Create and distribute marketing information linking the SMVF population to services in their area and state-wide services.
- Increase help-seeking behavior by raising awareness of available resources and encouraging utilization of services by SMVF.
- Work with kynect, Kentucky's statewide benefit portal, to provide resources for service members, veterans, and their families, professionals, providers, and the military community.
- ASK The Question Campaign pilot project in central Kentucky.

o The Kentucky Governor's SMVF Challenge Team began a pilot project within the faith-based community in Lexington, Kentucky, to end veteran suicide. This collaborative effort aids faith leaders in identifying service members, veterans, and their families (SMVF) within their audiences. The congregations will distribute special cards designed to link the SMVF populations to the resources they deserve. The resource cards list helpful contact information for the following programs: 988 suicide and crisis lifeline, benefits, healthcare, free psychotherapy, Military OneSource, and FindHelpNow.org.

o Four Lexington faith-based congregations with a combined size of more than 22,000 worshipers agreed to assist with the pilot project. Each agreed to distribute 500 resource cards within their congregation, totaling 2,000 cards distributed within their community. One church agreed to conduct a small group meeting of service members, veterans, and their families to discuss resources available to the SMVF population.

3. Reduce Access to Lethal Means and Reduce Veteran Suicides

- The Veteran Suicide Mortality Review Committee (SMR) was established in Louisville, KY, to reduce veteran suicide.
- o Suicide fatality reviews are an innovative data-sharing process to address suicides in the community. Reviews involve a case review process that generates information about decedents and their interactions with services and systems. This information can be used to craft recommendations to prevent future similar deaths. This process has been effective for reviewing homicides, child fatalities, overdoses, and maternal deaths, and it is now a nationally recognized model.
- o The SMR subcommittee was supported by a Cooperative Agreement funded by the U.S. Department of Veterans Affairs and SAMHSA. The Jefferson County Suicide Fatality Review (SFR) and Veteran SMR subcommittee are grateful to the Jefferson County Coroner's Office for providing a unique opportunity to review data related to suicide deaths in the county, expand understanding of suicide within the jurisdiction, and tailor prevention, intervention, and postvention efforts to reduce the number of lives lost.
- o In the Fall of 2024, the Jefferson SFR workgroup partnered with the Kentucky Department of Veteran Affairs (KDVA) to develop a veteran-specific suicide mortality review subcommittee (VSMR) that reviews veteran lives lost to suicide in Jefferson County. This subcommittee includes members from DBHDID, the Jefferson County Coroner's Office, Louisville Metro Public Health and Wellness (LMPHW), the University of Louisville, the Kentucky Injury & Prevention Research Center (KIPRC), Robley Rex VA Hospital, and the VA Midsouth Healthcare Network (VISN 9).
- DBHDID is conducting a landscape analysis to assess current suicide and overdose death review efforts across the state. This effort, guided by the VA/SAMHSA Suicide Mortality Review Toolkit, aims to identify gaps and opportunities to strengthen coordination, data use, and prevention planning.
- Reduce access to potential lethal means through education, safety control devices, and information dissemination.
- Develop a firearm safe storage option at local gun shops, law enforcement offices, or bonded organizations/businesses to hold firearms while an individual is experiencing suicidal ideations or in a mental health crisis.
- Engage multiple entities, including the regional prevention centers within the CMHCs and VA hospitals, in 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 communities to reduce the number of deaths associated with opioid 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 the lock boxes.
- Brief intervention and referral should be available at all events; clinical personnel should be on hand to help with direct referrals.
- All materials and events should follow the safe messaging guidelines and Framework for Successful Messaging.

Substance Use Primary Prevention:

Addressing the Need:

To address underage and binge drinking, each RPC will include an underage drinking component in the annual work plan submitted to the branch. Similarly, to address e-cigarette use by youth, each RPC will include an e-cigarette component within its annual work plan submitted to the branch. The work plan item will address either perceptions of approval, perceptions of risk, or reduction in access for youth.

Surveillance gaps are noted for the 18-25-year-old populations and for assessing illicit substance use, especially at the county level. Kentucky proposes to engage the State Epidemiology Outcomes Workgroup (SEOW) to analyze existing county-level data sources (admissions for alcohol treatment, DUI arrests, alcohol related traffic accidents and fatalities, rates of cirrhosis, and other alcohol related health problems) to identify critical areas of need around the 18-25-year-old population. This needs assessment will serve as the basis for future planning efforts to address alcohol use or other identified needs with the targeted adult population. The SEOW will also help identify data indicators that can be utilized to assess the need around use of illicit substances by adults at the regional and county level, specifically related to stimulants (cocaine, methamphetamines, and prescription drugs), cannabis use, and the increasing prevalence of fentanyl. Currently, there is no data beyond state-level data that identifies the local need for those over the age of 18.

To address the substance use issues identified through prevalence and incidence data, and risk factors for substance use, Kentucky's prevention efforts over the next two years will continue to focus on increasing capacity with a special emphasis on increasing the numbers and experience of the prevention workforce. Kentucky will focus on increasing the skills and abilities of the workforce to understand and effectively intervene at the community level. Kentucky plans to increase surveillance opportunities related to the identified substances of focus, especially as they affect the state's 18-25-year-old population.

Kentucky is also refining its needs assessment process, which now includes the provision of data related to incidence and prevalence through a dashboard that will guide county-level assessments. The dashboard provides easy access to information on alcohol, nicotine, cannabis, opioids, stimulants, and mental health issues, taking into consideration incidence, prevalence, morbidity, mortality, community contexts (poverty, lack of housing, discrimination), and health disparities. RPC staff will share this information with community members to identify their agreement with the issues in the community and conduct key stakeholder and focus group qualitative data collection to further identify local contexts that contribute to substance use and mental health issues, creating a focused action plan for each Kentucky county. They will also assess the readiness and capacity of the community to implement the identified strategies and guide communities in selecting those that are aligned with the community's current readiness level. The plans will include evaluation measures to understand the impact of those strategies and help refine the county-level work.

DBHDID program administrators meet in an annual strategic planning session to review available information from the regions, updated trend data on substances, and changes in readiness levels to develop an internal strategic plan that guides the branch's work in supporting the delivery of training and technical assistance to communities based on local needs.

Additionally, prevention program administrators will continue to provide monitoring and technical assistance to DBHDID-funded prevention programs by meeting one-on-one with providers at least monthly and holding virtual peer group meetings twice a month (one formal, one a peer-sharing call). Based on these calls and coupled with the needs assessment, a training and technical assistance plan is developed for each region. Needs noted across the regions are used to identify training and other skill-building opportunities for the RPCs.

In 2022, the state launched an onboarding training plan for all new hires, as well as providing Prevention 201 trainings for more advanced providers to ensure they retain and expand their prevention knowledge to keep up with changing trends, different substances used, and to connect with stakeholders based on identified shared risk and protective factors, especially factors revealed by new research. The onboarding system allows learning opportunities to be layered over the new hires' first year of employment, helps to facilitate the certified prevention specialist certification process, and creates a sense of purpose and mission among those entering the system, hopefully resulting in lower turnover and higher retention of prevention specialists. Addressing the capacity of the prevention system will allow for an intentional focus on the prevention of the use and consequences of the illicit substances identified.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Adults with SMI Data Tables

Table 1 – Adults with SMI receiving adult peer support

Service	SFY 2024	SFY 2023	SFY 2022
Adult Peer Support	4,222 (8.86%)	4,109 (8.49%)	3,656 (7.54%)

DBHDID Client/Event Data Set

Table 2 – Adults with SMI receiving supported employment

Service	SFY 2024	SFY 2023	SFY 2022
Supported Employment	536 (1.13%)	480 (0.99%)	480 (0.99%)

DBHDID Client/Event Data Set

Table 3 – Adults with SMI receiving targeted case management

Service	SFY 2024	SFY 2023	SFY 2022
Targeted Case Management	5,567 (7.03%)	3,421 (4.32%)	5,847 (7.38%)

DBHDID Client/Event Data Set

Table 4 – Adults with SMI receiving assertive community treatment

Service	SFY 2024	SFY 2023	SFY 2022
ACT	660 (1.39%)	742 (1.53%)	602 (1.24%)

DBHDID Client/Event Data Set

Table 5 – Adults with SMI served in consumer operated services programs

Service	SFY 2024	SFY 2023	SFY 2022
COSP	2,578 (3.3%)	2,065 (2.6%)	2,365 (3.0%)

DBHDID Client/Event Data Set

Table 6 – Adults with SMI 60+ served by CMHCs

CMHC Region	Adults with SMI 60+ Served in SFY 2024	Estimated Regional SMI 60+ Population	Percentage of Estimate Served
Four Rivers	432	1,439	30%
Pennyroyal Center	382	1,249	31%
River Valley	197	1,356	15%
LifeSkills	261	1,739	15%

Communicare	423	1,590	27%
Seven Counties	1,225	5,870	21%
NorthKey	629	2,497	25%
Comprehend	40	354	11%
Pathways	701	1,406	50%
Mountain	955	927	103%
Kentucky River	308	691	45%
Cumberland River	424	1,415	30%
Adanta	449	1,412	32%
New Vista	800	4,548	18%
Statewide Total	7,226	26,493	27%

DBHDID Client/Event Data Set

Children with SED Data Tables

Table 1 – Children with SED served by CMHCs

Child Census 2020	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served by CMHCs in SFY2023	Percentage of Children with SED Served by CMHCs in SFY2023	Kentucky Children with SED Served by CMHCs in SFY 2024	Percentage of Children with SED Served by CMHCs in SFY 2024
995,111	49,756	21,079	43%	19,940	40%

DBHDID Client/Event Data Set

Table 2 – Kentucky Families Data - 2020 Census, the Center for American Progress, the Center for Disease Control, and Spotlight on Poverty & Opportunity

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

Early Serious Mental Illness/First Episode Psychosis Data Tables

Table 1 -Demographics for Kentucky population (ages 15 – 30)

2023* Census Estimates (Kentucky State Data Center)	KY 2023
Total Population in KY	4,519,233
Total population between 15 -30 years old	903,847
% of population between 15-30 years old	20%
Race/Ethnicity for 15 -30 years old	
Black	90,385 10%
Asian	18,077 2%
White (non-Hispanic)	713,040 79%
Hispanic	45,192 5%
Other	27,115 3%
Gender 15 - 30 years old	
Female	49%
Male	51%

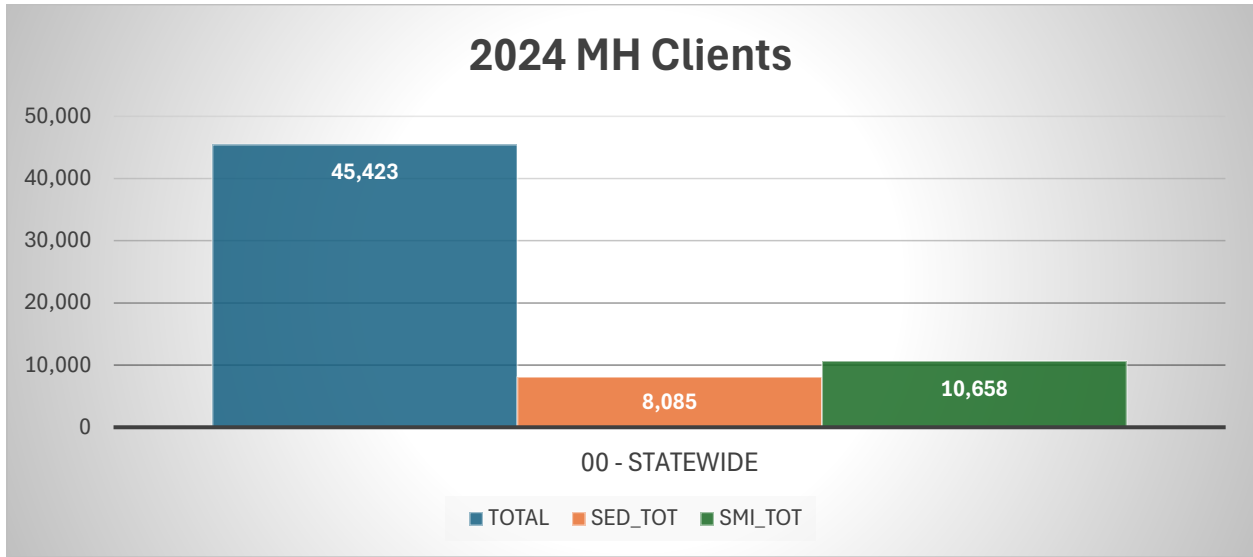
**2023 U.S. Census Data Population Estimates used due to 2020 Census data not including detailed breakouts.*

Table 2 – FEP estimates per Kentucky CMHC region

Kentucky Community Mental Health Centers 2023 Estimated Census Population Chart Kentucky State Data Center Per Year Estimated Incidence Rates for First Episode Psychosis		
CMHC	Total Pop	.03% national per year incidence estimate for FEP
Four Rivers	196,917	59
Pennyroyal Center	214,196	64
River Valley	214,425	65
LifeSkills	320,370	96
Communicare	283,756	85
Seven Counties	1,024,079	307
NorthKey	474,262	142
Comprehend	55,751	17
Pathways	133,070	40
Mountain	136,501	41
Kentucky River	103,030	31
Cumberland River	227,785	68
Adanta	208,276	62
New Vista	840,347	252
Kentucky	4,519,233	1,356

2023 U.S. Census Data

Table 3 – Mental Health Clients Aged 15 – 30 Served by CMHCs



DBHDID Client Data Set

Behavioral Health Crisis Services Data Tables

Table 1 – Number of Adults served with CMHC crisis services

Table 1. Total Number and Percentage of Adults Served by CMHC Crisis Programs SFY 2020-2024							
		Source or Formula	2020	2021	2022	2023	2024
A	Adults Age 18+ Served CMHC Mobile Crisis	CMHC Service Mix Utilization Adults Report	5,598	4,754	5,042	5,560	5,170
B	% of KY Adults Served CMHC Mobile Crisis	Row A / 2020 State Adult Census	0.18%	0.16%	0.17%	0.18%	0.17%
C	Adults Age 18+ Served CMHC Mobile, Walk-In, or Residential Crisis Service	CMHC Service Mix Utilization Report	22,461	19,583	19,906	20,218	19,430
D	% of KY Adults Served CMHC Mobile, Walk-In, or Residential Crisis Service	Row C / 2020 State Adult Census	0.74%	0.64%	0.65%	0.66%	0.64%

DBHDID Client/Event Data Set/U.S. Census Data 2020

Table 2 – Adults with SMI served with CMHC crisis services

Table 2. Total Number and Percentage of Adults with Serious Mental Illness Served by CMHC Crisis Programs SFY 2020-2024							
		Source or Formula	2020	2021	2022	2023	2024
A	Adults Age 18+ with SMI Served CMHC Mobile Crisis	CMHC Service Mix Utilization Adults Report	1,875	1,727	1,857	2,149	2,028
B	% of Adults Served by CMHC Mobile Crisis Teams Who Had SMI Marker	Table 1, Row A/ Table 2, Row A	33.5%	36.3%	36.8%	38.7%	39.2%
C	% of Adults with SMI Served by CMHC Mobile Crisis	Row A/ 2020 State SMI Estimate	2.1%	1.9%	2.1%	2.4%	2.2%
D	Adults Age 18+ with SMI Served CMHC Mobile, Walk-In, or Residential Crisis Service	Crisis Service Mix Utilization SMI Report	8,788	8,333	8,048	8,553	8,692
E	% of Adults Served by CMHC Mobile, Walk-In, or Residential Crisis Service Who Had SMI Marker	Table 1, Row C/ Table 2, Row D	39.1%	42.6%	40.4%	42.3%	44.7%
F	% of Kentucky's Adults Served by CMHC Mobile, Walk-In, or Residential Crisis Service and Had SMI Marker	Row D/ 2020 State Adult Census	0.29%	0.27%	0.26%	0.28%	0.29%

DBHDID Client/Event Data Set/U.S. Census Data 2020

Table 3 – Children served with CMHC crisis services

Table 3. Total Number of Children Served by CMHC Crisis Programs SFY 2020-2024							
		Source or Formula	2020	2021	2022	2023	2024
A	Children Aged 0-17 Served CMHC Mobile Crisis	CMHC Service Mix Utilization Adults Report	442	479	1,016	922	998
B	% of KY Children Served CMHC Mobile Crisis	Row A/ 2020 State Child Census	0.04%	0.05%	0.10%	0.09%	0.10%
C	Children Aged 0-17 Served CMHC Mobile, Walk-In, or Residential Crisis Service	CMHC Service Mix Utilization Children Report	4,498	3,493	5,865	5,256	5,393
D	% of KY Children Served CMHC Mobile, Walk-In, or Residential Crisis Services	Row C/2020 State Child Census	0.44%	0.34%	0.57%	0.53%	0.54%

DBHDID Client/Event Data Set/U.S. Census Data 2020

Table 4 – Children with SED served with CMHC crisis services

Table 4. Total Number and Percentage of Children with Serious Emotional Disturbance Served by CMHC Crisis Programs SFY 2020-2024							
		Source or Formula	2020	2021	2022	2023	2024
A	Children with SED Served CMHC Mobile Crisis Service	Crisis Service Mix/Utilization SED Report	395	327	656	672	557
B	% of KY Children with SED Served by a CMHC Mobile Crisis Service	Row A/2020 State SED Estimate	0.8%	0.9%	2.0%	1.4%	1.1%
C	% of Children Served by a CMHC Mobile Crisis Service Who Had SED Marker	Table 3, Row B/Table 4, Row A	89%	67%	65%	72%	55%
D	Children Aged 0-17 with SED Served by a CMHC Mobile, Walk-In, or Residential Crisis Service	Crisis Service Mix/Utilization SED Report	3,960	2,464	3,404	4,054	3,630
E	% of Kentucky's Children with SED Served by a CMHC Mobile, Walk-In, or Residential Crisis Service	Row D/2020 State SED Estimate	7.7%	4.8%	6.7%	8.1%	7.3%
F	% of Children Served by a CMHC Mobile, Walk-In, or Residential Crisis	Row D/Table 3, Row C	88%	71%	58%	80%	65%

	Service Who Had SED Marker						

DBHDID Client/Event Data Set/U.S. Census Data 2020

Table 5 – Individuals with SUD served with CMHC crisis services

Table 5. Total Number and Percentage of Individuals with Substance Use Disorder Served by CMHC Crisis Programs SFY 2020-2024							
		Source or Formula	2020	2021	2022	2023	2024
A	Total Individuals Served by CMHC Mobile, Walk-In, or Residential Crisis Services	CMHC Service Mix/Utilization Report	26,472	22,718	24,682	25,835	24,988
B	Total Individuals with SUD Served by CMHC Mobile Crisis Services	CMHC Service Mix/Utilization SUD Report	2,050	1,460	1,504	1,717	1,773
C	% of Individuals Served by CMHC Mobile Crisis Services Who Had an SUD Diagnosis	Row B/Row A	7.7%	6.4%	6.1%	6.6%	7.1%
D	% of Kentuckians Served by a CMHC Mobile Crisis Service and Had an SUD Diagnosis	Row B/State Census	0.05%	0.03%	0.03%	0.04%	0.04%
E	Total Individuals with SUD Served by CMHC Mobile, Walk-In, or Residential Crisis Service	CMHC Service Mix/Utilization SUD Report	7,413	6,751	6,573	6,687	6,898

F	% of Individuals Served by CMHC Mobile, Walk-In, or Residential Crisis Service Who Had an SUD Diagnosis	Row E/Row A	28.0%	29.7%	26.6%	25.9%	27.6%
G	% of Kentuckians Served by a CMHC Mobile, Walk-In, or Residential Crisis Service and Had an SUD Diagnosis	Row E/2020 State Adult and Child Census	0.16%	0.15%	0.15%	0.15%	0.15%

DBHDID Client/Event Data Set/U.S. Census Data 2020

Table 6 – 988/Call Center CMHC Data

Table 6. Total Number of Crisis, Warmline, and 988 Calls, Texts, and Chats Addressed by CMHCs SFY 2021-2024						
		Source or Formula	2021	2022	2023	2024
A	Regional Crisis and Warmline Calls, Texts, and Chats Addressed	DBHDID Form 113D Crisis Services Planning & Implementation Report	304,380	277,395	194,820	199,268
B	988 Calls, Texts, and Chats Addressed	988 Monthly Call Center Reports	15,461	17,257	23,601	31,431
C	Total Crisis and 988 Calls, Texts, and Chats Addressed by CMHCs	Row A + Row B	319,841	294,652	218,421	230,699

Vibrant 988 Call Center Reports/DBHDID Crisis Services Department Periodic Report

Adolescents with SUD or co-occurring Mental Health/Substance Use Disorders Data Tables

Table 1 – Kentucky Youth Risk Behavior Surveillance Survey (YRBSS)

Table 1	KY Middle School 2021	KY Middle School 2023	KY High School 2021	KY High School 2023	US High School 2021	US High School 2023
Ever use an electronic vapor product	24%	23%	45%	42%	36%	34%
Currently smoking cigarettes or cigars or using smokeless tobacco or electronic vapor products	12%	11%	22%	21%	19%	18%
Ever drank alcohol	19%	22%	--	--	--	--
Current alcohol use	--	--	17%	17%	23%	22%
Alcohol use prior to age 11	10%	9%	--	--	--	--
Alcohol use prior to age 13	--	--	14%	15%	15%	13%
Ever use marijuana	6%	6%	23%	25%	28%	30%
Marijuana use prior to age 11	2%	2%	--	--	--	--
Ever taken prescription pain medicine without a doctor's prescription or differently than prescribed	9%	9%	11%	13%	12%	12%
Ever use heroin	--	--	2%	2%	1%	2%

YRBSS Survey 2021/2023

Table 2 – National Survey on Drug Use and Health (NSDUH)

Table 2. 2021 National Survey on Drug Use and Health - Kentucky vs. US		
ITEM	12- 17 KY	12-17 US
Past Month Marijuana Use	5.27%	6.22%
Past Month Alcohol Use	5.25%	6.88%
Past Month Cigarette Use	1.50%	1.28%
Past Month Tobacco Product Use	5.21%	4.91%
Had at least one major depressive episode in the past year	20.53%	18.82%
Made any suicide plans in the past year	6.13%	6.07%

NSDUH 2021

Table 3a – Kentucky Incentives for Prevention (KIP) Military Family Data

Table 3a. Who in your family is currently in the military (all branches including National Guard, Coast Guard, or Reserves) or previously served in the military?			
Family Member on Active Duty or Veteran			
	No/Don't Know 62%	Yes, Grandparent or Other Relative 32%	Yes, Immediate Family Member 16%

KIP, 2021

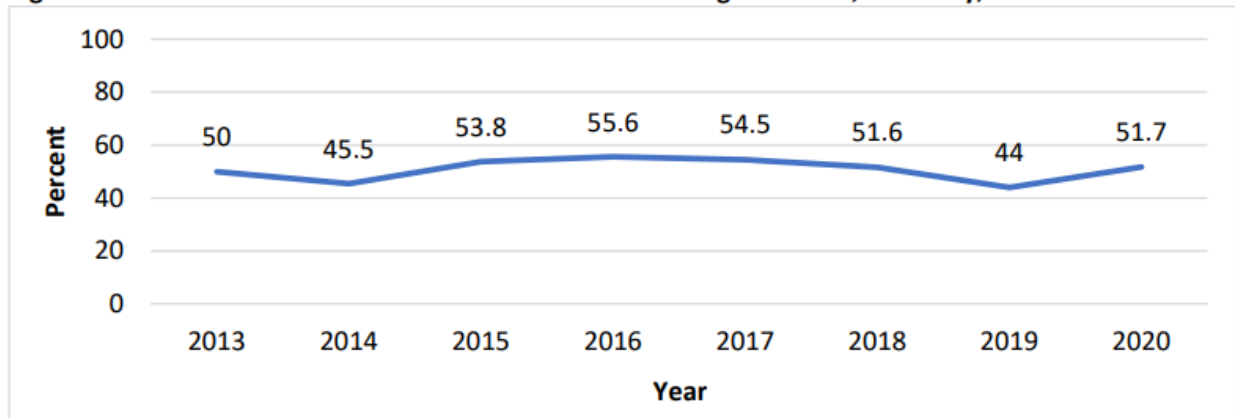
Table 3b – KIP Mental Health/Substance Use Data

Table 3b. Prevalence of Prescription Drug Use and Mental Health Correlates among 10th Graders from Military-Connected Families (KIP, 2021)			
30-Day Drug Use	No/Don't Know	1 military connected family member	2 or more Military connected family members
Cigarettes	10%	10%	14%
Alcohol	15%	16%	21%
Marijuana	10%	10%	12%
Prescription Drugs	4%	4%	6%
Mental Health	No/Don't Know	1 military connected family member	2 or more military connected family members
Serious Psychological Distress (past 30 days)	20%	22%	23%
Self-harm (ever in lifetime)	18%	21%	24%
Self-harm (ever in lifetime)	18%	21%	24%
Suicide plan (past year)	11%	13%	15%
Suicide ideation (past year)	13%	17%	18%

KIP, 2021

Planning Step 2 - Substance Use Disorder Data Tables
(Supportive documentation for SUD required populations)

Figure 3: Percent of Accidental Maternal Deaths due to Drug Overdose, Kentucky, 2013-2020



*Maternal death is defined as any female between the ages of 15-55 that was pregnant within one year prior to death or pregnant at death and died from any cause. Drug overdose is defined by the ICD-10 code X40-X49. The 2016-2020 data is preliminary, and numbers may change.

Data Source: KY Vital Statistics files, linked live birth, and death certificate files years 2013-2020.

Figure 6: Total Number of MMRC Pregnancy-Related Deaths and Rate of Deaths; Kentucky MMR 2017-2020

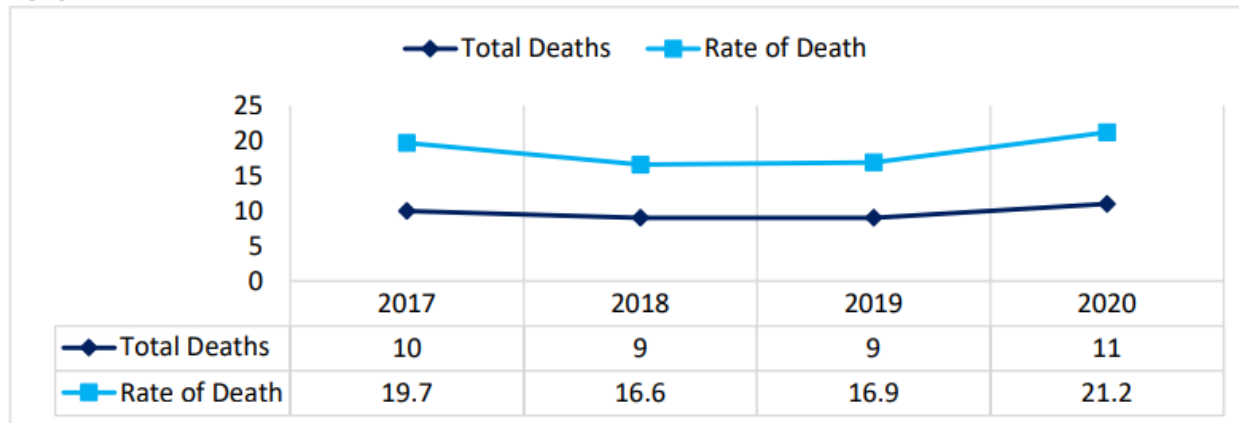
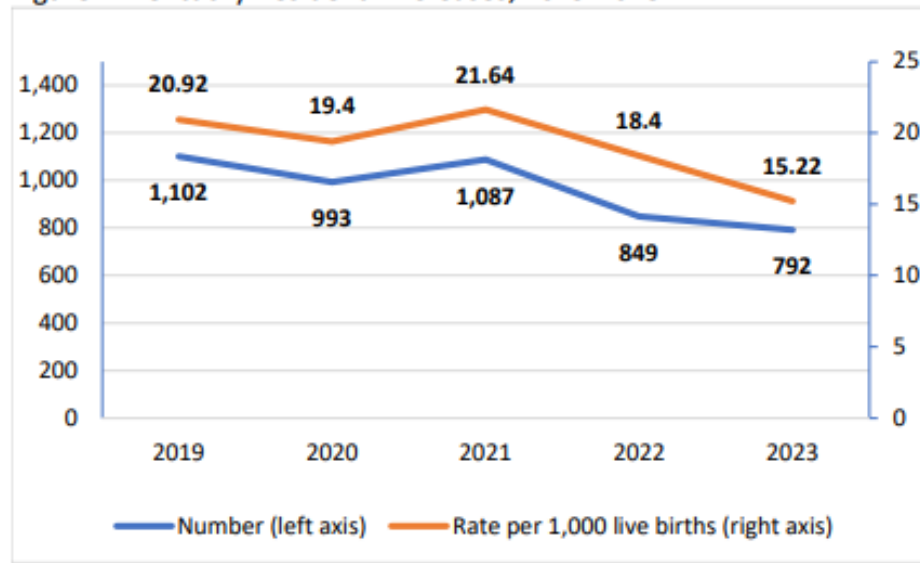
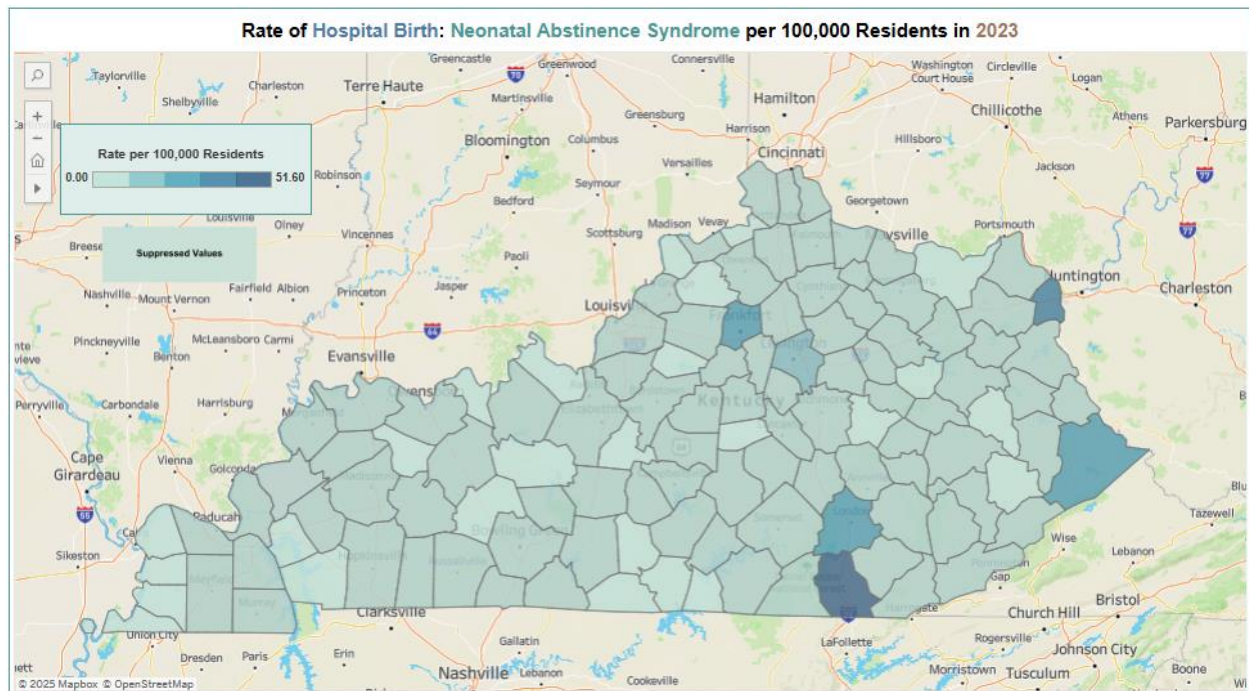


Figure 1. Kentucky Resident NAS Cases, 2019-2023



Source: Kentucky Cabinet for Health and Family Services (CHFS). (2024). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2024 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*. <https://www.chfs.ky.gov/agencies/dph/dmch/Documents/NASAnnualReport2024.pdf>

Table 4 – Neonatal Abstinence Syndrome in Kentucky



Source: Kentucky Cabinet for Health and Family Services (CHFS). (2024). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2024 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*. <https://www.chfs.ky.gov/agencies/dph/dmch/Documents/NASAnnualReport2024.pdf>

Figure 2. NAS Rate by ADD of Residence, 2023

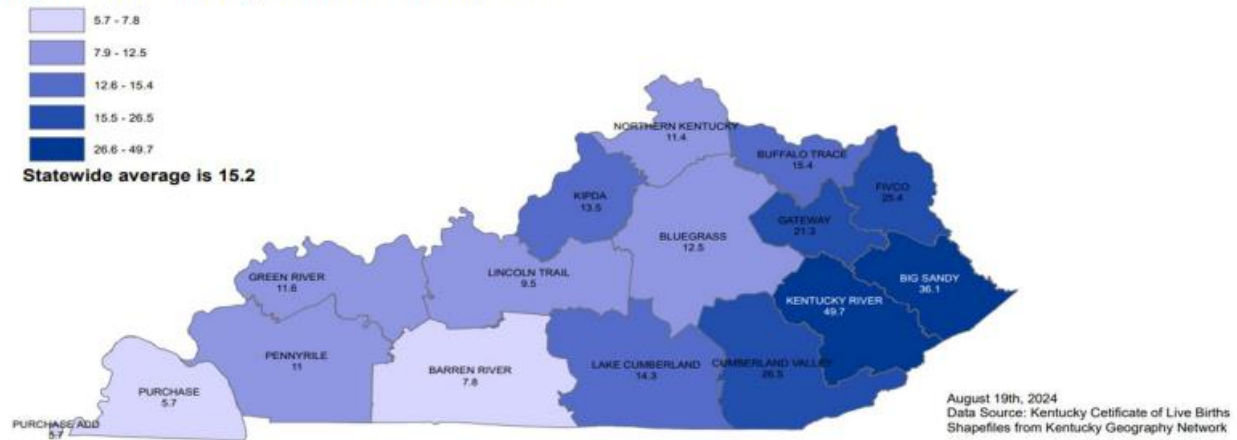


Table 5 – Child Maltreatment Report Data

		State	
		#	%
	Intakes that Met Acceptance Criteria (Reports)	51,035	
	CPS	51,035	100.00
Risk Factors Present that Contributed or Were Present in Reports with a Finding of Substantiation or Services Needed	Substance Abuse	10,478	
	Directly Contributed	3,707	35.38
	Indirectly Contributed	467	4.46
	Was a Risk Factor	1,473	14.06
	Not Applicable	4,831	46.11
Children in Substantiated or Services Needed Reports (Child based count; a child with multiple reports is counted multiple times)	# Children in Substantiated or Services Needed	18,865	
	Type of Maltreatment		
	Neglect	117	0.62
	Environmental Neglect	3,393	17.99
	Supervision Neglect	5,494	29.12
	Medical Neglect	255	1.35
	Physical Abuse	6,069	32.17
	Sexual Abuse	2,003	10.62
	Emotional Injury	375	1.99
	Substance Affected Infant Neglect	667	3.54
	Educational Neglect	492	2.61

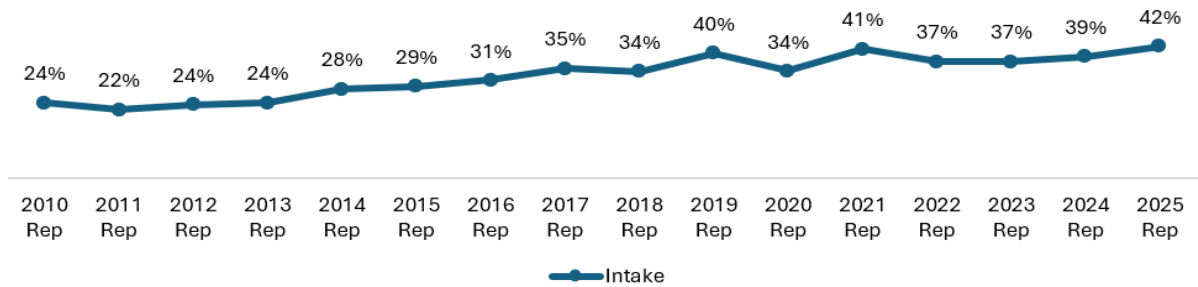
Source: Statewide Child Protective Services (CPS) Intake Fact Sheet. (2025). CPS Intakes Completed from 05/01/2024 to 04/30/2025. Retrieved May 30, 2025, from <https://www.chfs.ky.gov/agencies/dcb/dpp/Documents/cpsstatewide.pdf>.

FIGURE 1
Number of Persons Who Inject Drugs
Served by Community Mental Health Centers*
 DBHDID Client Data Set April 2025

SFY	PWID Served	Population	Percent Served
2024	10,123	4,461,952	0.23%
2023	9,924	4,461,952	0.22%
2022	10,187	4,461,952	0.23%

FIGURE 2

TREND IN PERCENT OF RESPONDENTS REPORTING HAVING EVER INJECTED ANY DRUG AT
 INTAKE, REPORTS 2010-2025¹



Source: Cole, J., Logan, T., & Scrijner, A. (2025). *Kentucky Treatment Outcome Study 2025 Annual Report*. Lexington, KY: University of Kentucky, Center on Drug & Alcohol Research.

FIGURE 3 - 2023 Opioid Dispensing Rate by State

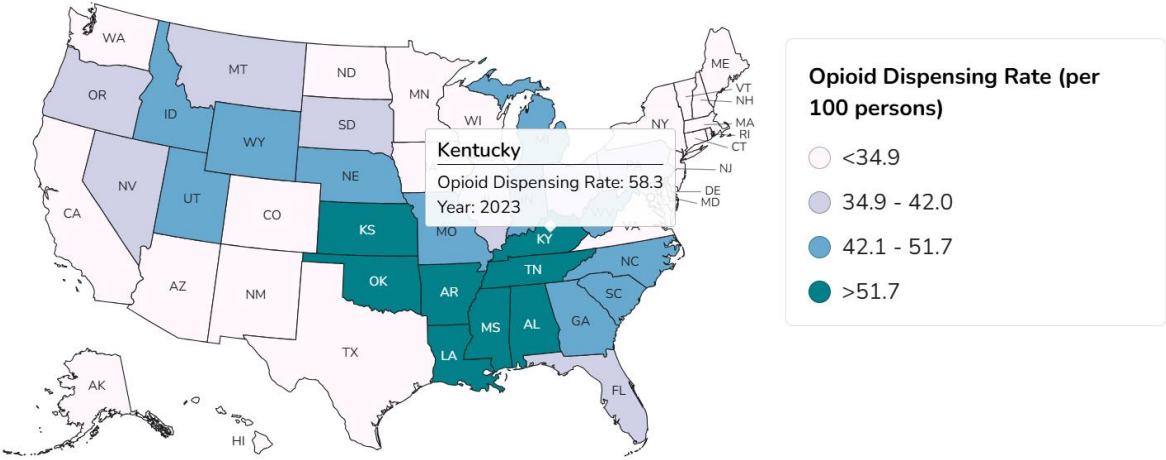
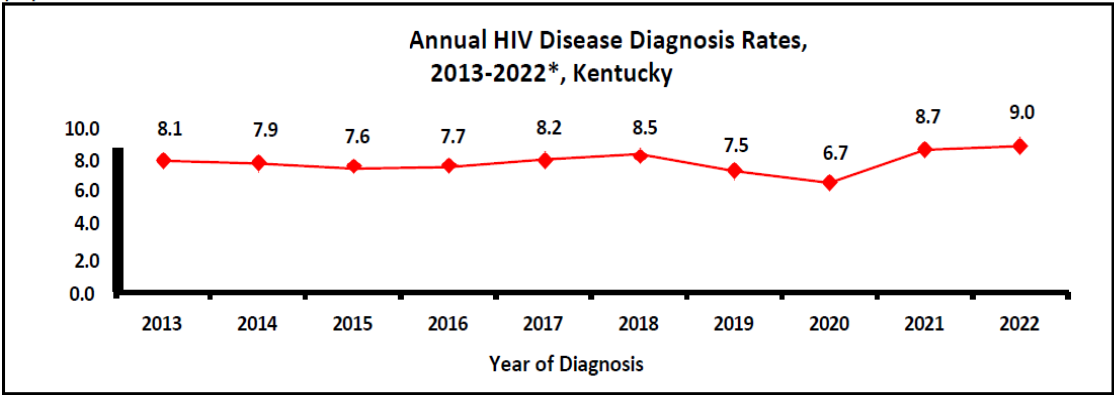


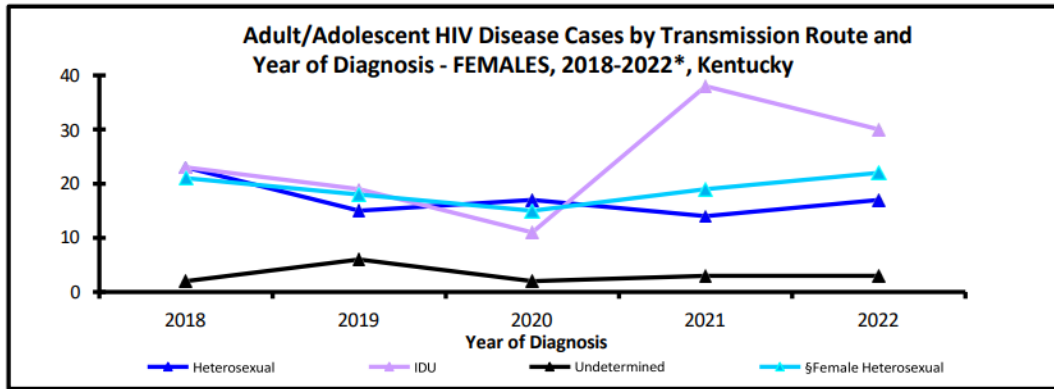
Figure 1 – Annual HIV Cases



*Data are current as of December 31, 2023. Data for 2023 and 2024 are considered preliminary due to reporting delays and not included in trend analysis.

Department for Public Health, 2024

Figure 2 – Female HIV Cases by Transmission Route

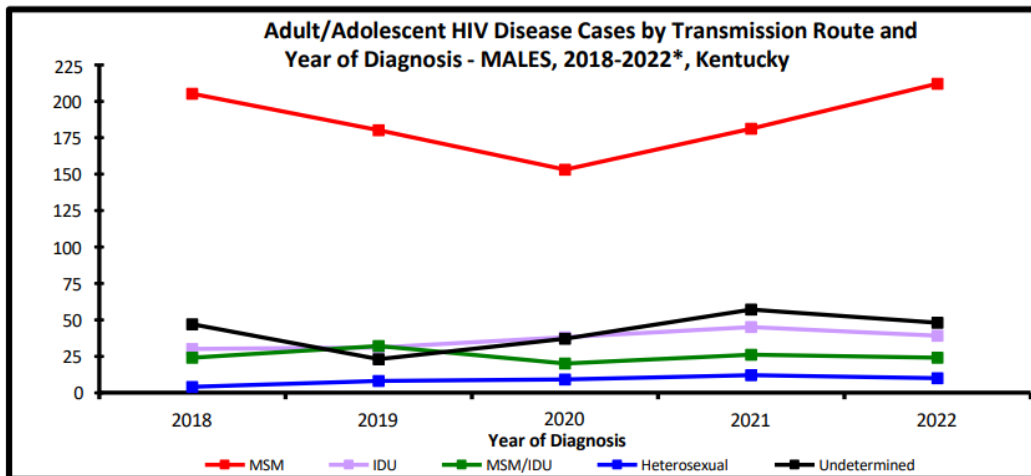


*Data for 2023 and 2024 are not included in trend analyses since they are considered provisional due to reporting delays.

§Female Heterosexual Contact is a female not reporting drug use but reporting sex with male with unknown HIV status or risk.

Department for Public Health, 2024

Figure 3 – Male HIV Cases by Transmission Route

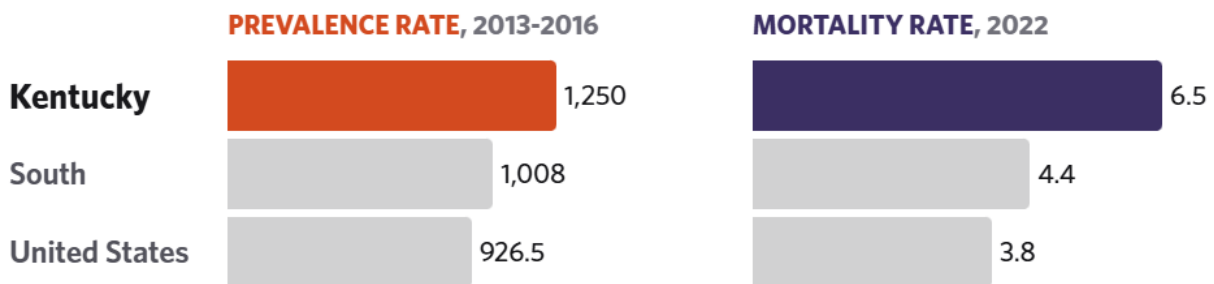


*Data for 2023 and 2024 are not included in trend analyses since they are considered provisional due to reporting delays.

Department for Public Health, 2024

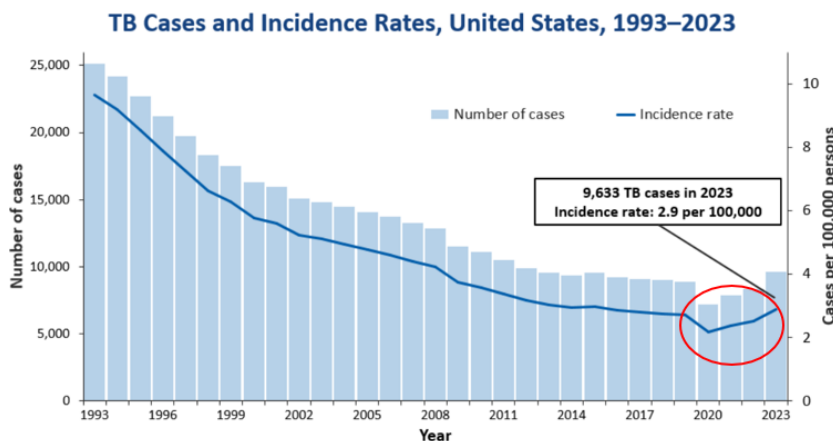
Figure 4 – Hepatitis Prevalence Rate and Mortality Rate Comparison Across Geographic Levels

RATE PER 100K (POPULATION)



HepVu (2024). *Understanding the Hepatitis C Epidemic in Kentucky*. Retrieved 5/20/2025 from [Understanding the Hepatitis C Epidemic in Kentucky - HepVu](#).

Figure 1 – TB Cases and Incidence Rates



Source: Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, National Center for HIV, Viral Hepatitis, STD and TB Prevention, National Tuberculosis Surveillance System. (Jul 2024). *Tuberculosis (TB) Disease in the United States 1993-2023*. Retrieved 04/24/2025 from [CDC TB Cases and Incidence Rates, U.S. 1993-2023](#)

Figure 1 – Non-Medical Drug Use

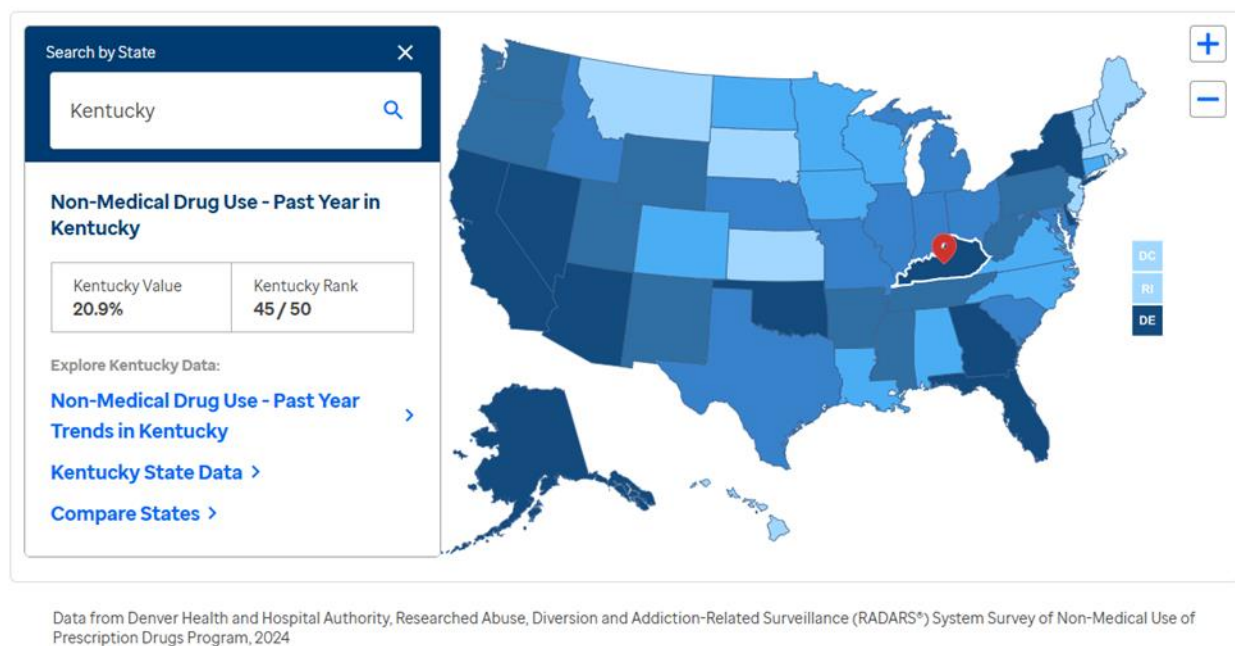
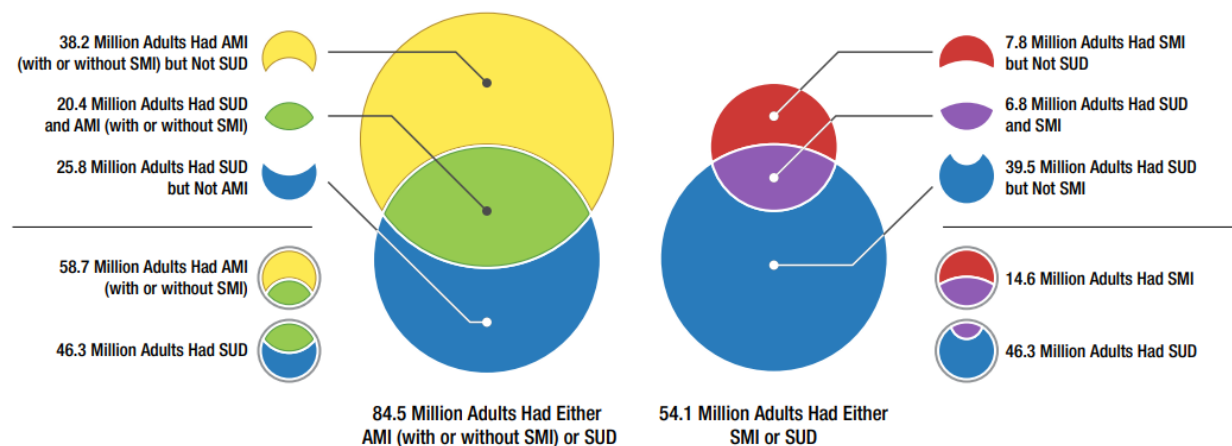


Figure 1 - Any Mental Illness or Substance Use Disorder

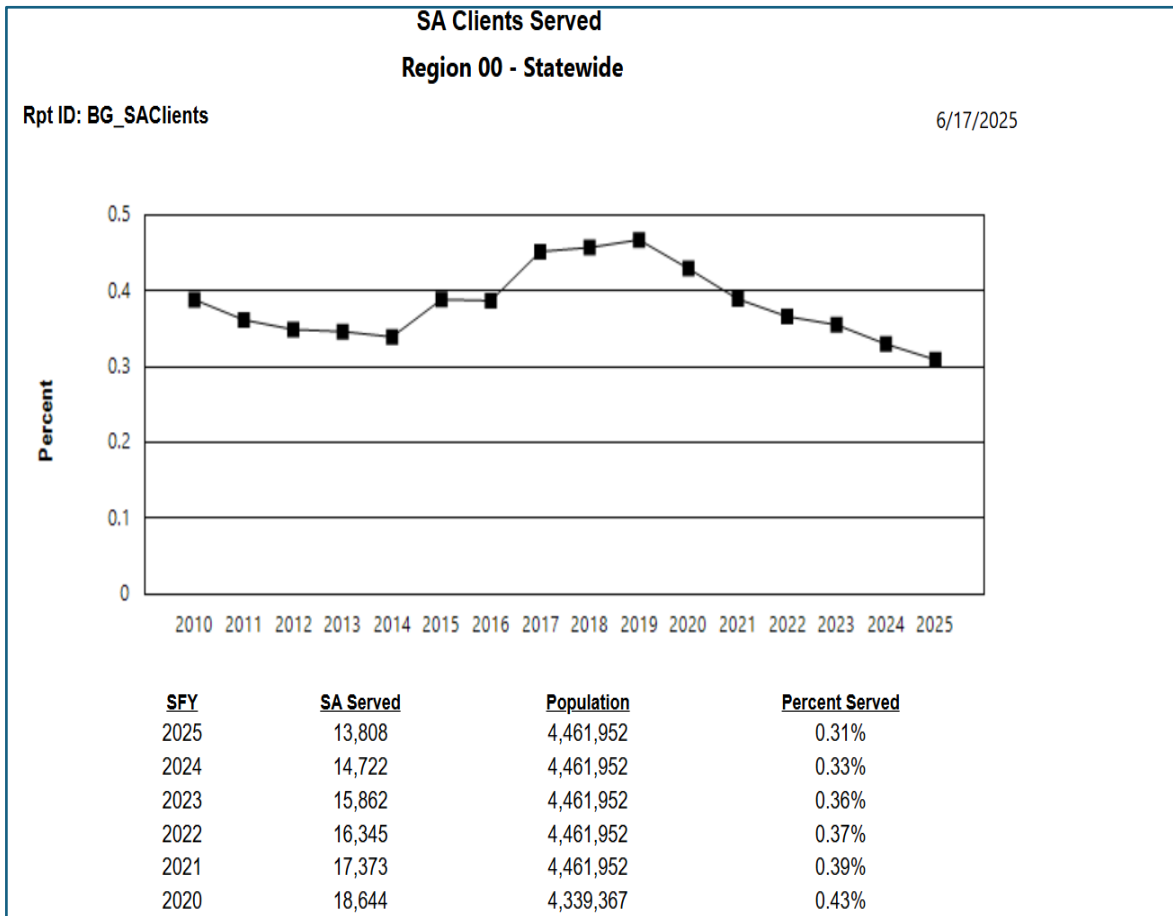
Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2023



Note: The numbers for the interior pieces may not add to the number for the whole circle due to rounding.

(NSDUH, July 2024)

Figure 2 – SA Clients Served

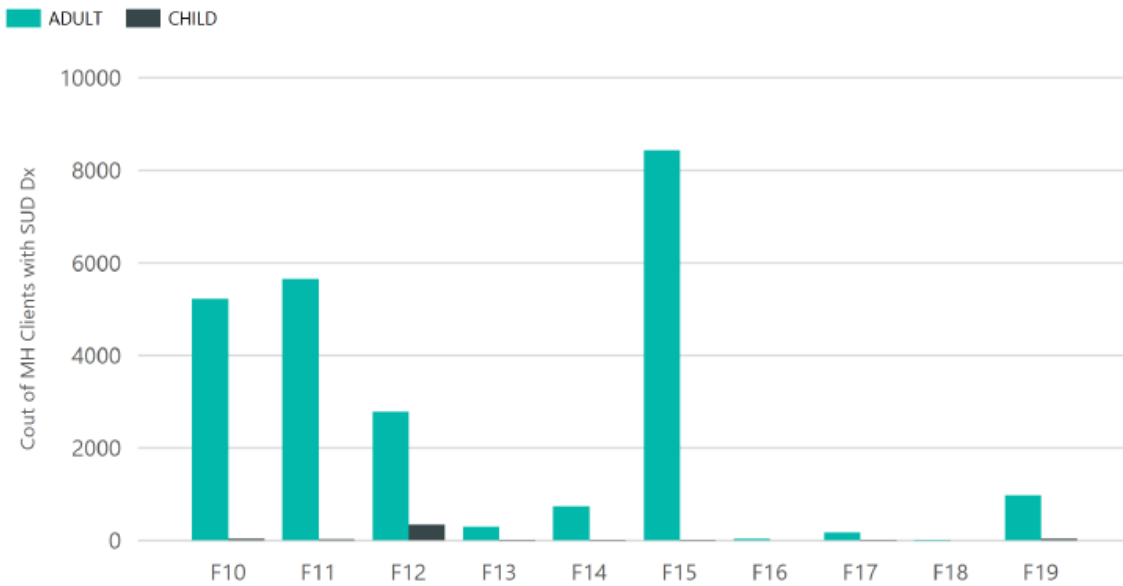


Note: The data table for Figure 2 has been abbreviated to the last 5 years of information. (SA Clients, 2025)

Figure 3 – M/SUD Clients Served 2024

MH Clients with SUD Diagnosis by Diagnostic Group
Adults (18 and up) and Children (under 18)
Region 00 - Statewide
State Fiscal Year - 2024

ReportID: Clients_Co-Occuring_SUD_MH_DX Report Date: 2025-07-03



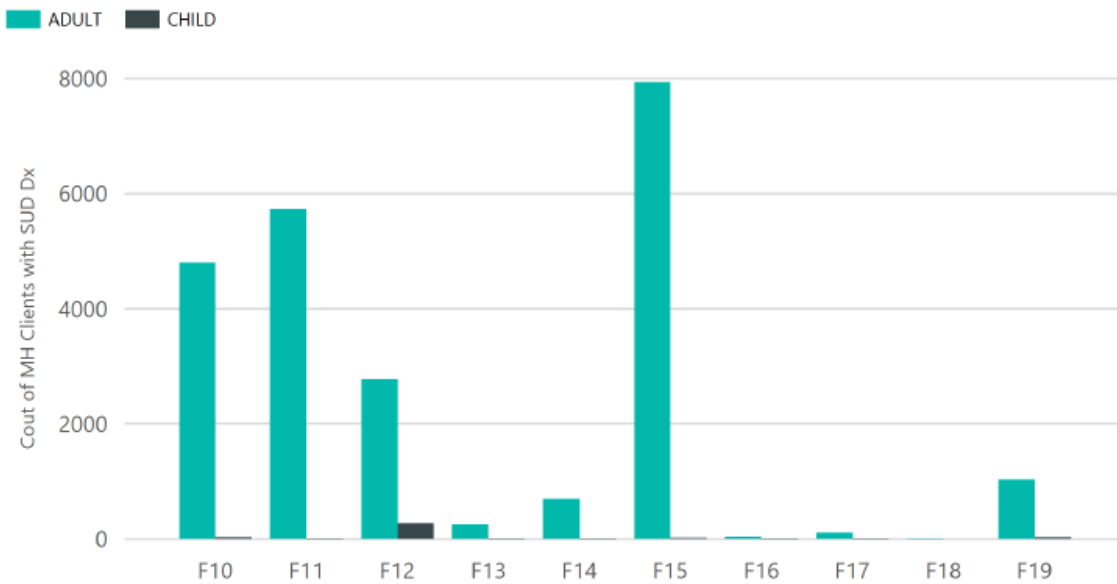
DX	ADULT	CHILD
F10 - Alcohol related disorders	5,224	27
F11 - Opioid related disorders	5,649	14
F12 - Cannabis related disorders	2,787	340
F13 - Sedative, hypnotic, or anxiolytic related disorders	300	1
F14 - Cocaine related disorders	743	1
F15 - Other stimulant related disorders	8,423	11
F16 - Hallucinogen related disorders	35	0
F17 - Nicotine dependence	166	5
F18 - Inhalant related disorders	11	0
F19 - Other psychoactive substance related disorders	975	27
Total MH Clients with SUD Diagnosis	24,313	426

(Clients with Co-Occurring, 2024 DBHDID Client/Event Data Set)

Figure 4 – M/SUD Clients Served 2023

MH Clients with SUD Diagnosis by Diagnostic Group
Adults (18 and up) and Children (under 18)
Region 00 - Statewide
State Fiscal Year - 2023

ReportID: Clients_Co-Occuring_SUD_MH_DX Report Date: 2025-07-03



DX	ADULT	CHILD
F10 - Alcohol related disorders	4,803	24
F11 - Opioid related disorders	5,727	10
F12 - Cannabis related disorders	2,776	279
F13 - Sedative, hypnotic, or anxiolytic related disorders	261	1
F14 - Cocaine related disorders	694	1
F15 - Other stimulant related disorders	7,941	14
F16 - Hallucinogen related disorders	35	3
F17 - Nicotine dependence	113	8
F18 - Inhalant related disorders	6	0
F19 - Other psychoactive substance related disorders	1,026	27
Total MH Clients with SUD Diagnosis	23,382	367

(Clients with Co-occurring 2023 DBHDID Client/Event Data Set)

Veteran and Active Duty Personnel Served by CMHCs

Veteran and Active Duty Personnel Served by CMHC's														
Fiscal Year 2024 (July 1, 2023 - June 30, 2024)														
CMHC	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
01 - Four Rivers	239	233	185	239	289	304	331	301	321	269	205	226	204	214
02 - Pennyroyal	288	349	460	477	369	267	400	251	350	336	325	356	373	473
03 - River Valley	85	101	79	66	54	50	50	45	56	84	71	63	69	62
04 - LifeSkills	142	77	95	87	117	150	167	100	61	59	77	49	77	105
05 - Communicare	147	150	139	283	306	267	282	254	305	291	235	220	176	160
06 - Seven Counties	285	287	231	252	297	351	387	375	384	352	301	276	264	303
07 - NorthKey	190	166	147	135	128	131	105	117	134	139	181	193	172	189
08 - Comprehend	91	108	134	96	86	67	87	75	64	56	33	33	28	27
10 - Pathways	251	284	262	248	228	262	260	252	250	188	192	193	217	240
11 - Mountain	155	133	134	144	162	216	244	253	260	302	300	336	349	360
12 - Kentucky River	61	123	115	73	72	73	66	93	45	45	41	37	46	49
13 - Cumberland River	123	9	15	10	27	105	143	173	157	114	99	106	86	72
14 - Adanta	164	132	120	132	158	195	194	289	192	169	154	130	125	106
15 - New Vista	432	365	352	303	315	204	177	159	165	137	141	154	168	195
Total Unduplicated Count	2,653	2,517	2,468	2,545	2,608	2,642	2,893	2,737	2,744	2,541	2,355	2,372	2,354	2,555

DBHDID Client/Event Data Set

Active Duty Personnel Served by CMHCs

Active Duty Personnel Served by CMHC's														
Fiscal Year 2024 (July 1, 2023 - June 30, 2024)														
CMHC	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
01 - Four Rivers	52	50	36	28	31	49	35	39	51	47	35	40	34	45
02 - Pennyroyal	81	82	93	95	92	66	112	63	63	64	51	82	80	122
03 - River Valley	47	52	29	34	31	29	24	27	13	16	15	12	21	13
04 - LifeSkills	101	29	35	31	48	41	31	22	15	20	32	18	10	26
05 - Communicare	13	15	14	78	84	76	75	66	95	96	70	67	53	53
06 - Seven Counties	54	53	43	55	65	80	104	97	91	70	57	54	52	54
07 - NorthKey	43	40	37	23	23	33	33	24	29	33	50	51	48	69
08 - Comprehend	41	38	38	29	34	20	36	23	13	17	16	7	11	11
10 - Pathways	34	50	41	37	44	36	34	42	38	39	35	38	39	56
11 - Mountain	92	71	74	54	60	76	101	87	85	100	94	105	135	125
12 - Kentucky River	26	67	58	30	32	32	31	30	17	15	14	4	10	12
13 - Cumberland River	0	3	5	5	5	33	37	65	58	46	42	38	35	30
14 - Adanta	34	22	19	24	33	42	49	73	59	52	43	31	26	24
15 - New Vista	74	62	71	59	62	51	58	47	53	42	45	54	65	64
Total Unduplicated Count	692	634	593	582	644	664	760	705	680	657	599	601	619	704

DBHDID Client/Event Data Set

Veterans Served by CMHCs

Veteran Served by CMHC's														
Fiscal Year 2024 (July 1, 2023 - June 30, 2024)														
CMHC	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
01 - Four Rivers	187	183	149	211	258	255	296	262	270	222	170	186	170	169
02 - Pennyroyal	207	267	367	382	277	201	288	188	287	272	274	274	293	351
03 - River Valley	38	49	50	32	23	21	26	18	43	68	56	51	48	49
04 - LifeSkills	41	48	60	56	69	109	136	78	46	39	45	31	67	79
05 - Communicare	134	135	125	205	222	191	207	188	210	195	165	153	123	107
06 - Seven Counties	231	234	188	197	232	271	283	278	293	282	244	222	212	249
07 - NorthKey	147	126	110	112	105	98	72	93	105	106	131	142	124	120
08 - Comprehend	50	70	96	67	52	47	51	52	51	39	17	26	17	16
10 - Pathways	217	234	221	211	184	226	226	210	212	149	157	155	178	184
11 - Mountain	63	62	60	90	102	140	143	166	175	202	206	231	214	235
12 - Kentucky River	35	56	57	43	40	41	35	63	28	30	27	33	36	37
13 - Cumberland River	123	6	10	5	22	72	106	108	99	68	57	68	51	42
14 - Adanta	130	110	101	108	125	153	145	216	133	117	111	99	99	82
15 - New Vista	358	303	281	244	253	153	119	112	112	95	96	100	103	131
Total Unduplicated Count	1,961	1,883	1,875	1,963	1,964	1,978	2,133	2,032	2,064	1,884	1,756	1,771	1,735	1,851

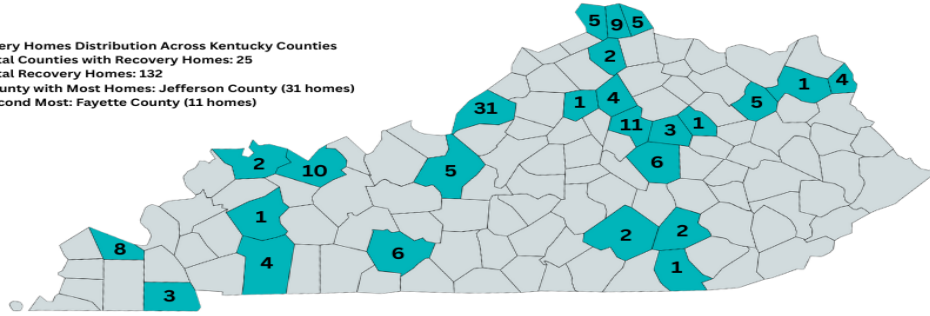
DBHDID Client/Event Data Set

Oxford House Kentucky Map

Oxford House - Kentucky

as of May 2025

- Recovery Homes Distribution Across Kentucky Counties
- Total Counties with Recovery Homes: 25
 - Total Recovery Homes: 132
 - County with Most Homes: Jefferson County (31 homes)
 - Second Most: Fayette County (11 homes)



Major Metropolitan Counties (10+ homes)

- Jefferson County: 31 homes
 - Louisville: 31 homes
- Fayette County: 11 homes
 - Lexington: 11 homes
- Daviess County: 10 homes
 - Owensboro: 10 homes

Mid-Range Counties (5-9 homes)

- Kenton County: 9 homes
 - Erlanger: 2 homes
 - Covington: 1 home
 - Fort Wright: 1 home
 - Lakeside Park: 2 homes
 - Ludlow: 1 home
 - Crestview Hills: 1 home
 - Elsmere: 1 home
- McCracken County: 8 homes
 - Paducah: 8 homes
- Madison County: 6 homes
 - Richmond: 6 homes
- Warren County: 6 homes
 - Bowling Green: 6 homes
- Boone County: 5 homes
 - Florence: 5 homes
- Campbell County: 5 homes
 - Newport: 3 homes
 - Highland Heights: 1 home
 - Fort Thomas: 1 home
- Hardin County: 5 homes
 - Elizabethtown: 5 homes
- Rowan County: 5 homes
 - Morehead: 5 home

Lower-Range Counties (2-4 homes)

- Boyd County: 4 homes
 - Ashland: 4 homes
- Christian County: 4 homes
 - Hopkinsville: 4 homes
- Scott County: 4 homes
 - Georgetown: 4 homes
- Calloway County: 3 homes
 - Murray: 3 homes
- Clark County: 3 homes
 - Winchester: 3 homes
- Grant County: 2 homes
 - Crittenden/Grant: 2 homes
- Henderson County: 2 homes
 - Henderson: 2 homes
- Laurel County: 2 homes
 - London: 2 homes
- Pulaski County: 2 homes
 - Somerset: 2 homes
- Single-Home Counties
 - Carter County (Grayson)
 - Franklin County (Frankfort)
 - Hopkins County (Madisonville)
 - Montgomery County (Mt. Sterling)
 - Whitley County (Corbin)

Planning Step 2

Data Sources Used for Planning Step 2 Questions 2 and 3 for All Required Populations

Adults with SMI

Data Sources:

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2024, SFY 2023, SFY 2022 Certified Data

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

DBHDID Department Periodic Report Form 172, Assertive Community Treatment – Project Report Form – SFY 2024, 2023, 2022

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

KYSTARS COSP fidelity data reports

Moser, L. L., & Monroe-DeVita, M. (2019). *A Call for Better Data to Guide ACT Policy and Programs*. Psychiatric Services, 70(6), 498–500. <https://doi.org/10.1176/appi.ps.201700561>

Adults with SMI who live in rural areas

Data Sources:

2020 Census Data

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

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2024 Certified Data

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

Adults with SMI experiencing homelessness

Data Sources:

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2024 Certified Data

Housing and Urban Development: The 2024 Annual Homelessness Assessment Report to Congress. Accessed via <https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf>

KHC K-Count (2023 and 2024) <https://www.kyhousing.org/Programs/Homeless-Programs/Pages/K-Count.aspx>

Louisville Coalition for the Homeless Street Count (2023 and 2024) accessed via <https://louhomeless.org/>

Older Adults with SMI
Data Sources:

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

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

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2024 Certified Data

Children with SED; Children with SED experiencing homelessness; Children with SED in rural areas; and Families:
Data Sources:

US Census Bureau (2020). 2020 Census Results. <https://www.census.gov/programs-surveys/decennial-census/decade/2020/2020-census-results.html>. Retrieved April 20, 2025.

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.

Williams, N.J., Scott, L., & Aarons, G.A. (2017). Prevalence of serious emotional disturbance among US children: A meta-analysis. *Psychiatric Services*. Retrieved April 20, 2025. <https://doi.org/10.1176/appi.ps.201700145>

Kentucky Management Information System (MIS) Client/Event Data Set – SFY 2023 and SFY 2024 Certified Data. University of Kentucky Institute for Biomedical Informatics (IBI).

Kentucky Department of Education Homeless Children and Youth Data and Reporting. <https://www.education.ky.gov/federal/progs/txc/Pages/Homeless-Children-and-Youth-Data-Collection-and-Reporting.aspx>.

National Wraparound Initiative (2017). Rigorous Research on Wraparounds' Effectiveness Summary Document. <https://nwi.pdx.edu/pdf/rigorous-research-on-wrap-effectiveness.pdf>.

2024 Kentucky KIDS COUNT *Data Book*, Kentucky Youth Advocates, Louisville, KY <https://kyyouth.org/2023-kentucky-kids-count-county-data-book/>

Kentucky Association of Counties Nov. 2024. <https://kaco.org/articles/county-stats-rural-and-urban-population-breakdown/>

Rural Health Information Hub (2025). <https://www.ruralhealthinfo.org/charts/7>

Center for American Progress. <https://talkpoverty.org/state-year-report/kentucky-2020-report/index.html>

Spotlight on Poverty & Opportunity. <https://spotlightonpoverty.org/states/kentucky/>

Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/pressroom/states/kentucky/ky.htm>

Early Serious Mental Illness/First Episode Psychosis

Data Sources:

Kentucky State Data Center (KSDC) University of Louisville - 2020 Census Data

Kentucky State Data Center (KSDC) University of Louisville - 2023 Census Demographic Estimates [Population and Housing Estimates | Kentucky State Data Center \(louisville.edu\)](#)

McGrath, J. et.al. (2008, May 14). Schizophrenia: A concise overview of incidence, prevalence, and mortality.

The National Alliance on Mental Illness (NAMI). First Episode Psychosis Programs: A Guide to State Expansion (February 2017). www.nami.org/earlypsychosis

Heinnsen, Robert K.; Goldstein, Amy B.; Azrin, Susan T. (2014, April 14). Evidence-based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. <https://www.nimh.nih.gov/sites/default/files/documents/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep.pdf>

Jennifer L. Humensky, Ph.D., Lisa B. Dixon, M.D., M.P.H., and Susan M. Essock, Ph.D., State Mental Health Policy: An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative in New York State. (September 2013) Accessed online at <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300186>

Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers. (December 13, 2017). Accessed via https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf#page=18

DBHDID Management Information Systems (MIS) Client/Event Data Set. University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2024 Certified Data

Sale, Tamara; Humensky, Jennifer; Fetzer, Patria; Baker, Megan; Hardy, Kate; Noordsy, Douglas; Adelsheim, Steven. The Integration of Early Psychosis Services in a System of Care Framework: Opportunities, Issues, and Recommendations. (April 2018). Accessed via <https://easacommunity.org/PDF/integration-ep-svcs-soc.pdf>

Behavioral Health Crisis Services

Data Sources:

Children's Crisis Data Sources

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

Adult Crisis Data Sources

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

SUD Crisis Data Sources

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

Call Center Data Sources

- DBHDID Form 113D Crisis Services Planning & Implementation Report (Fiscal Years 2020, 2021, 2022, 2023, 2024)
- DBHDID monthly 988 reports submitted by each 988 center
- Kentucky Broad State Metric Report, Provided by Vibrant Emotional Health (National Administrator of 988 Suicide and Crisis Lifeline)

University of Kentucky IBI Data Source

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

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

Data Sources:

- Kentucky Injury Prevention Resource Center. (n.d.). *2023 drug overdose Fatality Report*. 2023 Drug Overdose Fatality Report. <https://governor.ky.gov/attachments/2023-Drug-Overdose-Fatality-Report.pdf>
- Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System (YBRSS), 2023. Available at <https://www.cdc.gov/healthyyouth/data/yrbs/index.htm>
- Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 2018-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 2018-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. <http://wonder.cdc.gov/mcd-icd10-expanded.html>
- Kentucky Injury Prevention and Research Center <https://kiprc.uky.edu/programs/overdose-data-action/county-profiles> Slavova, Rock, Bush, Quesinberry, & Walsh, 2020. Signal of increased opioid overdose during COVID-19 from emergency medical services data. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7351024/>
- Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health (NSDUH) <https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables>
- Kentucky Cabinet for Health and Family Services (CHFS). (2020). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2019 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*. Retrieved from <https://chfs.ky.gov/agencies/dph/dmch/Documents/NASReport.pdf>.
- Svetla Slavova, PHD; Dana Quesinberry, DRPH; Sarah Hargrove, MS; Peter Rock, MPH; Candace Branto, MS; Patricia R Freeman, PHD; Sharon L. Walsh, PHD; JAMA Network Open, Trends in Drug Overdose Mortality Rates in Kentucky, 2019-2020

Individuals with SUD

Data Sources:

CDAR – Center for Drug and Alcohol Research, University of Kentucky

Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 2018-2019 on the CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 2018-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/mcd-icd10-expanded.html> on Jul 2, 2021, 10:09:13 AM.

Kentucky Cabinet for Health and Family Services (CHFS). (2023). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2022 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*. Retrieved from <https://chfs.ky.gov/agencies/dph/dmch/Documents/NASReport.pdf>

Kentucky Housing Corporation

Kentucky Injury Prevention and Research Center (KIPRC) April 2025. Kentucky 2024 Drug Overdose Annual Report; Justice and Public Safety Cabinet, Office of Drug Control Policy. Retrieved from <https://odcp.ky.gov/Reports/2024%20Drug%20Overdose%20Fatality%20Report.pdf>

Kentucky Opioid Response Effort (KORE) database.

Substance Abuse and Mental Health Services Administration, *2011 Opioid Treatment Program Survey: Data on Substance Abuse Treatment Facilities with OTPs*. BHSIS Series S-65, HHS Publication No. (SMA) 14-4807. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

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Data Sources:

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

Data Sources:

Kentucky collaborates with many agencies and departments to collect data regularly on substance-exposed infants. Kentucky data sources include the State Epidemiology Outcomes Workgroup (SEOW) child welfare data and vital statistics data (public NAS data collection). The KASPER system can provide statistics on the number of controlled substances dispensed to women of childbearing age to help identify potential substance exposure during pregnancy or risk of NAS.

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The Kentucky Perinatal Quality Collaborative. kypqc.org [KyPQC implementing strategies to improve outcomes for mothers and babies affected by substance use disorder | KIPRC](#)

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Women with a substance use disorder who have dependent children

Data Sources:

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Data Sources:

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Data Sources:

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Data Sources:

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Service Members, Veterans, and their Families in Kentucky ***Data Sources:***

US Census Data:

<https://www.census.gov/quickfacts/fact/table/KY/VET605223>

Kentucky Client/Event Data Set

Kentucky Commission on Military Affairs

<https://kcma.ky.gov/Pages/index.aspx>

Military OneSource, Military Community Demographics, click on the year for the report

<https://www.militaryonesource.mil/data-research-and-statistics/military-community-demographics/>

DoD Personnel, Workforce Reports & Publications

<https://dwp.dmdc.osd.mil/dwp/app/dod-data-reports/workforce-reports>

Statista - Geographic stationing of active-duty United States Armed Forces personnel in 2021, by U.S. state

<https://www.statista.com/statistics/232722/geographic-stationing-of-active-duty-us-defense-force-personnel-by-state/>

The Kentucky National Guard

<https://www.dma.ky.gov/Pages/index.aspx>

[Substance Use and Military Life DrugFacts | National Institute on Drug Abuse \(NIDA\)](#)

Department of Veterans Affairs, Veteran Data, click on the state for totals

https://www.va.gov/vetdata/Veteran_Population.asp

Substance Use Primary Prevention

Data Sources:

Kentucky Incentives for Prevention (KIP) 2024 - Since 1999, the KIP Survey has been administered in Kentucky through the Substance Use Prevention and Promotion Branch in the Cabinet for Health and Family Services, through agreements with individual school districts across the state. The survey intends to anonymously assess student use of alcohol, nicotine, and other drugs, as well as a number of factors related to potential substance use (e.g., peer influences, perception of risk, school safety). The survey has been conducted biannually in the fall in even-numbered years (2014, 2016, 2018, etc.); however, the 2020 administration was delayed as a result of school closings from COVID-19 until 2021, and the passage of legislation requiring parental consent delayed the administration further. The most recent administration was in the fall of 2024. The survey includes sixth, eighth, tenth, and 12th graders attending school in Kentucky communities. In 2024, 21,000 students from 109 school districts participated in the survey. This was down from more than 93,000 in 127 districts in 2021.

Treatment Episode Data Set (TEDS) 2021-2023 – The Treatment Episode Data Set is a national census data system of annual admissions to substance use disorder treatment facilities. TEDS

provides yearly data on the number and characteristics of persons admitted to public and private substance use disorder treatment programs that receive public funding. TEDS consists of data reported to state substance use disorder agencies by the treatment programs, which in turn report to SAMHSA.

National Survey on Drug Use and Health (NSDUH) - The National Survey on Drug Use and Health is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. 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 nicotine 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.

National Youth Tobacco Survey (NYTS) – The National Youth Tobacco Survey provides national benchmark data on commercial tobacco use behaviors and related risk factors among youth in the United States.

Healthcare Costs and Utilization Project (HCUP) - The Healthcare Cost and Utilization Project includes the largest collection of longitudinal hospital care data in the United States. Data collection began in 1988, and databases contain encounter-level information for all payers compiled in a uniform format with privacy protections in place. The Nationwide Emergency Department Sample specifically is a database that yields national estimates of emergency department (ED) visits. Databases within the HCUP were developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ).

Kentucky All Schedule Prescription Electronic Reporting (KASPER) is a controlled substance prescription monitoring system designed to provide information to assist practitioners and pharmacists in providing medical and pharmaceutical patient care using controlled substance medications. KASPER also provides an investigative tool for law enforcement and regulatory agencies to assist with authorized reviews and investigations.

Kentucky Injury Prevention and Research Center (KIPRC) – KIPRC was established in 1994 as a unique partnership between the Kentucky Department for Public Health and the University of Kentucky College of Public Health. This state–university partnership provides KIPRC access to expertise and support in injury and violence-related research, data, services, outreach, communications, interventions, evaluation techniques, and policy development at both the state government and academic levels. KIPRC uses injury prevention research to inform and implement targeted interventions that are evaluated and adopted into local and state injury prevention practice.

Kentucky Overdose Fatality Report 2024 – The Kentucky Overdose Fatality Report 2024 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 number of opioid overdoses in the state, as well as identifies demographic and geographic hotspots, to inform policymakers 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, the Kentucky Office of Vital Statistics, and other key data sources related to opioid consequences in the state.

Kentucky Overdose Response Effort (KORE) Needs Assessment – The KORE Needs Assessment report was initially completed in 2017 and is updated annually in response to the state's receipt of funding to address the opioid crisis in Kentucky. The assessment utilizes key data sources, including the National Violent Death Reporting System and Kentucky Injury Prevention Research Center data collection, to outline the demographic and geographic populations of focus toward which grant efforts will be targeted. The needs assessment provides a comprehensive narrative of opioid and other drug overdoses and their impact on the state's population.

Prevention Data System (PDS) – Kentucky currently has a data collection system that its providers are required to use. Regional prevention centers create data-driven work plans that address the substances being used in their regions. They prioritize by substance and develop plans that encompass all levels of the social ecology, employ the six strategies endorsed by the Center for Substance Abuse Prevention, and implement their strategies through universal, selective, and indicated methodologies. It is through the PDS that the Substance Use Prevention and Promotion Branch evaluates the work being done in each region and identifies the impact and outcome results occurring at the community level. Through these data collection efforts, the branch began identifying the gaps related to Kentucky's prevention workforce. With dedicated staff now available to oversee the PDS, missing and incomplete data rose to the top of the capacity concerns. Identified as problematic: data interpretation errors leading to poor problem statements and logic models, problem statements that did not match the needs assessment data, poor interpretation of PDS data points, gaps in data submission, and inconsistency in coding. As a result, a quality improvement process was implemented in 2020 and continues to evolve to ensure that the data in the Prevention Data System is accurate and complete.

Kentucky Office of Drug Control Policy (KY-ODCP) – The KY-ODCP is an organization within Kentucky's Justice and Public Safety Cabinet that was formed in 2004. This group advocates for the enhancement of resources for substance misuse initiatives, assists in developing policy and legislation, coordinates overall research and evaluation of effectiveness of programs and services, and serves as a repository of information on best practices and standards of practice for prevention, treatment, education, and law enforcement, as related to substance misuse.

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

State Lung Cancer Report 2024 – A report created by the American Lung Association that provides a state-specific understanding of the burden of lung cancer and opportunities to address this deadly disease.

Youth Risk Behavior Survey (YRBS) – A national survey conducted by the CDC that measures health-related behaviors and experiences among high school students in both public and private schools.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Adults with Serious Mental Illness
Priority Type:	MHS
Population(s):	SMI
Goal of the priority area:	To avoid an increase in the rate of adults, who did not already reside in personal care homes, being discharged to personal care homes from state-operated psychiatric hospitals.
Strategies to attain the goal:	The electronic medical record system utilized by state-operated psychiatric hospitals collects living arrangement at admission and discharge. Maintain collaborative partnerships between the state-operated psychiatric hospitals and the CMHCs to facilitate referrals to community services. Maintain contracts with CMHCs to provide evidence-based practices that assist individuals with SMI to live in the community: Assertive Community Treatment, Permanent Supportive Housing, Supported Employment, and Peer Support Services. Provide training, technical assistance and fidelity monitoring to ensure most effective implementation of these evidence-based practices. Maintain related infrastructure including regular Olmstead meetings and other meetings that require state-operated psychiatric hospitals, DBHDID, and community partner involvement. Provide technical assistance to the state-operated psychiatric hospitals and the CMHCs to address barriers to supporting community living.
Annual Performance Indicators to measure goal success	Indicator #: 1 Indicator: Adults discharged from a state-operated psychiatric hospital to a personal care home where the admission living arrangement was not personal care home. Baseline measurement (Initial data collected prior to and during 2026): The SFY 2024 percentage of adults discharged from a state-operated psychiatric hospital to a personal care home where the admission living arrangement was not personal care home was at 4%. First-year target/outcome measurement (Progress to the end of 2026): By the end of SFY 2026, the percentage of adults discharged from a state-operated psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be less than 8%. This number will be calculated annually. Second-year target/outcome measurement (Fidelity to the end of 2027): By the end of SFY 2027, the percentage of adults discharged from a state-operated psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be less than 8%. This number will be calculated annually. Data Source: DBHDID Facility Data Set Description of Data: Data report to show per State Fiscal Year (SFY): Report ID: COC_10-DC-LA_Not_From_PCH This report is found on Central Log In/Department Report/Continuity of Care Reports Living Arrangements at Discharge with Source Admission NOT Personal Care Home. The total number of adults admitted to a state psychiatric hospital where the living arrangement at admission was not personal care home, divided by the total number of adults discharged to a personal care home. (total the number for each monthly report at the bottom of the report from the three state hospitals for total admissions and total the number for each monthly report of discharges to a PCH)

The report is based on SFY (July 1 – June 30). This report is updated monthly.

The report includes data for Central State Hospital, Western State Hospital, and Eastern State Hospital. ARH utilizes a slightly different electronic medical record and is not included on this specific report.

Data issues/caveats that affect outcome measures:

The electronic medical record system is the source of data. Technical issues that are unique to each facility's system sometimes occur. Troubleshooting technical issues with this system as they arise involves a third-party vendor and a third-party data management contract. In addition, this rate would be impacted if a significant or unusual change occurred to the total number discharged in any single year.

It is expected that adults needing the levels of care described in this indicator are experiencing SMI. However, the specific data sets for both state-operated psychiatric hospitals and personal care homes are not required to have a specific SMI marker. Personal care home admissions are required to have a diagnosis of mental illness that is expected to last at least two (2) years, and individuals must need assistance with daily living/personal care functioning.

This performance indicator is being continued due to the importance of monitoring the rate of persons being discharged to personal care homes, where the living arrangement on admission is not personal care home.

Changes in State/Federal funding could negatively impact this measure.

Priority #: 2
Priority Area: Children with Serious Emotional Disturbance (SED)
Priority Type: MHS
Population(s): SED

Goal of the priority area:

Increase participation of parent and youth representatives (including alternates) on Regional Interagency Councils (RIACs) to improve well-being of children, youth, and transition age youth, including those with SED, within their designated regions.

Strategies to attain the goal:

Collaborate with Training Resource Information System (TRIS) administrators.

Engage youth and parent representatives in identifying onboarding needs.

Co-create onboarding materials.

Disseminate information about onboarding material.

Develop mechanisms to report training attendance and feedback.

Host live events and post on RIAC YouTube channel.

Build in survey to track attendance.

Create QR code for registration.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Develop and measure utilization of onboarding process for RIAC parent and youth representatives.
Baseline measurement (Initial data collected prior to and during 2026):	As of March 2025, there are no official RIAC onboarding materials for youth and parent representatives. As of March 2025, there are 18 parent and 19 youth representatives serving on RIACs.
First-year target/outcome measurement (Progress to the end of 2026):	By the end of SFY 2026, DBHDID will have developed Tier One onboarding material for RIAC youth and parent representatives and a method to track participation and completion of

onboarding training.

Second-year target/outcome measurement (Fidelity at the end of SFY 2027, youth and parent representatives on RIACs will utilize onboarding training modules).

Data Source:

Monthly RIAC reports; RIAC timesheet; onboarding training attendance log.

Description of Data:

Onboarding training module attendance report to track completion.

RIAC attendance report to track RIAC membership and attendance.

Feedback from attendees.

Data will be used to guide continuous quality improvement efforts such as modifying training material.

Creating new modules.

Developing multi-directional feedback loops among RIAC leaders, RIAC parent and youth representatives and DBHDID staff.

Data issues/caveats that affect outcome measures:

Federal/state funding changes could negatively impact this measure.

Any changes to RIAC state legislation could negatively impact this measure.

Priority #: 3

Priority Area: Early Serious Mental Illness/First Episode Psychosis (FEP)

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

Increased utilization of Coordinated Specialty Care (CSC) for individuals with first episode psychosis (FEP).

Strategies to attain the goal:

Provide training and technical assistance to all outpatient sites funded to provide Coordinated Specialty Care (CSC) to this population, including partnership with the University of Kentucky to support fidelity management efforts.

Utilize consultation from national experts in the field.

Convene quarterly meetings with all key contacts from CMHCs regarding this population to provide technical assistance/education regarding CSC and First Episode Psychosis.

Strengthen implementation efforts by embedding the FEP Program Administrator within the Adult Branch of the Division of Mental Health; embedding the University of Kentucky data and fidelity partners within the implementation planning process; including the CSC teams in statewide implementation efforts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of people with First Episode Psychosis enrolled in Coordinated Specialty Care Programs.

Baseline measurement (Initial data collected prior to and during 2026): At the end of SFY 2024, Kentucky had nine (9) CSC programs and a total of 115 young people with First Episode Psychosis enrolled in CSC programs.

First-year target/outcome measurement (Progress to the end of 2026):

By the end of SFY 2026, Kentucky will see an increase in the number of young people with First Episode Psychosis receiving CSC.

Second-year target/outcome measurement (Progress to the end of 2027):

By the end of SFY 2027, Kentucky will see an increase in the number of young people with First Episode Psychosis receiving CSC.

Data Source:

KNACK data base for FEP and additional Department Periodic Reports as necessary per CMHC Contract Reporting Requirement; IHope Active Enrollment Report from UK-HDI; Additional CSC site level data as needed.

Description of Data:

KNACK data reporting is required from each CSC team on an ongoing basis, including enrollment information. This data is collected via a contract with the University of Kentucky and Division of Mental Health staff work closely with the contractor on this data collection effort. Form 113H Department Periodic Reports.

Data issues/caveats that affect outcome measures:

Workforce issues, specialty training capacity issues, potential state or federal funding cuts may negatively impact this measure.

Societal stigma regarding mental health care and young people's interest/willingness to participate in this type of specialty care may negatively impact this measure.

Priority #:

4

Priority Area:

Behavioral Health Crisis Services

Priority Type:

BHCS

Population(s):

BHCS

Goal of the priority area:

Increase in-state crisis 988 calls, texts, and chats response.

Strategies to attain the goal:

DBHDID will continue to provide training and technical assistance to 988 call centers.

DBHDID will continue to convene monthly peer group meetings of 988 call centers so that centers can share implementation strategies and best practices.

DBHDID will maintain/continue to develop collaborative relationships and processes with partner agencies.

DBHDID will continue to pursue funding and coverage opportunities to enhance 988 services.

DBHDID will continue to engage in available regional and national training and technical assistance opportunities.

DBHDID will continue workforce initiatives to enhance 988 workforce development, recruitment, and retention.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Increase the number of 988 calls, texts and chats answered in-state by 1%.

Baseline measurement (Initial data collected prior to and during 2026):

In SFY 2024, Kentucky Call Centers responded to 29,202 calls, texts, and chats.

First-year target/outcome measurement (Progress to the end of 2026):

By the end of SFY 2026, Kentucky Call Centers will have responded to at least .50 percent more calls, texts, chats than baseline. (29,348 calls, texts, chats)

Second-year target/outcome measurement (Progress to the end of 2027):

By the end of SFY 2027, Kentucky Call Centers will have responded to an additional .50 percent more calls, texts, chats than baseline. (29,494 calls, texts, chats)

Data Source:

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

Crisis Lifeline).

Description of Data:

Statewide total number of 988 calls, texts, and chats answered by Kentucky's 14 (fourteen) 988 call centers, as reported monthly by Vibrant Emotional Health via the 988 Broad State Metrics for Kentucky report.

Data issues/caveats that affect outcome measures:

Vibrant is continuously refining 988 telephone technology and reporting in real time and data is impacted periodically.

988 experienced a blackout during 2022 that impacted all state and territory call centers for a day (national call centers were still operational). Although Vibrant addressed the issue and build in redundancies, something similar could happen again.

Any changes in Vibrant Unified Platform processes/changes in national 988 data contractors to manage 988 data, could negatively impact reports used for measuring this indicator.

Changes in State/Federal funding could negatively impact this measure.

Priority #: 5

Priority Area: Substance Use Primary Prevention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Strengthen and enhance implementation of evidence-based primary prevention programs, policies, and practices for coalitions and community partners, including Regional Prevention Centers.

Strategies to attain the goal:

- 1.1.1 Utilize prevention workforce survey, post-training surveys, community coalition surveys, and other data to identify additional training needs.
- 1.1.2 Prioritize identified prevention training needs based on strategic plan.
- 1.1.3 Research existing prevention trainings to meet those needs.
- 1.1.4 Work with national and state prevention trainers and DBHDID staff to develop identified trainings.
- 1.1.5 Pilot trainings with a group of prevention providers and revise trainings as needed.
- 1.1.6 Post trainings to Kentucky's online training portal.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of substance use/misuse primary prevention skills trainings available on the online learning management system.

Baseline measurement (Initial data collected prior to and during 2026): 88 substance use/misuse primary prevention trainings are available in SFY 2025.

First-year target/outcome measurement (Progress to the end of 2026): At the end of SFY 2026, there will be one (1) additional training available on evidence-based, evidence-informed, and promising prevention programs, policies, and practices. (89)

Second-year target/outcome measurement (Final to the end of 2027): At the end of SFY 2027, there will be one (1) additional training available on evidence-based, evidence-informed, and promising prevention programs, policies, and practices. (90)

Data Source:

Kentucky PreventionU (Kentucky's online learning management system.)

Description of Data:

Kentucky PreventionU is an online learning management system which includes substance use/misuse primary prevention trainings as well as general trainings available through the site developer. For this measure, Kentucky is only including the primary prevention specific trainings we have funded through other trainers or have developed internally. The additional trainings to meet this

performance indicator will be developed internally or in partnership with outside prevention providers.

These trainings are only one tool used to enhance implementation of evidence-based programs, policies, and practices for primary prevention.

Data issues/caveats that affect outcome measures:

The removal of any current trainings included in the baseline measure which are deemed outdated or no longer necessary could negatively impact this measure.

Funding reductions at the federal/state level that impact state-level primary prevention staff could negatively impact this measure.

Priority #: 6

Priority Area: Pregnant Women who have Substance Use Disorder (SUD)/Women who have SUD who have Dependent Children (PWWDC)

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Support the implementation of best practices for recovery residences that serve PWWDC with SUD.

Strategies to attain the goal:

Identify and address current barriers for recovery residence serving this population.

Facilitate recurring meetings to collaborate with other professionals with similar projects to share program challenges, successes, and resources.

Advise on housing program policies and procedures that better accommodate the needs of women with children, such as safe child-friendly spaces.

Maintain regular communication with the recovery residence and include provider/resident feedback in efforts to implement best practices and services.

Support the program in self-identification of program effectiveness, challenges, and areas of improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Provide technical assistance to an identified recovery residence that serves PWWDC.

Baseline measurement (Initial data collected prior to and during 2026): As of March 2025, there has been no technical assistance for recovery residences focusing on PWWDC-specific needs such as childcare, mental health, and maternal health.

First-year target/outcome measurement (Progress to the end of 2026): By the end of SFY 2026, DSUD staff will have provided at least two (2) technical assistance sessions to one (1) recovery residence.

Second-year target/outcome measurement (Final to the end of 2027): By the end of SFY 2027, DSUD will have provided at least two (2) additional technical assistance sessions to the recovery residence.

Data Source:

DBHDID reporting requirements, Client/Event Data Set, and the Memorandum of Agreement (MOA) with the recovery residence.

Description of Data:

Reporting Requirements for the Recovery Residence: These documents will include data as required in their contractual agreements. These reports will provide insight on implementation processes and service delivery, including metrics such as client retention and program completion.

Terms of Agreement within their MOA: This document will outline the agreed-upon targets and performance standards for the recovery residence.

Client/Event Data Set: This includes detailed information on PWWDC enrolled in the program, such as demographics, services received, satisfaction surveys, and retention/exit information. The data set will allow for tracking progress in terms of housing stability.

Data issues/caveats that affect outcome measures:

Changes to State/Federal funding could negatively impact this measure.

Priority #: 7

Priority Area: Persons who Inject Drugs (PWID)

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

To identify and enhance awareness of residential SUD treatment programs in Kentucky that provide treatment services for individuals who inject drugs with a substance use disorder (SUD) and have a Peripheral Inserted Central Catheters (PICC) line.

Strategies to attain the goal:

Gather information on SUD residential treatment programs in Kentucky who serve individuals within the 3.5 – 3.7 American Society of Addiction Medicine (ASAM) level of care to identify programs for data collection.

Survey those providers regarding the services and/or referral processes for PWID with a PICC line.

This survey will assist in establishing a baseline of awareness in services and resources for PWID with SUD presenting with a PICC line.

DSUD staff will disseminate information gathered to CMHC SUD Directors, and other providers. A post-survey will be given to analyze increased awareness.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Awareness of treatment/referral needs for individuals with PWID and PICC lines among SUD residential treatment programs who serve individuals within the 3.5 – 3.7 ASAM level of care.

Baseline measurement (Initial data collected prior to and during 2026): Currently, there is no centralized listing of programs in Kentucky specifically equipped to treat individuals with SUD and a PICC line.

First-year target/outcome measurement (Progress to the end of 2026): By the end of SFY 2026, there will be an inventory created of residential SUD treatment programs that serve individuals within the 3.5 – 3.7 ASAM level of care that are equipped to serve PWID with a PICC line.

Second-year target/outcome measurement (Final to the end of 2027): By the end of SFY 2027, a follow-up survey will have been conducted to review impact of disseminated information on awareness.

Data Source:

DBHDID; University of Kentucky Healthcare; New Vista Community Mental Health Center

Description of Data:

Data will offer insights into the number of resources currently available for this population.

Research suggests that individuals with substance use disorder who inject drugs are at higher risk of developing complications requiring PICC lines, such as infections and vascular damage. However, there is a notable lack of integrated care for people with both addiction and complex medical needs. While data on the exact number of individuals with both PICC lines and SUD remains limited, the need for integrated treatment programs that address both addiction recovery and medical management is growing, especially in light of the increasing number of people with opioid use disorder (OUD) and other injecting drug use.

Data issues/caveats that affect outcome measures:

State/Federal funding changes could negatively impact this measure.

Priority #: 8

Priority Area: Persons with or at risk of Tuberculosis (TB)

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Improve provider screening and referral for service processes for individuals with or at risk of tuberculosis.

Strategies to attain the goal:

Assess screening for tuberculosis at CMHCs among individuals receiving services for SUD and when appropriate referring for services.

Offer CMHCs technical assistance in updating and improving their policies and procedures regarding tuberculosis screening and referral.

Ensure CMHCs are utilizing the monitoring tool to review for adequate screening and referral.

Gather feedback from providers regarding the monitoring tool and the chart review process and make changes as indicated.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Screen persons who present for substance use services at the 14 CMHCs for tuberculosis and provide appropriate referrals to services.

Baseline measurement (Initial data collected prior to and during 2026): All CMHCs have TB policies and procedures for screening and referral. Two CMHCs have participated in TB process reviews.

First-year target/outcome measurement (Progress to the end of 2026): At the end of SFY 2026, DSUD program staff will have reviewed a minimum of 20 client files at one CMHC.

Second-year target/outcome measurement (Final to the end of 2027): At the end of SFY 2027, DSUD program staff will have reviewed a minimum of 20 client files at one additional CMHC.

Data Source:

TB monitoring tool and DSUD monitoring documentation. CMHC contract reporting requirements.

Description of Data:

The monitoring tool was developed during SFY 2024 by DSUD staff.

As this review process is early in implementation stages, feedback will be gathered with use and processes may be improved.

DSUD staff will develop performance plans with providers as needed as the assessment process is implemented.

Data issues/caveats that affect outcome measures:

Any state/federal funding changes may negatively impact this measure.

Priority #: 9

Priority Area: Persons in Need of Recovery Support Service for SUD

Priority Type: SUR

Population(s): PRSUD

Goal of the priority area:

Improve access to recovery support services for young adults (ages 18-25) with SUD within recovery community centers.

Strategies to attain the goal:

Collaborate with DSUD recovery community center staff.

Identify gaps and barriers to recovery support services for this population.

Determine current organizational capacity and readiness (motivation, facility space, staffing considerations, facility readiness, regulatory and policy consideration, etc.) within recovery community centers to serve this population.

Provide training and technical assistance to recovery community centers and DSUD recovery community center staff regarding this population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of recovery community centers in Kentucky equipped to provide recovery support services for young adults (ages 18-25) with SUD.

Baseline measurement (Initial data collected prior to and during 2026): As of SFY 2025, the number of recovery community centers serving young adults (ages 18-25) is currently unknown.

First-year target/outcome measurement (Progress to the end of 2026): By the end of SFY 2026, a landscape analysis will be completed that includes any recovery community centers that serve this population along with a list of programs that could potentially benefit from training/support.

Second-year target/outcome measurement (Progress to the end of 2027): By the end of SFY 2027, training and technical assistance will be provided to one recovery community center to enhance capacity to offer recovery support services for young adults (ages 18-25) with SUD.

Data Source:

Landscape analysis conducted with recovery community centers across the state.

Reports and surveys from recovery community centers on the services they provide.

Data from federal or public health agencies related to SUD services for young adults: Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute on Drug Abuse (NIDA), Centers for Disease Control and Prevention (CDC).

Kentucky Overdose Response Effort (KORE)-funded Recovery Community Center reports.

Description of Data:

The data will provide a thorough evaluation of the capacity of recovery community centers to support young adults (ages 18-25) with SUD, assessing available services, identifying gaps, and highlighting areas in need of technical assistance or additional support.

Insights from existing SUD treatment reports will identify opportunities to address gaps of specialized recovery support services for this age group.

Data issues/caveats that affect outcome measures:

Limited response rate from recovery community centers may result in incomplete data.

Any State/Federal funding changes could negatively impact this measure.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Kentucky is not a HIV/AIDS designated state. Therefore, there is no performance indicator noted for that population.

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention ^a and Treatment	\$28,610,852.00		\$0.00	\$51,720,923.00	\$20,891,138.00	\$0.00	\$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC) ^b	\$8,101,106.00		\$0.00	\$1,880,000.00	\$1,462,380.00	\$0.00	\$0.00	
b. All Other	\$20,509,746.00		\$0.00	\$49,840,923.00	\$19,428,758.00	\$0.00	\$0.00	
2. Recovery Support Services ^c	\$1,776,600.00		\$0.00	\$21,316,766.00	\$0.00	\$0.00	\$0.00	
3. Primary Prevention ^d	\$5,379,012.00		\$0.00	\$3,444,221.00	\$870,464.00	\$0.00	\$0.00	
4. Early Intervention Services for HIV ^e	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
5. Tuberculosis	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development ^f	\$6,234,138.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
13. Administration ^g	\$580,400.00		\$0.00	\$2,724,708.00	\$5,198,866.00	\$0.00	\$0.00	
14. Total	\$71,191,854.00		\$0.00	\$130,927,541.00	\$47,851,606.00	\$0.00	\$0.00	

^a Prevention other than primary prevention.

^b Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

^c This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

^d Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

^e The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

^f Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

^g Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Primary prevention set aside planned expenditures = Row 3 amount (5,379,012) + amount of Row 12 that is primary prevention only (3,688,988). That total is 9,068,010 which is the 20% set aside planned expenditures for the two year period. Kentucky allocates more than 20%.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds ^a
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDCC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award) ^b		\$2,989,002.00						\$168,282.00
7. State Hospital			\$143,744,133.00		\$374,257,450.00	\$4,181,647.00	\$522,706.00	
8. Other Psychiatric Inpatient Care					\$26,263,411.00			
9. Other 24-Hour Care (Residential Care)			\$49,144,607.00		\$24,198,853.00	\$6,026,492.00		
10. Ambulatory/Community Non-24 Hour Care		\$18,299,594.00	\$2,009,600.00	\$22,222,974.00	\$65,022,640.00			\$1,430,399.00
11. Crisis Services (5 percent Set-Aside) ^c		\$3,361,780.00		\$5,231,834.00	\$45,783,160.00			\$84,141.00
12. Other Capacity Building/Systems Development								
13. Administration		\$291,000.00	\$281,000.00	\$4,062,400.00	\$28,922,701.00			
14. Total		\$24,941,376.00	\$195,179,340.00	\$31,517,208.00	\$564,448,215.00	\$10,208,139.00	\$522,706.00	\$1,682,822.00

^aThe expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

^bRow 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

^cRow 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

^dPer statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:
Kentucky's BSCA allotment for 9/30/24 - 9/29/26 is \$841,411. Kentucky's BSCA allotment for 9/30/25 - 9/29/27 is \$841,411.

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

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

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the [Treatment Episode Data Set](#) (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	8733	132
Women with Dependent Children	103677	609
Individuals with a co-occurring M/SUD	322000	13945
Persons who inject drugs	11940	3243
Persons experiencing homelessness	835	3279

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

1A. Center for Behavioral Health Statistics and Quality. (2024). 2023 National Surveys on Drug Use and Health Public Use File (puf2023_102124). Rockville, MD: Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. (2024). 2023 National Surveys on Drug Use and Health Public Use File Codebook. Rockville, MD: Substance Abuse and Mental Health Services Administration. Kentucky Vital Statistics, live births data for 2023 2A. Center for Behavioral Health Statistics and Quality. (2024). 2023 National Surveys on Drug Use and Health Public Use File (puf2023_102124). Rockville, MD: Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. (2024). 2023 National Surveys on Drug Use and Health Public Use File Codebook. Rockville, MD: Substance Abuse and Mental Health Services Administration. U.S. Census Bureau, Population Division. (2024, Nov). Annual estimates of the resident population for selected age groups by sex: April 1, 2020, to July 1, 2023: Kentucky. Retrieved on May 29, 2025, from <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-detail.html> 3A. SAMHSA, Center for Behavioral Health Statistics and Quality. 2022-2023 National Surveys on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 45B at <https://www.samhsa.gov/data/report/2022-2023-nsduh-state-prevalence-estimates>. 4A. Center for Behavioral Health Statistics and Quality. (2024). 2023 National Surveys on Drug Use and Health Public Use File (puf2023_102124). Rockville, MD: Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. (2024). 2023 National Surveys on Drug Use and Health Public Use File Codebook. Rockville, MD: Substance Abuse and Mental Health Services Administration. U.S. Census Bureau, Population Division. (2024, Nov). Annual estimates of the resident population for selected age groups by sex: April 1, 2020, to July 1, 2023: Kentucky. Retrieved on May 29, 2025, from <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-detail.html> 5A. Kentucky Housing Corporation. (2023). 2023 K-Count Results. Frankfort, KY: Kentucky Housing Corporation. Retrieved on May 29, 2025, from <https://www.kyhousing.org/Data-Library/Pages/K-Count-Results.aspx>. A count of homeless individuals on January 29, 2023, who self-reported they had an alcohol and/or illicit drug use problem. 1B. Data are from the TEDS-A data for Kentucky for 2022. Cases were restricted to STFIPS = 21 (Kentucky). The public use dataset was downloaded from here, https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set/datafiles?puf_id=53165 2B. The TEDS-A dataset does not include the number of women with dependent children. Thus, data is from an outcome evaluation, Kentucky Treatment Outcome Study (KTOS), of SUD treatment programs in Kentucky's Community Mental Health Clinics (CMHC). Data from women who completed an intake survey in KTOS in SFY 2023 were analyzed: 1,419 women reported they had children under the age of 18 living with them and/or caregiver responsibility of children under the age of 18 (e.g., stepchildren). 3B. Data are from the TEDS-A data for Kentucky for 2022. Cases were restricted to STFIPS = 21 (Kentucky). The public use dataset was downloaded from here, https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set/datafiles?puf_id=53165 4B. Data are from the TEDS-A data for Kentucky for 2022. Cases were restricted to STFIPS = 21 (Kentucky). The public use dataset was downloaded from here, https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set/datafiles?puf_id=53165 5B. Data are from the TEDS-A data for Kentucky for 2022. Cases were restricted to STFIPS = 21 (Kentucky). The public use dataset was downloaded from here, https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set/datafiles?puf_id=53165

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention ^a and Treatment	\$14,305,426.00
2 . Recovery Support Services ^b	\$888,300.00
3 . Substance Use Primary Prevention ^c	\$2,689,506.00
4 . Early Intervention Services for HIV ^d	\$0.00
5 . Tuberculosis Services	\$0.00
6 . Other Capacity Building/Systems Development ^e	\$3,117,069.00
7 . Administration ^f	\$290,200.00
8. Total	\$21,290,501.00

^aPrevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

^bThis expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

^cThis row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

^dThe most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

^eOther Capacity Building/System Development include those activities relating to substance use per [45 CFR §96.122 \(f\)\(1\)\(v\)](#). The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

^fPer [45 CFR §96.135](#) Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Total Primary Prevention set aside amount equals Total from Row 3 (2,689,506) + Primary Prevention only Total included in Row 6 (\$1,844,499) = \$4,534,005. KY allocates approximately 21% to make sure we expend required 20%.

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBP ^s for Adults	8718076.00
1b. Crisis Services for Adults	1597390.00
1c. CSC/ESMI program for Adults	1218000.00
1d. Other outpatient/ambulatory services for Adults	427668.00
1e. *Other Direct Services for Adults	240000.00
2. Subtotal of Services for Adults	12201134.00
3. Services for Children	
3a. EBP ^s for Children	2888468.00
3b. Crisis Services for Children	1597390.00
3c. CSC/ESMI program for Children	1218000.00
3d. Other outpatient/ambulatory services for Children	427668.00
3e. *Other Direct Services for Children	40000.00
4. Subtotal of Services for Children	6171526.00
5. Other Capacity Building/Systems Development ^a	6277716.00
6. Administrative Costs ^b	291000.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation ^c	24941376.00

Please provide brief explanation for services with an asterisk* below:
Other Direct Services for Adults = Deaf and Hard of Hearing interpreting services for Adults with SMI and Reintegration/reentry funds for Adults with SMI serving out of prison. Other Direct Services for Children = Deaf and Hard of Hearing interpreting services for Children with SED.

^a This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

^b Administrative Costs should not exceed 5 percent of total MHBG allocation

^c The total budget should be equal to your MHBG allocation for the next two years.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The 10% set aside for ESMI/FEP includes the total from 1c (1,218,000) + total from 3c (1,218,000) + the ESMI/FEP only amount included in Row 5 (\$553,002) for capacity building activities. Together these amounts equal \$2,989,002, the amount allocated as the 10% set aside. Kentucky allocates over 10% to make sure we expend 10%.

The 5% set aside for CRISIS includes the total from 1b (1,597,390) + total from 3b (1,597,390) + the CRISIS only amount included in Row 5 (167,000) for capacity building activities. Together these amounts equal \$3,361,780, the amount allocated as the 5% crisis set aside. Kentucky allocates over 5%.

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	\$219,786
	Selective	\$269
	Indicated	\$1,345
	Unspecified	\$0
	Total	\$221,400
2. Education	Universal	\$50,832
	Selective	\$269
	Indicated	\$1,076
	Unspecified	\$0
	Total	\$52,177
3. Alternatives	Universal	\$2,958
	Selective	\$0
	Indicated	\$380
	Unspecified	\$0
	Total	\$3,338
4. Problem Identification and Referral	Universal	\$15,330
	Selective	\$0
	Indicated	\$2,690
	Unspecified	\$0
	Total	\$18,020
	Universal	\$2,340,226
	Selective	\$2,421

5. Community-Based Processes	Indicated	\$0
	Unspecified	\$0
	Total	\$2,342,647
6. Environmental	Universal	\$51,924
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$51,924
7. Section 1926 (Synar)-Tobacco	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$0
8. Other	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	
	Total	\$0
Total Prevention Budget		\$2,689,506
Total Award ^a		\$21,290,501
Planned Primary Prevention Percentage		12.63%

^a Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

When primary prevention total planned expenditures from Table 5a (2,689,506) is added to primary prevention only planned expenditures from Table 6 (1,844,499) the total planned expenditure for primary prevention is \$4,534,005, which matches the total from Table 4, Row 3 + the primary prevention only total included on Table 4, Row 6 (\$1,844,499) which is approximately 21% of the total award. Kentucky allocates more to ensure actual expenditure of 20%.

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	\$2,252,087
2. Universal Indirect	\$428,969
3. Selective	\$2,959
4. Indicated	\$5,491
5. Column Total	\$2,689,506
6. Total SUPTRS Award ^a	\$21,290,501
7. Primary Prevention Percentage	12.63%

^a Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

When the primary prevention total for Table 5b (2,689,506) is added to the primary prevention only total for Table 6 (1,844,499) the total planned expenditure for primary prevention is \$4,534,005, which matches the Table 4, Row 3 Total (2,689,506) + the primary prevention only total included in Table 4, Row 6 (1,844,499), which is approximately 21% of the total award. Kentucky allocates more to ensure actual expenditures of 20%.

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☒
Tobacco/Nicotine-Containing Products	☒
Cannabis/Cannabinoids	☒
Prescription Medications	☒
Cocaine	☒
Heroin	☒
Inhalants	☒
Methamphetamine	☒
Fentanyl or Other Synthetic Opioids	☒
Other	☐
Priority Populations	
Students in College	☒
Military Families	☒
American Indian/Alaska Native	☐
African American	☒
Hispanic	☒
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☐
Asian	☒
Rural	☒

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	\$474,570.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$474,570.00	\$0.00	\$0.00
2. Infrastructure Support	\$30,000.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$30,000.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$0.00	\$190,500.00	\$1,396,534.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$1,099,873.00
b. All other subrecipient contracts	\$0.00	\$190,500.00	\$296,661.00
4. Planning Council Activities	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$0.00	\$0.00	\$357,965.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$357,965.00
6. Research and Evaluation	\$200,000.00	\$0.00	\$0.00

a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$200,000.00	\$0.00	\$0.00
7. Training and Education	\$377,500.00	\$0.00	\$90,000.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$377,500.00	\$0.00	\$90,000.00
8. Total	\$1,082,070.00	\$190,500.00	\$1,844,499.00

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025

MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG ¹	B. BSCA Funds ²
1. Information Systems	\$211,252.00	\$0.00
2. Infrastructure Support	\$0.00	\$0.00
3. Partnerships, Community Outreach, and Needs Assessment	\$2,718,200.00	\$678,100.00
4. Planning Council Activities	\$13,700.00	\$0.00
5. Quality Assurance and Improvement	\$1,797,184.00	\$0.00
6. Research and Evaluation	\$0.00	\$0.00
7. Training and Education	\$1,537,380.00	\$388,991.00
8. Total	\$6,277,716.00	\$1,067,091.00

¹ The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [July 1, 2025 – June 30, 2027, for most states].

² The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [July 1, 2025, through June 30, 2027 for most states].
OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The total MHBG included for ESMI/FEP 10% set aside total ONLY is \$553,002.
The total MHBG included for CRISIS 5% set aside total ONLY is \$167,000.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

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

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections.** SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: [The Essential Aspects of Parity: A Training Tool for Policymakers](#); [Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States](#).

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.¹ Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings.** States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:
 - a) Adults with serious mental illness (SMI)
 - b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)
 - c) Pregnant women with substance use disorders
 - d) Women with substance use disorders who have dependent children
 - e) Persons who inject drugs
 - f) Persons with substance use disorders who have, or are at risk for, HIV or TB
 - g) Persons with substance use disorders in the justice system
 - h) Persons using substances who are at risk for overdose or suicide

- i) Other adults with substance use disorders
- j) Children and youth with serious emotional disturbances (SED) or substance use disorders
- k) Children and youth with SED and a co-occurring I/DD
- l) Individuals with co-occurring mental and substance use disorders

a. Adults with serious mental illness

Each CMHC provides a full array of outpatient services, including, but not limited to, screening, assessment, individual therapy, group therapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, medication education and peer support services. Every effort is made to place these outpatient clinics in close geographic proximity to individuals, in order to ensure easy access to needed services. Additional areas of focus include:

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

In 2024, Kentucky added a mental health treatment resource to the findhelpnow.org website. The mental health resource allows users to search for mental health services by location and preferred treatment type. Additional filters on the site allow users to search for facilities providing services for intellectual or developmental delays and conditions such as SMI.

Kentucky continues to expand telehealth infrastructure across its behavioral health system, enabling adults with SMI and co-occurring disorders, particularly in rural areas, to access psychiatric services, therapy, peer support, and care coordination remotely. Telehealth flexibility has improved appointment adherence, reduced geographic disparities, and allowed for continuity of care during crises. DBHDID continues to monitor utilization patterns and quality outcomes to ensure telehealth services are effective and person-centered.

Kentucky has implemented the RISE (Recovery, Integration, Support, and Empowerment) initiative through its 1915(i) Medicaid State Plan Amendment to provide a structured, community-based service array for eligible adults with serious mental illness (SMI) and co-occurring disorders. RISE targets individuals who may not qualify for traditional waivers but still require functional supports to remain stable in the community and avoid unnecessary institutionalization. The initiative encompasses a focused array of person-centered, Medicaid-reimbursable services, including person-centered service planning, person-centered coaching, independent living skills training, residential support, tenancy support, and supported education/employment. Each service is designed to promote autonomy, build daily living and coping skills, reduce crisis episodes, and support long-term recovery within a trauma-informed and culturally responsive framework.

To ensure high-quality implementation, the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has provided extensive training, technical assistance, and quality monitoring for all enrolled provider agencies. The RISE initiative emphasizes integrated care coordination and aligns closely with Kentucky's Olmstead compliance goals by offering meaningful alternatives to institutional care. Services must be directly connected to a participant's person-centered plan and delivered by qualified, supervised staff under certified provider agencies. Through RISE, Kentucky is advancing the adult system of care by expanding access to recovery-aligned supports that are flexible, community-driven, and tailored to the complex needs of individuals living with SMI and co-occurring disorders across diverse settings, including rural and underserved communities.

Kentucky Medicaid reimburses for assertive community treatment, peer support services, comprehensive community support services, intensive outpatient treatment, and many other mental health services that are aligned with the state Medicaid plan. DBHDID contracts with each CMHC to provide the Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) services, regardless of payor source. This includes, but is not limited to, assertive community treatment, peer support services, targeted case management, supportive housing, and additional community placement services for individuals with SMI who are at risk of institutionalization.

To further strengthen access for adults with serious mental illness (SMI), Kentucky utilizes the InReach initiative as part of DIVERTS, a proactive strategy to identify and engage individuals with SMI who are residing in institutional settings, at risk of unnecessary hospitalization, or experiencing barriers to successful community reintegration. InReach specialists, at each CMHC, work closely with hospitals, personal care homes, jails, and other congregate settings to identify eligible individuals and facilitate timely discharge planning, warm handoffs, and person-centered service linkage. InReach is deeply aligned with Kentucky's Olmstead compliance efforts, and progress is regularly reviewed through the Olmstead Regional Transition Committee (RTC) meetings. These RTCs serve as interagency coordination hubs where system partners, including DBHDID, CMHCs, Department for Protection and Advocacy (DPA), Ombudsman, and hospital discharge planners, collaborate to remove systemic barriers and track transitions

into less restrictive, community-based settings. This process reinforces Kentucky's commitment to the rights of individuals with disabilities to live in the most integrated settings appropriate to their needs.

Additionally, Kentucky Medicaid reimburses for several crisis services, including crisis intervention, mobile crisis services, and crisis stabilization services. Walk-in crisis intervention services are provided in all 14 CMHC regions. Mobile crisis services for adults are available in 75/120 counties, with varying access. Ten CMHCs have staffed mobile crisis teams during business hours and nine during evenings and weekends, as well as providing on-call coverage. As this service develops more robustly, it will improve access to services for this population.

To enhance engagement with adults with SMI, DBHDID supports numerous recovery-based programs and has designated positions for individuals with lived experience to serve on Assertive Community Treatment (ACT) teams, First Episode Psychosis (FEP) teams, and the steering committee for Individual Placement and Support (IPS) supported employment and ACT programs. People with lived experience are employed as Employment Specialists in several IPS-supported employment programs. DBHDID also funds several statewide advocacy organizations and other programs to provide input and guide infrastructure for this population, including a statewide Center for Peer Excellence, which employs peer support specialists.

In alignment with national best practices, Kentucky has entered the discovery phase of implementing the Peer Bridger model, in partnership with the Alliance for Rights and Recovery. The Peer Bridger model is designed to embed peer specialists within inpatient and community settings to support individuals with SMI as they prepare for discharge from psychiatric hospitals and transition back into the community. While full implementation logistics are still being developed, the model is expected to strengthen Kentucky's continuum of care by improving engagement, reducing readmission rates, and supporting recovery through consistent peer relationships.

Additionally, one state psychiatric hospital has an agreement with a local mental health advocacy organization to provide peer support specialists to work within the hospital, offering recovery support, including individual and group sessions, as well as contact with family members during visitation. This contact with peers before discharge helps connect these individuals and their families with follow-up care.

Kentucky has significantly expanded its Individual Placement and Support (IPS) Supported Employment program, now serving 78 of the state's 120 counties. This initiative is delivered through 14 Community Mental Health Centers (CMHCs) and seven additional community providers. The program has also broadened its scope to include individuals with intellectual and developmental disabilities, as well as those experiencing substance use disorders, ensuring more comprehensive support for a broader population.

DBHDID has received a five-year, \$5 million Treatment for Individuals Experiencing Homelessness (TIEH) grant from SAMHSA to implement a street outreach initiative targeting unsheltered homelessness in the Louisville Metro area. The initiative, TEAM SOAR (Team-Engaged Assertive Mechanics for SSI/SSDI Outreach, Access, and Recovery), is a collaboration between DBHDID and Seven Counties Services, Louisville's Community Mental Health Center. TEAM SOAR focuses on individuals experiencing homelessness who are also living with serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring disorders, including veterans and transition-age youth (TAY). TEAM SOAR deploys multidisciplinary teams trained in the SOAR model, comprising a therapist, case manager, and peer support specialist to conduct outreach, screening, and referrals directly in encampments and on the street. A second team provides dedicated support to transition-age youth. The program enhances access to SSI/SSDI benefits, behavioral health services, and recovery supports, helping individuals navigate complex systems and engage in long-term care. By building on existing outreach efforts and utilizing evidence-based practices, TEAM SOAR aims to enhance service access, expedite benefit acquisition, and increase engagement among those most vulnerable to chronic homelessness. Lessons learned from the Louisville implementation will inform the development of a replicable model, with plans to expand this approach to other regions across Kentucky in the coming years.

Kentucky has strengthened its Assertive Community Treatment (ACT) program by contracting with the University of Kentucky Human Development Institute to hire a statewide ACT Trainer. This trainer collaborates with the ACT Program Administrator at the Division of Mental Health to conduct fidelity reviews and provide specialized training and coaching to ACT teams.

A primary focus of these trainings has been increasing knowledge and confidence in treating co-occurring disorders, which has led to greater acceptance of clients with these conditions. As a result of these efforts, all 14 ACT teams in Kentucky actively accept and recruit clients with co-occurring disorders. Each ACT team includes a dedicated substance use specialist with advanced training and/or lived experience in co-occurring disorders. Additionally, ACT teams offer monthly substance use and recovery-based groups, which are available both virtually and in person to ensure accessibility for rural communities. These initiatives reflect Kentucky's commitment to integrated care, ensuring individuals with complex needs receive comprehensive support.

In addition to these training advancements, Kentucky has made targeted improvements in how ACT teams approach complex case work, particularly for individuals with overlapping clinical, legal, and social challenges. This includes people with serious mental illness who are also involved in the forensic system, experiencing chronic homelessness, or presenting with neurocognitive conditions and personality disorders. DBHDID has developed and implemented a structured ACT Clinical Review Protocol to guide case consultation and decision-making for high-risk referrals, ensuring consistency, transparency, and fidelity to evidence-based practices. This protocol enables ACT teams to engage in a collaborative review with DBHDID leadership, providing a structured

venue to assess the appropriateness of ACT enrollment and coordinate wraparound supports for clients who fall outside of typical eligibility criteria but still require intensive, multidisciplinary intervention.

Kentucky's Assisted Outpatient Treatment (AOT) program is a court-ordered intervention aimed at improving treatment outcomes for individuals with serious mental illness (SMI) who have a history of non-compliance with voluntary treatment and are at high risk of hospitalization, incarceration, or self-harm or harm to others. AOT enables courts to require community-based treatment as a less restrictive alternative to inpatient hospitalization, with the goal of helping individuals stabilize, engage with services, and avoid cycles of crisis and institutionalization.

The AOT process in Kentucky relies on collaboration among community mental health centers (CMHCs), local courts, law enforcement, and family members. Eligibility is determined by clinical criteria, including the presence of a serious mental illness and a demonstrated need for structured treatment engagement based on the individual's history.

AOT is more than a legal tool — it is a coordinated care model that integrates court oversight with comprehensive wraparound services. These can include outpatient psychiatric care, case management, medication oversight, peer support, housing assistance, and other personalized services that promote community integration and recovery.

Kentucky's AOT Program is deeply integrated into the state's behavioral health System of Care (SOC) and care coordination strategies, especially for adults with SMI. The SOC approach emphasizes person-centered, recovery-focused, trauma-informed services provided through integrated networks of providers and support. AOT enhances interagency collaboration by bringing together behavioral health providers, courts, law enforcement, and social service agencies to support individuals with complex needs. CMHCs play a crucial role in coordinating care, ensuring that those under AOT receive timely access to services such as case management, psychiatric care, crisis stabilization, and peer support. The program promotes service continuity and accountability through regular court oversight and personalized treatment planning, thereby fostering stability and reducing unnecessary hospitalizations and justice system involvement. Additionally, AOT aligns with Kentucky's data-driven approach to behavioral health by using outcome metrics—such as treatment adherence, reduced emergency service use, and increased housing stability—to guide system improvements. By serving individuals who are often the hardest to engage, AOT operationalizes the core values of Kentucky's System of Care and helps extend the reach and effectiveness of the state's coordinated service delivery system.

b. Adults with SMI and a co-occurring intellectual/developmental disability

Kentucky's Division of Developmental and Intellectual Disabilities (DDID), within DBHDID coordinates statewide services and supports for individuals with developmental and intellectual disabilities. However, DMH and DSUD management and programmatic administrators work in tandem with DDID staff to provide quality screening, assessment, and treatment services to individuals with all disabilities, including those with co-occurring developmental and intellectual disabilities.

As mentioned above, Kentucky encourages all CMHC providers to screen and assess for multiple co-occurring disorders, including developmental and intellectual disabilities.

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c. Pregnant women with substance use disorders

Kentucky's behavioral health system of care has incorporated programs to address the needs of individuals who are pregnant and/or parenting. These programs address substance use disorder by developing a continuum of care that includes screening, assessment, outpatient, intensive outpatient, and residential treatment services, along with prevention services and recovery supports, including case management, peer support, recovery housing, and other community-based recovery supports.

In particular, the KY-Moms Maternal Assistance Towards Recovery (MATR) program is implementing a statewide effort to improve the health of all babies in Kentucky by decreasing the use of alcohol, tobacco, and other substances during pregnancy and postpartum periods. This program is a behavioral health prevention and case management program focused on addressing the risks and effects of substance use and misuse. It provides education, information, resources, support, and hope to individuals who are pregnant or postpartum, their families, and the professionals who serve them.

This program is currently operating in all 14 CMHCs across Kentucky, where collaborative outreach services seek to identify and engage individuals who are pregnant or postpartum and are at-risk for substance use and/or present with a substance use disorder. Individuals who are pregnant and/or postpartum are connected with the resources and tools they need to recognize and overcome risk factors and symptoms of prenatal and postpartum substance use/misuse. KY-Moms MATR services are focused on providing universal, selective, and indicated prevention services to an at-risk population of individuals who are pregnant

and/or, up to 12 months postpartum, to increase overall awareness of substance use risk factors. Individuals who are pregnant and post-partum and diagnosed with a substance use disorder can receive case management services during pregnancy and up to 12 months after delivery. Prevention and case management services are designed to reduce harm to Kentucky children resulting from maternal substance use during and after pregnancy.

In addition to serving pregnant and postpartum families, KY-Moms MATR increases awareness and reduces stigma surrounding prenatal and postpartum substance use/misuse by connecting and educating professionals in Kentucky with resources and tools they need to recognize, learn about, and treat substance use disorders while also developing partnerships to strengthen the support network in our communities.

d. Women with substance use disorder who have dependent children

Kentucky continues to expand its plan of safe care (POSC) initiative through development of regional committees at 11 of the 14 CMHCs, and plans for further expansion as funding allows. This initiative aims to improve access to evidence-based, quality services for pregnant women with dependent children (PWWDC) and to develop a coordinated and collaborative community-based system of care that supports the needs of families served.

In 2015, Kentucky Senate Bill 192 was introduced to provide funding for the Kentucky Justice and Public Safety Cabinet to combat heroin and substance use disorder in the Commonwealth. The Office of Drug Control Policy, within the Justice and Public Safety Cabinet, collaborates with DBHDID to select award recipients for programs on addressing neonatal opioid withdrawal syndrome (NOWS) and neonatal abstinence syndrome (NAS). Qualified providers receive funding to develop or expand comprehensive, evidence-based residential treatment services, increase access to recovery housing, and other recovery supports for individuals who are pregnant and/or parenting and their families. From SFY 2018 to SFY 2024, based on programmatic reporting, more than 8,227 individuals and their families have received treatment and utilized services from over 22 selected providers across the state, supported by these funds.

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

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

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

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

e. Persons who inject drugs

DBHDID provides oversight to all CMHCs to support consistent screening processes for intravenous drug use on initial contact and referral of clients to appropriate services. In addition, DBHDID will continue to work collaboratively with the Department for Public Health, and other advocacy groups and recovery organizations to increase harm reduction and support services for this population statewide. In addition, DBHDID will work to enhance access to peer support services to these individuals as well as access to evidence-based opioid use disorder (OUD) services, including medications for opioid use disorder (MOUD).

CMHC Contractual requirements include guidelines for providing education and referral services for individuals identified at risk for diseases associated with intravenous drug use. Each CMHC is required to have written policies for screening individuals who are seeking substance use services and referring them for appropriate treatment services.

f. Persons with substance use disorders who have, or are at risk for, HIV or TB

The CMHCs are required by contract to submit their written policies and protocols detailing the process for offering education, HIV testing, screening for risk, and referral for all individuals seeking services for substance use disorders. To continue to enhance oversight of this process, CMHCs will continue to submit their specific written procedures, training processes, and training

curriculum to DBHDID as part of the yearly reporting process. These written procedures are now required to include a training curriculum designed to ensure staff receive adequate instruction on effective and consistent implementation of HIV/AIDS protocols. Providers also consult the Department for Public Health, HIV/AIDS program for technical assistance with writing their policies and protocols as needed.

The Kentucky Department for Public Health has supported the development of syringe services programs (SSPs) across the state. There are currently 84 SSPs in 66 counties in Kentucky. Many of these programs provide outreach services, including harm reduction information/education, access to peer support and treatment services. Block grant funds are not used to support SSPs.

g. Persons with substance use disorders in the justice system

Through the State Opioid Response (SOR) grants, the Kentucky Overdose Response Effort (KORE) has supported the provision of training and technical assistance designed to build and strengthen workforce capacity. As part of the Responsive Education to Support Treatment in Opioid Recovery Efforts (RESTORE) program, the Administrative Office of the Courts implemented a quarterly training series for court staff (i.e., judges, attorneys, clerks) to increase their knowledge, attitudes, and behaviors as it relates to serving individuals with opioid and/or stimulant use disorder. KORE also supports initiatives through partnerships with the Department of Corrections to increase access to Medications for Opioid Use Disorder (MOUD) for incarcerated individuals and assist with reentry supports for individuals leaving incarceration. DBHDID strives to link individuals who are justice-involved with an array of services and supports in their local communities. Reentry coordinators create individualized reentry plans for those with substance use disorder prior to release from custody. The plans support coordination of physical and behavioral health services in addition to addressing other reentry barriers including housing, transportation, and employment.

Kentucky has made significant progress in supporting individuals with substance use and mental health disorders who are also involved in the justice system through the implementation of Forensic Assertive Community Treatment (FACT) teams. In November 2024, the state secured a Transformation Transfer Initiative (TTI) grant from the National Association of State Mental Health Program Directors (NASMHPD) to explore and establish these teams.

FACT builds upon the ACT model and incorporates forensic components to address criminogenic risks and needs. The teams provide intensive, community-based services, including psychiatric care, case management and therapeutic interventions, helping individuals stabilize and reduce recidivism.

Three community mental health center ACT teams with the highest number of justice-involved individuals were selected for early implementation. The state plans to eventually expand FACT teams to all 14 regions statewide to ensure broader access to specialized care. Nearly all justice-involved clients in these three regionals have a co-occurring diagnosis, allowing for integrated treatment that address both mental health and substance use disorders.

In addition, DBHDID has collaborated with the Department for Medicaid Services, the Department of Corrections, and the Department of Juvenile Justice (DJJ) on the application and implementation planning of the 1115 Reentry Waiver. This waiver was approved July 2, 2024, and allows for limited Medicaid coverage for a targeted set of services provided to incarcerated individuals in Kentucky's state prisons and youth placed in DJJ facilities. The pre-release benefit package is designed to improve care transitions for individuals returning to the community, by promoting continuity of coverage and proactively identifying and planning for physical, behavioral health and health related social needs.

h. Persons using substances who are at risk for overdose or suicide

DBHDID has worked to increase access to behavioral health services for individuals at risk of overdose or suicide by expansion of quick response teams (QRT) in Kentucky. QRTs provide compassionate, assertive outreach to adult and adolescent survivors of overdose to facilitate treatment and harm reduction services. Teams are composed of peer specialists, treatment providers, and first responders. CMHCs provided QRT services in 27 counties during SFY 2024 and in 30 counties during SFY 2025.

i. Other adults with substance use disorders

Kentucky's behavioral health system of care includes 14 CMHCs as well as multiple licensed and credentialed private providers as specified in the DBHDID provider directory. These programs provide access within the state to a full continuum of services, including education, screening, brief intervention, assessment, outpatient, intensive outpatient, residential, withdrawal management, and recovery supports. Kentucky is continuously working to identify specific populations of need and provide services focused on those populations. Those populations include Service Members, Veterans, and their Families (SMVF), adolescents, individuals who are pregnant and/or parenting, individuals experiencing homelessness, older adults, individuals with co-occurring substance use and mental health disorders, and others as identified. Kentucky promotes the use of MOUD as the gold standard in treatment of opioid use disorder. Kentucky's administrative regulations support access to buprenorphine formularies. Kentucky has removed prior authorizations for buprenorphine formularies including the long-acting injectable formulation, Sublocade and Brixadi. Additionally, Kentucky has established an online treatment locator platform called FindHelpNowky.org that is a real-time substance use disorder treatment availability locator and information center. The locator lists treatment openings and providers including CMHCs; private, non-profit, and faith-based treatment providers; and providers of MOUD. Providers are encouraged to update their treatment availability and facility information daily. FindHelpNowky.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, and recovery resources. FindHelpNowky.org was created by the Kentucky Injury Prevention and Research Center (KIPRC) as an agent for the Kentucky Department for Public Health in partnership with the Kentucky Office of Drug Control Policy, DBHDID, and Operation UNITE

Managed care organizations (MCOs) in Kentucky require the use of American Society of Addiction Medicine (ASAM) Criteria for determining level of care for Medicaid billable services. CMHC contracts require the use of ASAM Criteria for level of care determination for SUD treatment services. Training on the ASAM Multidimensional Assessment has been offered statewide and included ASAM Criteria overview, ASAM criteria skill building, individualized service planning, and Motivational Interviewing, as an effort to build workforce capacity and increase access. DBHDID is actively developing new training programs to assist treatment providers statewide in implementing the ASAM Criteria Fourth Edition. This training series supports treatment providers across the state to offer person centered, evidence-based care in alignment with the updated standards. Additionally, in collaboration with the Children's Mental Health and Recovery Services Branch, there are 492 (as of June 2025) trauma-informed care trainers statewide in which the Adult Substance Use Treatment and Recovery Services Branch assists with facilitation of ongoing training efforts and technical assistance.

The Division of Substance Use Disorder (DSUD), which has operated a revolving loan fund in partnership with the Kentucky Housing Corporation since the early 1990s, transitioned operational control of that loan fund during calendar year 2023 to Oxford Housing, Inc. The evidence-based Oxford House model was chosen to establish additional recovery homes utilizing the loan fund. Beginning in January 2016, DBHDID contracted directly with Oxford House, Inc. to expand the recovery home network in the commonwealth. Since that time, Kentucky's network has grown from four houses in Northern Kentucky providing 32 recovery beds, to 132 houses across the state including houses for men with children (seven) and houses for women with children (21). The contract with Oxford House, Inc. provides Kentucky with outreach workers who identify, open, and sustain community-based recovery housing, who then establish relationships with local service providers to ensure linkages to the available continuum of care. There is also an Oxford House women's resource coordinator who is responsible for services focusing on women and women with children.

DSUD became the state affiliate of the National Alliance for Recovery Residences (NARR) on April 1, 2020. Since then, DSUD has operated the Kentucky Recovery Housing Network (KRHN), a voluntary certification program for recovery housing. To date, KRHN has certified 331 recovery residences with 4,613 recovery beds. KRHN has established a monthly open call to promote quality recovery housing and to grow and strengthen the recovery housing community in Kentucky. The KRHN advisory board has also worked with community partners, providing input on HB 248, which mandates that all recovery houses operating in Kentucky become certified through KRHN. This bill allows for the exception of Oxford Houses, Recovery Kentucky Centers operated by the Kentucky Housing Corporation, or faith-based non-profits directly affiliated with a faith-based organization in their county. In addition, KRHN worked with the Kentucky Injury Prevention Research Center (KIPRC) at the University of Kentucky to develop FindRecoveryHousingNowKY.org, a recovery housing directory that helps potential residents and community partners locate quality recovery housing.

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

j. Children and youth with SED or substance use disorders

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

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

Kentucky's statewide Early Childhood Mental Health (ECMH) program has been in existence for over twenty years and was originally created to provide outreach, education, consultation, and training for early care and education providers, families, and

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

At the opposite end of the age spectrum for youth, Kentucky has made significant strides in improving access to developmentally appropriate evidence-based/informed practices for transition age youth (age 16-25). A Transition Age Youth (TAY) Cross Branch Implementation Team exists across the Divisions of Mental Health; Substance Use Disorder, and Developmental & Intellectual Disabilities. This cross branch team is comprised of key liaisons within each branch. Its focus is on seamless coordination of services and supports to transition age youth across child and adult services within and across; mental health, substance use, and developmental/intellectual disability prevention, treatment, and recovery. Key goals include increasing service capacity and easy access to care; improving youth voice in services and the youth leadership network; improving the public's awareness of behavioral health issues and reducing stigma; and improving cross-system collaboration and training.

At the local level, a Transition Age Youth Coordinator has been established in each CMHC region. This position serves as the regional expert in transition age youth best practices and works to build the capacity within the region to provide excellent supports and services for the TAY population between 16-25 years old. They provide consultation; referral; education; training; technical assistance; coaching; outreach, and system development within the regional CMHC and community to increase seamless and easily accessible supports for TAY. Additionally, each CMHC is also required to have a Youth Substance Use Treatment Coordinator (YTC) who specializes in substance use and co-occurring supports for youth and young adults. The YTCs facilitate connections within the CMHCs across divisions and programs (i.e., substance use prevention; substance use treatment; child behavioral health) to ensure that youth who are identified as needing substance use services can access developmentally appropriate, evidence based co-occurring care, regardless of how they entered the system. The YTCs support their communities by reaching out to schools, substance use prevention groups, and other community-based health groups by providing information on trends in youth substance use and help bridge any gaps to service access.

Building on the success of two SAMHSA Healthy Transitions Grants, funding has also been used to expand a TAY drop-in center model of behavioral health care. There are now 13 Transition Age Youth Launching Realized Dreams (TAYLRD) Drop-in Centers across the state that work to follow the TAYLRD Practice Guidelines established through the Healthy Transitions Grant. An array of behavioral health services is provided in an environment that is easily accessible and inviting to youth and young adults. These supports are developmentally appropriate, culturally responsive, promote protective factors, and are tailored to the individual needs of TAY. Services include both formal and informal services such as peer support, employment, education, and career planning, medication management, age specific behavioral health treatment, coordination of care, life skills, and health care navigation.

The DBHDID contracts with eight Community Mental Health Centers (CMHCs) to deliver iHOPE (Helping Others Pursue Excellence), Kentucky's Coordinated Specialty Care (CSC) model for youth and young adults ages 15-30 who are experiencing First Episode Psychosis (FEP). Each iHOPE program includes a transdisciplinary team trained to provide early, recovery-oriented intervention, including individual therapy, supported employment and education, case coordination, psychiatric care, and family engagement. In addition to these contracted programs, all 14 CMHCs are required to designate FEP Key Contacts within both their child and adult service lines to ensure statewide responsiveness and system navigation.

To enhance access and engagement, DBHDID strongly encourages collaboration between iHOPE programs and TAYLRD Drop-In Centers. These peer-driven, youth-friendly spaces reduce stigma and promote early help-seeking. In regions where both services are available, this integrated model has demonstrated success in lowering treatment delays. One such area has expanded its capacity by opening a second iHOPE team to meet rising demand, illustrating how coordinated early intervention can scale to meet population-level needs when supported by community partnerships.

At the system level, the State Interagency Council (SIAC) for Services and Supports to Children and Transition Age Youth was established by statute in 1990 to serve as the governing body for Kentucky's system of care for children and youth with or at-risk of developing behavioral health (inclusive of mental health, substance use, and co-occurring mental health and substance use) challenges. In this role, the SIAC has served as the governing body for all past and present SAMHSA SOC and adolescent CSAT grants, as well as other federal grants (suicide prevention; healthy transitions; Children's Bureau trauma; and others) and state-level initiatives focused on these populations and their families. The SIAC members include:

- Commissioner-level representatives from 12 state agencies (across 5 Cabinets) that serve children, transition-age youth, and their families;

- Nonprofit Family Organization;
- Youth Representative;
- Parent Representative; and
- Subcommittee for Equity & Justice for All Youth (SEJAY).

The SIAC was created and continues to serve as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition age youth with or at risk of developing behavioral health needs and their families. This statutorily mandated group meets monthly and is engaged in Phase I of creating a comprehensive, multi-perspective Children's Behavioral Health Plan (CBHP) to support state agencies in creating services and supports that are available and accessible across the state and regardless of how or through what agency the child, youth, and family enter the system of care. In 2025, SIAC is focusing on priority areas that are organized into the following three workgroups that emerged from a Care Pathways Analysis of qualitative and quantitative data related to Kentucky's system of care: Standardized Screening and Assessment, Service Engagement and Retention, and Kentucky Rapid Response and Stabilization Services. These workgroups report their progress to SIAC on a quarterly basis. Output of these workgroups will drive Phase II of CBHP and guide SIAC in determining next steps for incorporating these efforts into its strategic plan.

In addition to the SIAC, 18 Regional Interagency Councils (RIACS) with similar membership serve as regional loci of accountability for the system of care by:

- Conducting regional system of care planning and operations
- Coordinating system-level continuous quality improvement
- Identifying and developing system of care expansion opportunities
- Promoting system of care awareness
- Initiating and adopting interagency agreements as necessary for providing services & supports to children and transition age youth with behavioral health needs by agencies on the RIAC
- Advising the SIAC regarding the system of care within the region

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

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

In developing the TEAM SOAR initiative, DBHDID intentionally incorporated a focus on the unique vulnerabilities and service needs of transition age youth (TAY) experiencing unsheltered homelessness. Recognizing that TAY often face significant barriers to engagement—stemming from developmental factors, lack of consistent support systems, and higher prevalence of behavioral health conditions—DBHDID wrote specific outreach goals into the TEAM SOAR grant proposal to ensure that this population would receive targeted attention. These goals are reflected in the program design through the inclusion of a dedicated TAY outreach team and the integration of youth-centered practices into engagement, assessment, and service linkage strategies. By embedding these objectives at the proposal stage, DBHDID established a clear framework for addressing service disparities and promoting early intervention among TAY at high risk of chronic homelessness.

k. Children and Youth with serious emotional disturbance and co-occurring intellectual/developmental disabilities. Kentucky is striving to improve availability of and access to services for children and youth with mental health and co-occurring developmental and intellectual disabilities. From SFY 2023 to SFY 2025, the number of children and youth age birth through seventeen, served by the 14 CMHCs, who had co-occurring mental health and developmental disabilities increased from 845 to 1602 (a 53% increase). While no programming specific to this vulnerable population has been implemented, the growth is attributed to focused efforts in multiple areas.

Early Childhood Mental Health Program (ECMHP). The statewide ECMHP emphasizes the importance of well-being in early childhood and providing services and supports to children age birth through five and their families. Regional ECMHP staff includes early childhood specialists and consultants who offer consultation and training on topics such as physical and mental health; developmental and intellectual disorders; early childhood development, impact of early trauma; in utero and in-home exposure to substance use; social-emotional development and building resilience through positive childhood experiences. These professional development opportunities are offered to a variety of agencies that serve young children and their families as well as parents and other caregivers. Training and coaching in evidence-based/informed clinical services supports are offered to provider agency staff as well. Additionally, ECMHP staff provide child, classroom, program observation and recommendations, screening, and referral support to early care and education providers. Finally, ECMHP staff offer clinical services and supports such as assessment; child and family treatment; family peer support; and targeted case management to children age birth through five with identified needs. The ECMHP program is inclusive of young children with co-occurring SED and IDD and works closely with Kentucky's home visitation; IDEA Part C Early Intervention; public preschool; IDEA Part B programs; substance use treatment programs for families with young children; and child welfare plan of safe care efforts.

Transition Age Youth Launching Realized Dreams (TAYLRD). Drop-in Centers for transition age youth and young adults are in operation in 7 of the 14 CMHCs. An array of behavioral health services are provided in an environment that is easily accessible,

engaging, inviting to transition age youth (TAY) and includes open access hours. Supports are targeted to any transition age youth between the ages of 16-25 years old with or at risk of developing serious behavioral health issues. All transition age youth are welcome, and IDD is not excluded. This programming provides seamless services for this population to help minimize gaps between child, adolescent and adult mental health and substance use programs. Warm handoffs to other specialty services are provided when needed and available.

Next Steps

Within the Kentucky Cabinet for Health and Family Services, the Departments for Medicaid Services; Behavioral Health, Developmental & Intellectual Disabilities, and Community Based Services (Kentucky's child welfare agency) are partnering with Myers & Stauffer to create a children's 1915(c) Waiver application. The waiver, named Community Health for Improved Lives and Development (CHILD) intended to serve children with the highest acuity needs and require intensive behavioral health and residential services and supports. It will provide home and community-based waiver services to Kentucky children and youth ages birth through 21 who have a Serious Emotional Disturbance; Intellectual Disability; Developmental Disability, or Autism Spectrum Disorder and who meet level of care for Psychiatric Residential Treatment Facility or Intermediate Care Facility for Intellectual Disability. Priority enrollment will be granted to those children who are unhoused, are at risk of being unhoused, or transitioning out of an institution. The following services will be included in the 1915(c) application:

1. Case Management
2. Respite – Including in-home, community, and facility-based options.
3. Community Living Supports
4. Environmental and Minor Home Modifications
5. Step-Down and After Care Support (includes parental and family support)
6. Supervised Residential Care

The CHILD waiver is intentionally focused on the specific population of children and youth with the highest acuity needs and who require intensive behavioral health and residential supports. It is part of a two state approach and is planned to launch on January 1, 2026. The second stage is the launching of a comprehensive 1915(i) State Plan Amendment (SPA) and Tax Equity and Fiscal Responsibility Act (TERFA). This SPA will add services to Kentucky's Medicaid state plan and will be available to a larger group of children than the CHILD waiver. It is currently in early stages of development with an anticipated implementation date of January 1, 2027.

I. Individuals with co-occurring mental and substance use disorders

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

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

Kentucky is partnering with ZiaPartners to facilitate the implementation of a statewide system of care that addresses the service needs of individuals with co-occurring mental health and substance use disorders. ZiaPartners is conducting a system assessment, developing a plan of action, organizing a statewide change process, facilitating initial action steps, and monitoring outcomes. As part of the change process, DBHDID will bring together an inaugural cohort of agencies to participate in training during which each agency evaluates its policies and procedures and develops an action plan to promote program co-occurring capability and provider co-occurring competency.

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

DBHDID contracts with an advocacy organization to provide statewide training on Double Trouble in Recovery (DTR), a mutual aid fellowship adapted from the 12-step Alcoholic Anonymous program of recovery for adults with co-occurring mental and substance use disorders. Traditional mutual aid groups are not always tailored for this specific population, and in fact sometimes impede mental health recovery. To implement this DTR support group, DBHDID provides funding for materials, training, and other support necessary to have peers trained as leaders for implementing these support groups. DTR groups are led by peers with lived experience with co-occurring mental health and substance use disorders and several communities across Kentucky have active DTR groups.

As part of Kentucky's broader efforts to address the needs of individuals with co-occurring mental health and substance use disorders, the state's 1915(i) RISE (Recovery, Integration, Support, and Empowerment) initiative provides Medicaid-reimbursable, home- and community-based services designed to support functional recovery and promote stability in the least restrictive setting. While RISE services are not diagnosis-specific, they are structured to support individuals with complex behavioral health needs, including those with co-occurring disorders, by focusing on person-centered planning, skill-building, and environmental supports. Services such as independent living skills training, person-centered coaching, crisis prevention and support, residential support, and tenancy support are designed to be delivered in natural settings and tailored to the participant's goals. All services must align with a person-centered plan and be delivered by trained, supervised staff under certified provider agencies. The RISE service model supports ongoing engagement and stabilization for individuals who may struggle with traditional treatment settings, including those with dual diagnoses, and reinforces Kentucky's commitment to recovery-oriented, integrated care that crosses diagnostic and system silos.

Lastly, to further enhance access and engagement, Kentucky operates eight Consumer Operated Services Programs (COSPs) through its Community Mental Health Centers (CMHCs). While administered by the CMHCs, these programs are grounded in SAMHSA's COSP evidence-based framework. They are staffed by peers with lived experience of recovery from SMI and co-occurring disorders. COSPs function as welcoming, peer-driven drop-in centers that offer recovery support, social connection, and linkage to clinical and community-based services. By offering low-barrier access points rooted in mutual support, these programs help engage individuals who may be disconnected from formal treatment and connect them to needed services and recovery pathways.

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

Kentucky legislature enacted a behavioral health parity law in July of 2000. However, parity was not fully realized until the federal Mental Health Parity and Addiction Equity Act of 2008, when more attention was focused on behavioral health parity.

Kentucky legislation currently requires behavioral health parity as mandated in the federal Mental Health Parity and Addiction Equality Act of 2008 through KRS 304.17A-661.

This Kentucky statute defines "mental health disorder" as any diagnosis contained in the Diagnostic and Statistical Manual (DSM), including substance use disorders.

At the time of the parity law, the Kentucky Medicaid plan did not include reimbursement for substance use disorder services, except for pregnant women. In 2015, Kentucky legislature passed a bill requiring the Department for Medicaid Services (DMS) to cover services for SUD. When a new Medicaid State Plan Amendment (SPA) was approved around that time, a full array of services for individuals with substance use disorders was included for all eligible Medicaid recipients with substance use disorders. Additionally, more evidence-based services were added through this SPA for mental health disorders.

DBHDID collaborated closely with Kentucky DMS in developing the new SPA, and in creating subsequent administrative regulations regarding newly reimbursable services.

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

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

DBHDID supports the provision of integrated services for individuals with co-occurring mental and substance use disorders through a combination of standardized screening tools, coordinated care models, and evidence-based treatment services delivered by Community Mental Health Centers (CMHCs) and other behavioral health providers.

Screening and assessment for co-occurring disorders occur at multiple entry points, including outpatient clinics, crisis response services, and targeted case management. Tools such as the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) and other validated screening instruments are used by CMHCs to identify both mental health and substance use concerns, triggering comprehensive biopsychosocial assessments and referrals to appropriate levels of care.

Integrated treatment is delivered through multiple pathways within Kentucky's behavioral health system. These include outpatient therapy, intensive outpatient programs (IOP), medications for opioid use disorder (MOUD), peer support services, and targeted case management, all of which are Medicaid-reimbursable and available statewide. Providers are encouraged to implement stage-wise interventions and motivational enhancement techniques consistent with integrated dual disorder treatment (IDDT) principles. While ACT teams are one provider type required to implement IDDT with fidelity, many CMHCs extend integrated care principles across additional service lines such as outpatient and residential levels of care.

Additionally, cross-training, technical assistance, and internal collaboration across mental health and substance use teams continue to support co-occurring capable care throughout the system. Integrated service planning—particularly in cases involving high acuity, chronic SUD, or risk of institutionalization—is increasingly emphasized through provider quality improvement efforts and contractual expectations, even in the absence of a statewide fidelity monitoring system.

a. Please describe how this system differs for youth and adults.

As described in item 1.j. above, services and supports for youth with co-occurring mental health and substance use disorders are coordinated through the children's divisions within the CMHCs. This differs from the adult service system in that for adults, substance use treatment services, and supports are coordinated through CMHC SUD treatment divisions and adult mental health treatment is coordinated through mental health divisions. Providing services for youth with SUD or co-occurring mental health and SUD is complex due to their evolving developmental needs, as well as the need to include their support system or address their lack of supports.

Related to integrated services and supports for adults with co-occurring disorders, the description of the service system is also in item 1.j. above.

All CMHCs are required to provide American Society for Addiction Medicine (ASAM) assessments on all individuals with SUD and Level of Care Utilization System (LOCUS) assessments on all individuals with SMI. CMHCs also administer the Child and Adolescent Needs and Strengths to youth with child welfare and/or juvenile justice involvement and youth who are partnering in High Fidelity Wraparound. The Child and Adolescent Level of Care Utilization System (CALOCUS) and Early Childhood Service Intensity Instrument are also used to assist in determining level of care. Additionally, the iHOPE teams utilize the PRIME Screen tool and the Structured Interview for Psychosis Risk Syndromes (SIPS) assessment to determine level of necessary care for young people referred to iHOPE teams. CMHC contracts include a requirement for an appropriate warm hand-off within 48 hours of determination that an individual is not appropriate for iHOPE services. Additionally, many CMHCs, especially those with iHOPE teams, have included the PRIME Screen tool in their electronic medical record system and require use with all adolescents/young adults seeking care.

Many CMHCs utilize Integrated Dual Diagnosis Treatment (IDDT) as implemented based on SAMHSA's toolkit within the last decade. DBHDID staff have provided reviews utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) assessments with all CMHCs and most, if not all, CMHCs were determined to be co-occurring capable at that time. Workforce issues that have occurred during and after the pandemic requires DBHDID to reconsider assisting providers more closely with this work. The Division of Substance Use Disorder is the process of hiring a program administrator for co-occurring disorders. The Division of Mental Health already includes co-occurring program staff for children, youth and transition age youth. Work in this area continues.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Yes. Kentucky provides evidence-based integrated treatment for co-occurring disorders (IT-COD) through multiple service platforms. All ACT and Forensic ACT teams are required to deliver integrated dual disorder treatment (IDDT) consistent with ACT fidelity standards. Beyond ACT, several CMHCs incorporate IT-COD principles within outpatient, residential, and case management services, utilizing integrated care teams, stage-wise interventions, and motivational strategies to address both mental illness and substance use disorders.

c. How many IT-COD teams do you have? Please explain.

DBHDID currently supports nine IT-COD teams across the CMHC network. This includes ACT teams with embedded IDDT components, as well as designated outpatient or community-based integrated treatment teams operated by CMHCs. These teams deliver co-occurring capable services aligned with IT-COD best practices.

d. Do you monitor fidelity for IT-COD? Please explain.

DBHDID previously implemented IDDT across the state and at that time DDCAT and DDMHT fidelity reviews were completed and training and technical assistance provided to ensure quality services that fit the integrated treatment model. More recently, to support co-occurring capable programming and integrate service delivery, DBHDID required CMHCs to complete DDCAT or DDMHT self-assessments as part of their contract deliverables. While formal state-level IT-COD fidelity monitoring is not currently conducted, these self-assessment tools remain available to CMHCs and are referenced in some internal quality improvement processes.

e. Do you have a statewide COD coordinator?

☒ Yes ☐ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

- a) Access to behavioral health care facilitated through primary care providers
- b) Efforts to improve behavioral health care provided by primary care providers
- c) Efforts to integrate primary care into behavioral health settings
- d) How the state provides integrated treatment for individuals with co-occurring disorders

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

Primary care providers represent a meaningful setting for increasing access to behavioral health care. Integrated care efforts have resulted in millions of dollars in cost savings across states and across models (Bipartisan Policy Center, 2021). Integrated care has also been shown to produce better health outcomes such as increased access to care, reduced hospitalizations, and improvement of chronic diseases such as diabetes and high blood pressure (Bipartisan Policy Center, 2021). With approximately 17% of Kentuckians having three or more chronic disease conditions (America's Health Rankings, 2022) and over 40% reporting symptoms of anxiety or depression (Mental Health in Kentucky, 2021), integrated case management could produce positive results.

In Kentucky, our primary care safety net system consists of Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Medicaid data tells us that there are over 120 FQHCs and more than 400 RHCs in Kentucky. FQHCs and RHCs serve primarily low-income, under or uninsured, and Medicaid/Medicare populations.

About half of the FQHCs in Kentucky have offered at least one behavioral health service in the past two years. About a third of the RHCs in Kentucky offered behavioral health services. The majority of mental health services provided within FQHCs and RHCs is psychotherapy. This work is also supported across various community partners such as the Kentucky Primary Care Association which conducts various activities within their network of FQHCs, including a behavioral health roundtable and an opioid roundtable.

Most of the primary care organizations that provide these services only employ between 1-10 behavioral health staff. 76% of the behavioral health providers employed in these two settings are psychiatrists, with the remaining being largely Licensed Clinical Social Workers (11%) and Licensed Professional Clinical Counselors (10%).

While primary care providers continue to seek opportunities for integrating behavioral health care into primary care settings, the state of Kentucky has developed several strategies to support the effort. In 2024, the Kentucky state legislature amended 907 KAR 1:082 expanding services and provider types that are now Medicaid billable by Rural Health Centers, including behavioral health services/providers. This amendment eliminated the previous requirement that RHCs provide at least 51% of their services as primary care services. This policy change may increase the amount of behavioral health services provided by RHCs.

DBHDID also implements several programs and strategies to support the integration of behavioral health into physical health settings. DBHDID implements the Zero Suicide program, which operates as a partnership between University of Kentucky/St. Claire health system and Pathways, the CMHC for the Morehead, Kentucky area. The Zero Suicide framework is an evidence-based approach for effective and safe suicide care. This framework enables health systems to approach every suicide death as a preventable occurrence – there is no acceptable number of suicide losses. This partnership in the eastern part of the state has been developing training, policies, and clinical protocols for Zero Suicide. Some examples include: 1) UK/St. Claire screens and conducts warm hand offs and referrals to Pathways for behavioral health care, 2) emergency department conducts safety plans prior to discharge or referral to care, 3) Pathways conducts 48 hour follow ups after referral. This grant work supports common integrated care components such as formalized MOUs between community health partners, data sharing and EHR integration, and enhanced referral and care pathways.

The National Strategy for Suicide Prevention (NSPP) grant is also administered by DBHDID. The grant, through the Western Kentucky Senior Suicide Prevention Network, is working to implement evidence-based training for community care providers within the Pennyriple Area Development District. As a required part of the Taskforce's long-term strategic plan, an evidence-based suicide prevention training calendar will be created to include community care and clinical service providers who serve adults aged 60+. Using braided funding streams, the targets for training will include, but are not limited to, state and area agencies on aging, justice systems, primary care settings, substance use prevention and mental disorder treatment programs, and mental health programs. Training will include identification of suicide risk and providing appropriate support to at-risk groups, conducting safety planning and lethal means counseling, and implementing evidence-based suicide care practices (e.g., Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP); Dialectical behavior therapy (DBT); Collaborative Assessment and Management of Suicidality (CAMS); Brief cognitive-behavioral therapy; Attempted Suicide Short Intervention Program).

Kentucky's Assertive Community Treatment (ACT) teams have expanded their focus to ensure that all clients have a primary care provider (PCP) and receive comprehensive physical health care. In addition to securing PCPs for clients, ACT teams are actively supporting them in attending yearly physical exams, follow-up appointments, specialty referrals, and managing prescribed medications. To further enhance care coordination, ACT staff often accompany clients to their medical appointments and maintain ongoing communication with PCPs. This collaborative approach helps address physical health concerns while ensuring continuity of care. By integrating primary care into ACT services, Kentucky is strengthening its commitment to holistic, person-centered treatment for individuals with complex needs.

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

In 2024, DBHDID created a new position associated with the receipt of the Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) grant that focuses on integrated care advancement across Kentucky. This position is located in the Division of Mental Health and oversees all integrated care efforts for the department. Hiring for this position has increased capacity for DBHDID to create integrated care resources, provide technical assistance, guide systems change decisions, and convene providers to increase access to, and quality of, behavioral health settings utilizing a 'no wrong door' policy.

The Kentucky Mental Health Care Access Program (KY MARK) is administered by the Kentucky Department for Public Health, Division of Maternal and Child Health. KY MARK provides free psychiatric teleconsultation for pediatric primary care providers with the goal of meeting the increasing need for access to mental health care for Kentucky's pediatric population. This program is in year three out of five and is expanding capacity to increase enrollment statewide. Alongside participation in the board for this program, DBHDID and DMS are also exploring ways to collaborate with KY MARK to develop a sustainability plan for the program, as well as to develop integrated care training opportunities for enrolled primary care providers. These opportunities are placed on the University of Kentucky's continuing education (CE) Central website, a continuing education platform. Trainings center around behavioral health knowledge and skills, provider collaboration, and programmatic integrity.

Additionally, DBHDID and DMS are engaged in a SAMSHA Center for Substance Abuse Treatment (CSAT) Learning Collaborative titled "Integration of Physical Health, Substance Use Services, and Mental Health Care." CSAT provides learning, collaboration, and technical assistance to assist with state specific integrated care goals. DBHDID and DMS are focused on enhancing Collaborative Care utilization in Kentucky, an evidence-based integrated care program that is currently Medicaid billable in Kentucky, as well as utilizing data to develop strategic initiatives towards improving the provision of behavioral health care in primary care settings.

c. Efforts to integrate primary care into behavioral health settings

Mental illness is associated with an increased risk for physical health problems. Adults with mental illness may die ten years earlier than the general population and adults with serious mental illness die fifteen to twenty years earlier on average, largely due to treatable and preventable physical health conditions (Mayo Foundation for Medical Education and Research, 2022) (Liu et al, 2017). People with SMI are less likely to access physical health services and are more likely to have chronic health conditions and to be hospitalized for those conditions (Agency for Healthcare Research and Policy, 2014). Individuals with SUD are less likely to initiate and receive quality primary care services and are more likely to experience barriers such as socioeconomic hardships and stigma in health care settings (Ross et al, 2015). Because of this, access to primary care services within a behavioral health setting can be a paramount strategy for increasing the health of individuals with SMI, SUD, and co-occurring mental health/substance use disorders.

There are 14 Community Mental Health Centers in Kentucky. Of those 14, five of them currently offer concurrent primary care services. These centers include Mountain Comprehensive Care Center, New Vista, NorthKey Community Care, Pathways, Inc., and Seven Counties Services.

Mountain Comprehensive Care Center operates as an FQHC look alike, which allows them to provide extensive primary care services. They house the Homeplace Clinic, with a mission of improving the health of the underserved and homeless population of Eastern Kentucky. They provide services to a wide population across fifteen locations, including one location that offers OBGYN services, one location that specializes in care for adults with serious mental illness, and another that serves as an eye care center.

New Vista added additional primary care clinics, case management, and care coordinators after they received the Certified Community Behavioral Health Clinic (CCBHC) demonstration grant in 2020. New Vista now has four primary care clinics across their 17-county service region. They report that primary care patients were largely not being served by FQHCs in the area, indicating that their primary care population skews towards individuals with moderate to severe behavioral health needs who were not receiving care elsewhere. They operate as an integrated practice, with all providers having access to the care plan. Their primary care providers also provide medications for opioid use disorder (MOUD) services.

NorthKey Community Care has five on-site primary care clinics in their eight-county region. NorthKey utilizes nurses as Integrated Care Coordinators to support the integration and linkage between primary and behavioral health services. Patients are screened and referred into primary care through health assessment criteria. Assessments include behavioral health and medical history, medications, medical equipment, preventative health care history, HIV and hepatitis B screeners, psychiatric advanced directives, nutrition, and more. Criteria for referral into primary care includes having a medical condition that could lead to hospitalization, experiencing recent hospitalization, a patient self-reporting that they have not seen a primary care provider within a recent time frame, a patient self-reporting lack of dental care, patient use of psychiatric medications or a controlled substance, or if a patient has regular lab requirements.

At Pathways, primary care services are available at the Crisis and Residential Recovery Units which includes four locations.

Seven Counties Services has four primary care clinics. They also have a partnership with Norton's that allows them to place behavioral health providers alongside Norton primary care providers. Seven Counties has a primary care patient population that skews towards individuals with moderate to high behavioral health needs. They also employ nurses as Integrated Care Coordinators. Every new client is screened for medical and dental needs, and are offered a variety of referrals, both to external primary care providers and to their own primary care clinics. Additionally, their drop in TAYLRD site (Transitional Age Youth Launching Realized Dreams) is so close to their physical health clinic they can walk young people over to meet their physical

health needs if someone shows up with a physical health need.

Four of Kentucky's CMHCs are also Certified Community Behavioral Health Centers (CCBHC). In 2025, Kentucky opened up the CCBHC demonstration to eight additional applicants, six of which are currently CMHCs and two of which are BHSOs. By January of 2026, it is anticipated that Kentucky will have 10 CCBHCs. CCBHCs are required to provide primary care screening and monitoring services and to coordinate the provision of integrated primary and behavioral healthcare. The current CCBHCs have been successfully meeting these criteria.

Kentucky is a recipient of the 2023 SAMHSA PIPBHC grant. Through these funds, Kentucky has partnered with two CMHCs, LifeSkills, Inc. and Pennyroyal Center, to integrate bidirectional primary and behavioral health services. In Warren County, LifeSkills has partnered with a Federally Qualified Health Center, Fairview Community Health Center, to provide services. LifeSkills co-locates therapists within the FQHC for short term intervention therapies. LifeSkills and Fairview engage in bidirectional screening and referral services, social care coordination, and health data integration practices to offer collaborative and coordinated care. In Christian County, Pennyroyal is exploring multiple integration pathways, including establishing their own primary care clinic to offer enhanced primary care to individuals with SMI, SUD, and SED, as well as co-locating therapists within a rural health clinic to increase access to behavioral health care. Preliminary success stories indicate that integrated care is leading to improved social health outcomes, better management of behavioral health conditions, and more coordinated whole person care. Across both counties, health outcomes of focus include physical health outcomes especially for chronic diseases, behavioral health outcomes, social health outcomes, symptom management, risk factor reduction, functionality, utilization of care, screening and connection to care, and quality of care.

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

DBHDID provides and sponsors a variety of trainings and technical assistance throughout the year including Kentucky School of Alcohol and Other Drug Studies, Operation Immersion, Gambling Association Conference, and case management and peer support specialist conferences. Virtual and in-person trainings continue to be offered to support continuing education for providers. Educational offerings have included the Prevention Academy and the System of Care Academy along with trainings for peer support specialists, case managers, and for staff providing services to specific populations including individuals who are pregnant and/or parenting, Service Members, Veterans, and Family members (SMVF), and older individuals. DBHDID has also established the Community Behavioral Health Training Program which offers Mental Health First Aid (MHFA) trainings virtually. During SFY 2025, approximately 148 participants were trained in MHFA, and additional community-level trainings were delivered by trainers who have sustained efforts from previous years.

d. How the state provides integrated treatment for individuals with co-occurring disorders.

Individuals with co-occurring mental health, substance use, and intellectual/developmental disorders (IDD) are at higher risk for physical health conditions that may reduce quality and quantity of life.

There are three state-owned integrated specialty clinics for persons with intellectual and/or developmental disabilities. These three clinics are the Hazelwood Center in Louisville, the Lee Specialty Clinic in Louisville, and the Oakwood Community Center in Somerset. These centers provide a space for individuals with IDD to receive whole-person care.

At the Hazelwood Center, services include Primary Care, Dentistry, Psychiatry, Psychology, Neurology, Ophthalmology, Vital Stimulation Therapy, Spasticity Management, Scoliosis Management, Audiology, Physical Therapy, Occupational Therapy, Baclofen Pump Assessment and Management, Speech Therapy, Behavior Therapy, Medication Counseling, Nutrition Counseling, and Lab/EKG services. Intellectual and adaptive functioning evaluations and comprehensive behavioral assessments are services offered at Hazelwood. Based on those assessments, a range of interventions are developed ranging from support plans which provide the individual's basic needs to extensive and detailed positive behavior support plans designed to teach replacement behaviors and bypass challenging behaviors. As members of the interdisciplinary teams at Hazelwood, behavioral health

professionals collaborate to craft treatment plans to prepare Hazelwood residents to live successfully in a less restrictive environment in the community.

The Lee Specialty Clinic also offers similar services. These services include Developmental Medicine, Developmental Dentistry, Psychiatry, Neurology, Physical Therapy, Occupational Therapy, Speech and Language Pathology, Behavioral Analysis, Crisis Intervention, Ophthalmology, Podiatry, Audiology, and Nutrition. They also provide services or referrals for gynecology, gastroenterology, endocrinology, cardiology, prosthodontics, oral surgery, and periodontal surgery. The behavioral health team works closely with other providers in the clinic to offer holistic care coordination.

The Oakwood Community Center provides Autism Services, Mobile Crisis Team, Nutrition, Therapy Services, Behavioral Health, Developmental Dentistry, and Developmental Medicine. The care team operates in a similar, integrated fashion.

Additionally, DBHDID administers Medicaid waivers that support integrated care for the IDD population. The Supports for Community Living (SCL) waiver as well as the Michelle P. Waiver is part of Kentucky's 1915(c) Home and Community Based Services (HCBS) Medicaid waiver program. Both waivers provide assistance to individuals with IDD to help them live in the community as independently as possible. The SCL waiver has a residential component, whereas the Michelle P. Waiver is home-based community support only.

Some Federally Qualified Health Centers have employed psychologists to meet the growing needs of children in need of diagnosis and treatment for intellectual or developmental disabilities. Services are also done in coordination with school systems. Around 80% of school districts in Kentucky contract with external healthcare providers for a myriad of services which may include services for children with IDD conditions, primary care, and behavioral healthcare. However, individuals with co-occurring needs may have behavioral health conditions that cannot commonly be treated by most primary care providers. The Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs) are responsible for coordinating care and services for individuals with co-occurring needs. CMHCs and CCBHCs have various staff roles such as Integrated Care Coordinators, Targeted Case Managers, Care Coordinators, and more that are responsible for wrapping services around individuals with high-risk co-occurring needs. The care provided in primary care clinics that are situated within the CMHC or CCBHC is tailored specifically to address the needs of individuals with co-occurring behavioral health conditions. These clinics operate differently than traditional primary care: they are much more flexible and accommodating for missed appointments or walk ins which occur more often with populations that have behavioral health conditions; they offer much longer appointment times for individuals which allows them time to address multiple complex conditions; they are capable of providing medication assisted treatment for substance use disorder; and the care teams are much more informed and trained on interacting and treating patients with complex behavioral health conditions. These primary care clinics develop long-term relationships with patients who otherwise may not feel comfortable accessing physical healthcare services with other providers who may not be as familiar with their co-occurring behavioral health conditions.

Additionally, Kentucky Medicaid and Managed Care Organizations monitor evidence-based quality measures related to integrated care for individuals with serious mental illness or serious emotional disturbance. Integrated Healthcare Effectiveness Data and Information Set (HEDIS) measure categories include 1) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication, 2) diabetes monitoring for people with diabetes and schizophrenia, 3) cardiovascular monitoring for people with cardiovascular disease and schizophrenia, 4) metabolic monitoring for children and adolescents on antipsychotics, and 5) metabolic monitoring for children and adolescents on antipsychotics. Beginning in 2025 through the Center for Substance Abuse Treatment Learning Collaborative (Integration of Physical Health, Substance Use Services and Mental Health Care), DBHDID in collaboration with Medicaid are working on developing strategies for the ongoing monitoring of these HEDIS measures for integrated care access and quality, as well as for performance improvement.

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

- a) Adults with serious mental illness (SMI)
- b) Adults with substance use disorders
- c) Adults with SMI and I/DD
- d) Children and youth with serious emotional disturbances (SED) or substance use disorders
- e) Children and youth with SED and I/DD

a. Adults with serious mental illness

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

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

b. Adults with substance use disorders

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

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

c. Adults with serious mental illness and intellectual/developmental disabilities.

In Kentucky, care coordination for adults with co-occurring serious mental illness (SMI) and intellectual/developmental disabilities (I/DD) is delivered through multiple integrated service models tailored to individual complexity.

For individuals with high acuity and functional impairment, Assertive Community Treatment (ACT) teams provide intensive, team-based care coordination. ACT teams include licensed clinicians, peer specialists, and other professionals trained to support individuals with dual diagnoses. ACT fidelity standards require integrated dual disorder treatment (IDDT), ensuring that individuals with co-occurring SMI and substance use disorders receive coordinated support. As part of ongoing implementation improvements, ACT is also being leveraged to manage complex case work, particularly for individuals who present with both psychiatric and developmental needs. The state's clinical guidance encourages ACT teams to collaborate with developmental disability providers and guardianship representatives to support cross-system planning for individuals dually served.

Additionally, DBHDID, through the Division of Developmental and Intellectual Disabilities, operates several 1915(c) Home and Community-Based Services (HCBS) waivers—including the Michelle P. Waiver (MPW) and the Supports for Community Living (SCL) waiver—which provide care coordination for individuals with I/DD. These waivers support participants in accessing residential services, supported employment, behavioral therapies, and other long-term care services. For individuals with co-occurring SMI, CMHCs often coordinate with waiver case managers to ensure continuity and appropriateness of mental health supports alongside waiver-funded developmental services.

DBHDID also coordinates care for individuals with co-occurring SMI and I/DD through the Pre-Admission Screening and Resident Review (PASRR) process. Within DBHDID, the Division of Mental Health and the Division of Intellectual and Developmental Disabilities (DIDD) work collaboratively to review PASRR Level II evaluations for individuals being considered for nursing facility admission. When SMI is identified, clinical reviewers assess the individual's psychiatric and developmental support needs and provide recommendations to ensure services are delivered in the least restrictive, most integrated setting. DBHDID staff offer technical assistance to CMHCs and other providers to support implementation of these recommendations and ensure alignment with waiver services or diversion strategies as appropriate.

Care coordination is funded through a combination of Medicaid (including ACT and waiver services), state general funds, and federal block grant funds. Service intensity is determined by clinical and functional assessments, such as the Level of Care Utilization System (LOCUS). Cross-agency coordination—particularly between the Divisions of Mental Health and DIDD, CMHCs, and waiver case managers—is essential in managing complex transitions, avoiding institutional placement, and ensuring that individuals dually served receive person-centered, integrated support across systems.

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

Kentucky's youth and families have access to both Targeted Case Management and High-Fidelity Wraparound partnerships that are grounded in the principles associated with Person-Centered Planning, with a specific emphasis on the voices of family members in addition to the participating youth. High Fidelity Wraparound Facilitators are specifically trained to engage with families in a way that empowers families to build and own their plans. With the help of their High-Fidelity Wraparound Facilitator, families drive the work of the team and make decisions regarding team composition, meeting frequency and location, and goal development. No family's Wraparound plan is completed or amended without the youth and family present and participating.

There are also five Managed Care Organizations (MCOs) that assist with care coordination for the individuals who are covered by Medicaid insurance. Aetna SKY (Serving Kentucky Youth) is the single MCO that services children and youth in state custody. Aetna SKY offers three levels of care coordination for its enrolled youth, based on individual need:

- Population Health/Preventative Wellness

- Intensive Care Coordination
- Complex Care Coordination

e. Children and youth with SED and intellectual/developmental disabilities.

The care coordination models described above (i.e., targeted case management and high-fidelity wraparound) are available to youth with SED and co-occurring IDD. Additionally, children enrolled in Kentucky Early Intervention System (KEIS), the state's IDEA Part C initiative, receive service coordination, a team-based planning and review process ensuring identified needs of enrolled children and families are met either via KEIS programming or referrals to other services. All children served by KEIS have an identified developmental or intellectual disability and may have co-occurring SED.

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

DBHDID supports the provision of integrated services for individuals with co-occurring mental and substance use disorders through a combination of standardized screening tools, coordinated care models, and evidence-based treatment services delivered by Community Mental Health Centers (CMHCs) and other behavioral health providers.

Screening and assessment for co-occurring disorders occur at multiple entry points, including outpatient clinics, crisis response services, and targeted case management. Tools such as the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) and other validated screening instruments are used by CMHCs to identify both mental health and substance use concerns, triggering comprehensive biopsychosocial assessments and referrals to appropriate levels of care.

Integrated treatment is delivered through multiple pathways within Kentucky's behavioral health system. These include outpatient therapy, intensive outpatient programs (IOP), medications for opioid use disorder (MOUD), peer support services, and targeted case management, all of which are Medicaid-reimbursable and available statewide. Providers are encouraged to implement stage-wise interventions and motivational enhancement techniques consistent with integrated dual disorder treatment (IDDT) principles. While ACT teams are one provider type required to implement IDDT with fidelity, many CMHCs extend integrated care principles across additional service lines such as outpatient and residential levels of care.

Additionally, cross-training, technical assistance, and internal collaboration across mental health and substance use teams continue to support co-occurring capable care throughout the system. Integrated service planning—particularly in cases involving high acuity, chronic SUD, or risk of institutionalization—is increasingly emphasized through provider quality improvement efforts and contractual expectations, even in the absence of a statewide fidelity monitoring system.

As described in item 1.j. above, services and supports for youth with co-occurring mental health and substance use disorders are coordinated through the children's divisions within the CMHCs. This differs from the adult service system in that for adults, substance use treatment services, and supports are coordinated through CMHC SUD treatment divisions and adult mental health treatment is coordinated through mental health divisions. Providing services for youth with SUD or co-occurring mental health and SUD is complex due to their evolving developmental needs, as well as the need to include their support system or address their lack of supports.

Related to integrated services and supports for adults with co-occurring disorders, the description of the service system is also in item 1.j. above.

All CMHCs are required to provide American Society for Addiction Medicine (ASAM) assessments on all individuals with SUD and Level of Care Utilization System (LOCUS) assessments on all individuals with SMI. CMHCs also administer the Child and Adolescent Needs and Strengths to youth with child welfare and/or juvenile justice involvement and youth who are partnering in High Fidelity Wraparound. The Child and Adolescent Level of Care Utilization System (CALOCUS) and Early Childhood Service Intensity Instrument are also used to assist in determining level of care. Additionally, the eight iHOPE teams utilize the PRIME Screen tool and the Structured Interview for Psychosis Risk Syndromes (SIPS) to determine level of necessary care for young people referred to iHOPE teams. CMHC contracts include a requirement for an appropriate warm hand-off within 48 hours of determination that an individual is not appropriate for iHOPE services.

Many CMHCs utilize Integrated Dual Diagnosis Treatment (IDDT) as implemented based on SAMHSA's toolkit within the last decade. DBHDID staff have provided reviews utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) assessments with all CMHCs and most, if not all, CMHCs were determined to be co-occurring capable at that time. Workforce issues that have occurred during and after the pandemic requires DBHDID to reconsider assisting providers more closely with this work. The Division of Substance Use Disorder is the process of hiring a program administrator for co-occurring disorders. The Division of Mental Health already includes co-occurring program staff for children, youth and transition age youth. Work in this area continues.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

DBHDID supports the provision of integrated services for individuals with co-occurring mental health and

intellectual/developmental disabilities (I/DD) through a layered, cross-agency system that includes screening, assessment, coordination, and treatment planning. The system differs in structure and delivery mechanisms for youth versus adults, though it shares a common foundation of person-centered, community-based service values.

Adults:

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) delivers adult services through two collaborating divisions: the Division of Mental Health and the Division of Intellectual and Developmental Disabilities. These divisions work jointly to coordinate services and reduce system fragmentation for individuals with co-occurring SMI and I/DD.

Integrated supports include Assertive Community Treatment (ACT) for high-acuity individuals with SMI, with clinical guidance encouraging cross-system collaboration when developmental disabilities are also present. In some regions, ACT teams actively partner with I/DD case managers, guardianship staff, and waiver service providers to ensure alignment of psychiatric care and developmental supports. ACT teams also participate in interagency case conferencing and complex case review processes designed to resolve service access barriers and prevent institutionalization.

The 1915(c) Home and Community-Based Services (HCBS) waivers—such as the Michelle P. and Supports for Community Living waivers—include care coordination functions that can operate alongside behavioral health services. For those eligible, waiver case managers collaborate with Community Mental Health Centers (CMHCs) and other providers to support behavioral health engagement and stability.

In addition, the PASRR (Pre-Admission Screening and Resident Review) process is a formalized interagency mechanism that brings together DBHDID's two divisions to assess and determine appropriate care settings for individuals being considered for nursing facility placement. This process ensures that persons with SMI, I/DD, or both are screened and receive recommendations that reflect integrated, community-based alternatives whenever possible.

Youth:

Integrated services for youth with co-occurring behavioral health and developmental disabilities are anchored in Kentucky's System of Care framework. The Children's Mental Health and Recovery Services Branch is actively engaged in interagency collaboration that includes the Division of I/DD; Department for Public Health (Kentucky's IDEA Part C Lead State Agency), and the Department of Education. Services are structured to ensure that children and youth with dual diagnoses receive early identification, multi-disciplinary assessments, and coordinated plans of care across educational, clinical, and home-based settings.

Key mechanisms supporting integration include High-Fidelity Wraparound, which facilitates cross-system planning and family- and youth-driven service design. Youth eligible for SED and I/DD services are often served by multi-disciplinary teams in collaboration with school-based mental health professionals, early interventionists, community-based organizations, natural supports, I/DD case managers, and others as identified for inclusion by the youth and family. Additionally, Kentucky Early Intervention Services (KEIS), the state's IDEA Part C program (for ages 0–3) and the statewide Early Childhood Mental Health Program build early developmental and behavioral screening capacity within provider agencies; early care and education settings; preschools, and pediatric care.

Specific to youth who are in the child welfare system, Kentucky's Children's Review Program (CRP) contributes to identifying and triaging youth with complex needs, facilitating referrals to appropriate placement and care coordination services. For youth with co-occurring disorders who require residential levels of care, Kentucky ensures cross-agency review of placement and treatment planning to avoid unnecessary institutional care and prioritize family-based or community-based supports.

Cross-Cutting Supports:

Across age groups, DBHDID emphasizes co-occurring competence in service delivery and supervision, with training provided to both behavioral health and I/DD providers to increase clinical understanding of dual diagnoses. Technical assistance is provided through complex case workgroups, provider consultation, and interagency guidance documents. Additionally, DBHDID supports inter-branch collaboration on workforce development strategies to ensure that clinical teams are prepared to engage individuals across diagnostic boundaries and support whole-person resilience and recovery.

8. Please indicate areas of **technical assistance needs** related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED]*. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

- 1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care (CSC) based on the Early Assessment and Support Alliance (EASA) model. Kentucky’s CSC teams are called iHOPE (Helping Others Pursue Excellence).	8.00
	0.00
	0.00

	0.00
	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,434,501.00	1,434,501.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Kentucky iHOPE teams utilize Medicaid and other private insurances for services provided to iHOPE participants in addition to funds from DBHDID to support those individuals who are uninsured or underinsured. Currently, there is no Medicaid bundled rate for CSC in Kentucky. iHOPE teams can bill Medicaid for a variety of CSC services, including screening, assessment, person-centered treatment planning, individual/group/family therapy, peer support, targeted case management, and prescriber services as individual services delivered. While the Kentucky Office of Vocational Rehabilitation funds some short-term services for supported employment, Kentucky Medicaid does not cover supported employment/education services; thus, the longer-term supports needed for this population do not have a payor source for reimbursement. Kentucky Medicaid recently received approval for a 1915(i) state plan amendment that will include coverage of supported employment/education for eligible individuals with serious mental illness. However, this new package of services is in early stages, and it is yet unclear how those services will impact young people experiencing their first episode of psychosis. Kentucky's CSC model includes occupational therapy for participants who need this service. Kentucky Medicaid covers occupational therapy services, but NOT through the behavioral health network. There are currently three iHOPE sites that are located within a Certified Community Behavioral Health Clinic (CCBHC). For CCBHCs, occupational therapy can be a reimbursable service. IHOPE sites not connected to a CCBHC can utilize mental health block grant funding to assist with securing occupational therapy assessments and services for their participants who need them. Advocacy regarding occupational therapy will continue. Four additional CMHCs with existing iHOPE teams are also applying to enter the CCBHC expansion effort which will be effective January 2026. Kentucky has implemented Multi-Family Group Therapy (MFG) as the family psychoeducation model for CSC teams. This evidence-based practice combines components of psychoeducation with family and group therapy models. While psychotherapy is a covered service through Kentucky Medicaid, the service definition does not fit the MFG model. iHOPE teams are providing MFG, and most are billing individual/group/family therapy. Kentucky's CSC model also relies strongly on outreach, which is not currently billable but is covered under the CCBHC expansion grant overhead. IHOPE teams that are not CCBHCs are encouraged to utilize mental health block grant funds to provide community outreach, aiming to identify these young people early in their illness progression.

Most private insurances only cover therapy and prescriber services. iHOPE teams are encouraged to utilize block grant funds to cover any needed services not covered under Medicaid/private insurance, or for individuals experiencing a first episode of psychosis that may be uninsured.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

Kentucky utilizes implementation science as outlined by the National Implementation Research Network throughout the execution of the first episode of psychosis (FEP) programming. Kentucky is implementing the Early Assessment and Support Alliance (EASA) model of Coordinated Specialty Care (CSC). Kentucky has been utilizing EASA for technical assistance since the inception of iHOPE, as Oregon and Kentucky have similar state and local behavioral health care systems. EASA continues to provide monthly consultation to each Kentucky CSC team as well as to the state FEP team. EASA also hosts a multi-state learning collaborative in which Kentucky participates. iHOPE Practice Guidelines are embedded in each provider contract and are modeled directly from EASA's Practice Guidelines for CSC. In addition to a public website that includes detailed information for providers, states, and participants, EASA provides virtual training opportunities for all CSC programs. Kentucky partnered with EASA to develop several introductory CSC training modules, which are now available on the EASA website for all providers. In addition, EASA has provided training in the Structured Clinical Interview for DSM-5 (SCID-5) and Multi-Family Group Therapy, as well as other offerings, via virtual formats.

Several evidence-based practices are being utilized in the implementation of ESMI/FEP programming, and are included in the overall evidence-based practice of CSC, including:

- Individual Placement and Support (IPS) Model of Supported Employment/Supported Education integrates the IPS model of Supported Employment with Supported Education to ensure that young people with early serious mental illness (ESMI), including those experiencing a first episode of psychosis (FEP), are supported in achieving meaningful roles in their communities. IPS is an evidence-based model that emphasizes rapid job search and placement aligned with individual preferences, integrated with

behavioral health treatment, and extended into post-secondary educational supports. CSC teams collaborate directly with IPS specialists to align vocational and academic goals with person-centered treatment plans, empowering participants to pursue recovery through purposeful engagement in work and school.

- Person Centered Planning is foundational to all services delivered through iHOPE. CSC teams are trained to use strengths-based planning approaches that prioritize participant voice, choice, and autonomy. This includes identifying individualized recovery goals related to wellness, relationships, education, and employment, while ensuring flexibility in service delivery as youth and young adults transition through stages of engagement, stabilization, and recovery. The person-centered approach helps align all elements of the CSC model, including medication management, therapy, peer support, and care coordination, with the specific aspirations and developmental needs of each participant.
- Targeted Case Management is embedded in CSC service delivery through the iHOPE model to provide comprehensive coordination of care. Each youth or young adult served by a CSC team is assigned a case manager who is responsible for facilitating access to needed medical, behavioral health, social, and educational supports. TCM services are delivered in accordance with Medicaid regulations and are tailored to the unique needs of individuals experiencing early psychosis. Case managers act as liaisons across multiple systems—school, vocational, healthcare, housing—ensuring continuity of care, reducing service fragmentation, and helping individuals navigate complex systems during critical early stages of illness.
- Youth Peer Support assists with participant engagement and goal identification. Some CSC teams also have Family Peer Support Specialists to assist with family engagement when working with young people.
- Specialized Screening and Assessment Tools to support specific first episode of psychosis programming and include the PRIME Screen, the Structured Clinical Interview for DSM-5 (SCID-5), and the Structured Interview for Psychosis-Risk Syndromes (SIPS). These provide CSC teams, as well as other outpatient clinic staff, with more accurate screening, assessment and treatment for youth and young adults that experience early psychosis.
- Cognitive Behavioral Therapy for Psychosis (CBTp) provides CSC teams as well as other outpatient clinicians, specific skills to utilize when providing treatment to youth and young adults that experience early psychosis.
- Recovery Oriented Cognitive Therapy (CT-R) is a model in the beginning stages of implementation in Kentucky. It is a treatment approach designed to promote empowerment, recovery and resiliency in individuals with serious mental illness, including early serious mental illness.
- Multi-Family Group Therapy (MFG) offers educational and supportive sessions for multiple families simultaneously, focusing on specific diagnostic categories. The practice can be modified to work with one family at a time.

5. Does the state monitor fidelity of the chosen EBP(s)? ☒ Yes ☐ No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☐ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracts with eight CMHCs to provide CSC through the iHOPE program. Contract deliverables for these agencies include requirements for rapid access to care within the team (within 48 hours of referral) as well as fast access (within 7 days of admission) to a prescriber. DBHDID contracts with the University of Kentucky Human Development Institute (UK/HDI) to operate a data platform specifically for iHOPE teams, which is capable of collecting client-related demographic and outcome data. This data platform is in early stages and will inform additional training, technical assistance, outcomes, and fidelity monitoring needs. DBHDID also contracts with UK/HDI for fidelity support and to provide specialized training and coaching based on assessment results.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

SFY 2026:

- Continue ongoing state-level technical assistance and national consultation and training with the Early Assessment and Support Alliance (EASA) for all iHOPE teams, as well as for agencies without iHOPE to increase capacity for this population.
- Increase Cognitive Behavior Therapy (CBT) and Recovery Oriented Cognitive Therapy clinical competency for iHOPE teams by providing additional foundational and issue-specific CBT training courses in a virtual format.
- Strengthen provider diagnostic skills through continued implementation of SCID-5 training and technical assistance as well as the available use of the NetSCID, which is an electronic version of the SCID-5.
- Continue collaboration with the Kentucky Occupational Therapy Association (KOTA) to increase access to local occupational therapists for iHOPE teams, and to advocate for inclusion of this service into behavioral health programming.
- Provide specialized training and consultation for iHOPE prescribers.
- Continue data collection in collaboration with UK/HDI and continue analyzing data to inform on access and outcome issues.
- Continue enhancing fidelity processes in collaboration with UK/HDI.
- Continue learning opportunities for this specific population to a broader audience to enhance statewide capacity.
- Continue regular statewide meetings with iHOPE teams and with all agencies.
- Continue regular team-based and state-level consultation with EASA and other partners.
- Continue regular trainings/refreshers on screening/assessment tools.

SFY 2027:

Kentucky allocates funds and plans accordingly per the state fiscal year. The plans above will be continued through SFY 2027, and

additional plans will be created as needed following funding updates and as identified through data analysis and consultations/statewide meetings.

9. Please list the diagnostic categories identified for each of 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 ESMI/FEP, including individuals with the diagnoses of schizophrenia spectrum and other psychotic disorders, and other psychotic and affective diagnoses that include psychosis as identified in the DSM-5. (Delusional Disorder, Brief Psychotic Disorder, Schizoaffective Disorder, Schizophreniform Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Other Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder with psychotic features, and Bipolar I with psychotic features). Kentucky's CSC eligibility criteria include youth and young adults who have experienced a first episode of psychosis within the last year.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

Kentucky estimated the FEP incidence rate by using 2023 Census data and utilizing the incidence rate of .03% of the general population, the incidence rate for FEP established through the OnTrack NY study and published on September 1, 2013. (Jennifer L. Humensky, Ph.d., Lisa B. Dixon, M.D., M.P.H., and Susan M. Essock, Ph.D., State Mental Health Policy: An Interactive Tool to Estimate Costs and Resources for a First Episode Psychosis Initiative in New York State. Accessed online at <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201300186>

Kentucky has the following estimates of FEP incidence Statewide: 1,356 individuals per year. See the chart uploaded as an attachment to this section for regional estimates by CMHC.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Kentucky's state FEP team will continue to provide ongoing technical assistance in this area with help from EASA and other partners. Effective outreach initiatives will be targeted, focusing on larger-scale efforts, including, but not limited to, the use of social media.

While the state FEP team will continue to focus on outreach and engagement efforts statewide with both child (including transition age youth) and adult systems of care, immediate plans include outreach and engagement efforts within the adult system of care to include crisis stabilization centers, emergency departments, colleges and universities, primary care providers, urgent treatment centers, etc. iHOPE teams will have support in creating consistent points of contact with the state and local hospitals in their regions and to streamline the identification and referral process for individuals with FEP in their areas.

12. Please indicate area of technical assistance needs related to this section.

None at this time.

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Footnotes:

Kentucky allocates funds on an annual basis. SFY 2027 allocation estimates are based on SFY 2026 allocations.

Kentucky Community Mental Health Centers 2023 Census Population Chart Kentucky State Data Center Per Year Estimated Incidence Rates for First Episode Psychosis		
CMHC	Total Pop	.03% national per year incidence estimate for FEP*
Four Rivers	196,917	59
Pennyroyal Center	214,196	64
River Valley	214,425	65
LifeSkills	320,370	96
Communicare	283,756	85
Seven Counties	1,024,079	307
NorthKey	474,262	142
Comprehend	55,751	17
Pathways	133,070	40
Mountain	136,501	41
Kentucky River	103,030	31
Cumberland River	227,785	68
Adanta	208,276	62
New Vista	840,347	252
Kentucky	4,519,233	1,356

(Jennifer L. Humensky, Ph.d., Lisa B. Dixon, M.D., M.P.H., and Susan M. Essock, Ph.D., State Mental Health Policy: An Interactive Tool to Estimate Costs and Resources for a First Episode Psychosis Initiative in New York State. Accessed online at <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201300186>

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from <https://acl.gov/news-and-events/announcements/person-centered-practices-resources>

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

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

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

Kentucky has an active Behavioral Health Planning and Advisory Council (BHPAC) that includes many individuals with lived experience and family members and parents of individuals with lived experience, including SMI and SED. By regulation, membership must comprise at least 51% of individuals or their family members with lived experience. Council meetings throughout the year offer opportunities for open communication about behavioral health services across the state. New and existing programming provides presentations to BHPAC regarding services, rationale, and receives input and guidance on needs.

Kentucky also has a very active State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) that consists of partners from child serving agencies and organizations across the state, a parent representative, a transition-age youth (age 16 – 25) representative, and a family-run organization (full description in Environmental Factor #6 MHBG Criterion 1). This statutorily mandated group meets monthly and is engaged in Phase I of creating a comprehensive, multi-perspective Children's Behavioral Health Plan (CBHP) to support state agencies in developing services and supports that are available and accessible across the state and regardless of how or through what agency the child, youth, and family enter the system of care. In 2025, SIAC is focusing on three priority areas, which are organized into three workgroups that report their progress to SIAC every quarter. The output of these workgroups will drive Phase II of CBHP and inform SIAC's next steps in incorporating these efforts into its strategic plan. Family members and transition-age youth with lived mental health and/or substance use experience are members of not only the SIAC but also each of the workgroups, as well as ad hoc committees that are established based on need. The SIAC serves as the governing body of Kentucky's System of Care, and youth and parent leaders have an active voice in policies, budgets, services, and supports for those with or at risk of behavioral health disorders in Kentucky.

In addition, the Division of Mental Health (DMH) employs several individuals with lived experience who are involved in programming decisions and bring a wealth of knowledge regarding engagement, treatment, and recovery for youth and adults with behavioral health disorders. DBHDID also contracts with multiple consumer and family advocacy organizations to provide leadership training and coaching for adults, families, and youth, as well as professional development opportunities focused on family and youth engagement for both agency staff and individuals with lived experience, including SMI. They also provide consultation regarding services and programming across the state.

Although language differs by specific population, required elements of PCP and shared decision making are included in provider contracts for all persons with SED, SMI and SUD served statewide. CMHC contracts include definitions (e.g., System of Care language for family-guided and youth-driven planning for children and youth with SED; Recovery Oriented System of Care language for SUD; PCP language for adults with SMI) and expected deliverables and CMHC staff are trained in the PCP behavioral health model.

Through the behavioral health PCP model, specified for providers serving adults with SMI, individuals seeking services are encouraged to include family members, supporters, and other identified community members in their treatment planning process. Goals are defined in the individual's own words, strengths are assessed and incorporated into strategies for addressing goals, and goals and objectives are written in recovery-oriented, person-first language. This model ensures the client and family/supporters are active members of the treatment planning, signifying the collaborative effort between providers and individuals seeking care. Although treatment plans have client signatures, their signature alone is not the only way to demonstrate active participation. This PCP model ensures simple language, agreed upon with the client, with a clear understanding of how each service provided seeks to address an identified goal/objective in the plan. Additionally, peer specialists are included on treatment teams to enhance client engagement and facilitate active client participation in setting goals and developing strategies for achieving them.

The Adult Mental Health and Recovery Services Branch within DMH employs a program administrator to oversee the implementation of the behavioral health model of PCP for providers who serve adults with SMI. Through this branch, statewide training and coaching efforts are coordinated as well as contract monitoring. Utilizing a fidelity tool, developed for this purpose, treatment plan documentation is reviewed for each CMHC region to determine regional strengths and areas for continued coaching.

In Kentucky, services and supports for families and youth with behavioral health needs are established as part of Kentucky's System of Care. The System of Care values align with those of Person-Centered Planning, specifically in that the approaches are family-driven and youth-guided. Within the System of Care, a specific strategy is the support of High-Fidelity Wraparound partnerships for youth and families with high service intensity needs. Wraparound is based on key principles that include a foundational emphasis on family strengths and the voice and choice of families and youth. Families determine the membership of the wraparound team and have the final say on the goals and interventions. In addition, all targeted case managers in Kentucky are taught Wraparound principles as part of their initial training. The values associated with Person-Centered Planning are infused throughout Kentucky's child and youth-serving behavioral health system.

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

During SFY 2025, DBHDID hired a national consultant to train CMHC/DBHDID staff on the concepts of Person-Centered Planning for behavioral health treatment, explicitly focusing on solidifying service delivery into a recovery-oriented, shared decision-making service system based on the strengths of each individual. This project originated as part of the 2013 Settlement Agreement entered into with Kentucky Protection and Advocacy, concerning adults with SMI residing in personal care homes and transitioning to community living. Person-centered planning was a requirement in the Settlement Agreement, and DBHDID chose to educate and train all providers. The Division of Mental Health (DMH) worked with CMHCs to identify lead trainers in each region for training and continuing consultation. This "train the trainer" model was incorporated in the four state psychiatric hospital catchment areas across the state, with identified regional leads from each CMHC attending two-day training events to learn principles and processes.

Embedded in this training and consultation was technical assistance on how to structure the treatment planning process in a way that was person-centered while also meeting medical necessity needs. In addition, other partners were trained in this model, including Kentucky Protection and Advocacy, the Department for Aging and Independent Living (DAIL), the Department for Community Based Services (DCBS), the Department for Medicaid, and the contracted Managed Care Organizations (MCOs). Person-centered training has occurred multiple times since the 2013 settlement agreement, and DBHDID provides training tailored to current workforce needs at community mental health centers. A Person-Centered Planning fidelity tool was created, and DMH staff monitor the person-centered planning process across the state by reviewing plans that utilize this tool. In SFY 2025, the fidelity tool was updated and replaced with a new version, the New England Mental Health Technology Transfer Center's Person Centered Recovery Planning (NMH PCRP Q1 Tool). The new tool offers numerous improvements, including a significantly simplified scoring structure. In April 2025, DBHDID, along with our PCP training contractor, provided statewide training on the new tool (NMH PCRP Q1 Tool) to all targeted case manager supervisors across Kentucky's community mental health centers.

For individuals receiving services for SUD, the Division of Substance Use Disorder (DSUD) provides training and technical assistance to enhance client care by focusing on the key concepts inherent in a Recovery Oriented System of Care. Those concepts include ensuring service planning is person-centered, self-directed, strengths-based, and participatory, involving family members, caregivers, significant others, friends, and community partners identified by the client.

As stated above, Kentucky's youth and families have access to both Targeted Case Management and High-Fidelity Wraparound partnerships, which are grounded in the principles associated with Person-Centered Planning. This approach places a specific emphasis on the voices of family members, in addition to the participating youth. High Fidelity Wraparound Facilitators are specifically trained to engage with families in a way that empowers families to build and own their plans. With the help of their High-Fidelity Wraparound Facilitator, families drive the team's work and make decisions regarding team composition, meeting frequency and location, and goal development. No family's Wraparound plan is completed or amended without the youth and family present and participating.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as [A Practical Guide to Psychiatric Advance Directives](#))?

Kentucky has a state statute, "Advance Directives in Mental Health Treatment" (KRS 202A.420 – 432), governing the use of advance

directives for this population. This statute was enacted in 2003 as a result of an advocacy movement led by individuals with lived experience and a statewide legislative advocacy group. During that time, the Division of Mental Health (DMH) partnered with the individuals who championed this effort and created a brief video, explaining the new law and providing information about the process of developing advance directives for mental health care. This video was created in a partnership with Kentucky's Protection and Advocacy, as well as the National Alliance on Mental Illness and a statewide consumer organization. As peer support became a recognized service, peers and providers across the state were educated about psychiatric advance directives through this video. Adult peer support certification training also includes a curriculum requirement for education on psychiatric advance directives.

In addition, as DMH implemented Wellness Recovery Action Planning (WRAP) for individuals with SMI, training included teaching peer specialists how to assist in creating these advance directives, which in WRAP planning is very similar to a WRAP crisis plan. Since that time, language encouraging providers to assist individuals receiving behavioral health services has been included in many Medicaid and DBHDID regulations. The law stipulates that a provider for an individual cannot be listed as a surrogate or witness to an advance directive. However, providers are encouraged to assist adults in creating these plans, primarily through the assistance of peer support specialists. Even though the title of the statute is Advanced Directives for Mental Health Treatment, many adults with co-occurring SUD have been able to utilize the forms and process to assist with their treatment as well.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in [42 U.S.C. § 300x-5](#) and [42 U.S.C § 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\(g\)](#), there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and 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?

All contracts that involve federal funds include specific written guidelines relevant to each specific grant (e.g. block grants). All reporting documents also include these written guidelines along with more specific programmatic guidelines relevant to each specific grant. All provider Chief Financial Officers (CFOs), and financial staff from additional agencies, communicate regularly with a DBHDID financial liaison to address questions related to expending and reporting federal funds. Additionally, the DBHDID Commissioner convenes regular meetings with CMHC Chief Executive Officers (CEOs) where any issues, programmatic or financial, can be addressed.

DBHDID utilizes the Division of Program Integrity, to support quality and safety standards among all facilities and programs managed by DBHDID.

The Division of Program Integrity (DPI) oversees critical organizational functions for DBHDID, including the following:

- Regulation/legislative review;
- Business information/intelligence gathering, analysis, and reporting;
- Contract monitoring;
- Risk Management;
- Training support and facilitation; and
- Oversight and monitoring for a statewide network of certified and licensed SUD programs.

Within this Division are three branches – the Data Analytics Branch, the Program Support Branch, and the Substance Use Disorder Program Licensure Branch.

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

Program Support Branch: This branch is composed of four primary work units:

- **Contract Monitoring** - The Contract Monitoring team administers the process to assist in assuring delivery of specified goods and services in the manner contractually specified in contracts each year. Reported results provide accountability to DBHDID and their contracted vendors and offer an opportunity for improvement in future policy and resource allocation decisions. Contract monitoring also improves the quality of the contract content by proposing appropriate revisions that are written in more measurable and objective descriptions of specified goods and services.
- **Education/Event Coordination** - The Educational and Events Coordination team coordinates and implements DBHDID-wide events and trainings which include continuing education units and are open to the general public. Determinations are issued on provider training curricula for Community Support Associates, Peer Support Specialists and Targeted Case Managers to work in agencies to provide these specific services.
- **Risk Management and Mortality Reviews** -The Risk Management team oversees incidents that occur in state facilities involving individuals served. Risk management includes the components of effective abuse protection recommended by the Centers for Medicare & Medicaid Services (CMS); incident investigation; tracking and trending of incidents; incident data analysis; and implementing effective actions to protect from harm those individuals served.
- **Legislation/Regulations** - The Legislation/Regulations team is responsible for the drafting and amendment of administrative regulations. Additionally, this team processes open records requests and citizen complaints.

Each work unit in the Program Support Branch is led by a Team Leader, and staff work cooperatively with other Divisions within DBHDID to ensure delivery of high-quality products, accountability, and transparency that are representative of the DBHDID commitment to effective delivery of behavioral health, developmental and intellectual disability services to Kentuckians.

Substance Use Disorder Program Licensure Branch: This branch brings together the DBHDID Driving Under the Influence (DUI) Program, Narcotic Treatment Programs (NTPs), and the licensure of Alcohol and Other Drug Treatment Entities (AODEs). The DUI program is responsible for monitoring and regulating the statewide network of DUI programs licensed and certified to provide alcohol and other drug assessments, education, and treatment services to persons convicted of DUI. The NTP Program is responsible for the oversight and regulation of the NTPs across the Commonwealth that are licensed to provide medication-assisted treatment for individuals with an opioid use disorder. The AODE licensure program oversees the outpatient and residential substance use disorder treatment facilities that are licensed, regulated, and inspected annually. The responsibility of AODEs was transferred to DBHDID in April of 2023.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):
 - a) ☒ Data on consequences of substance-using behaviors
 - b) ☒ Substance-using behaviors
 - c) ☒ Intervening variables (including risk and protective factors)
 - d) ☐ Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - a) ☒ Children (under age 12)
 - b) ☒ Youth (ages 12-17)
 - c) ☒ Young adults/college age (ages 18-26)
 - d) ☒ Adults (ages 27-54)
 - e) ☒ Older adults (age 55 and above)
 - f) ☒ Rural communities

i) ☒ Other (please list)

Service members, Veterans, and Families; farm families.

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

a) ☒ Archival indicators (Please list)

Census Data

b) ☒ National survey on Drug Use and Health (NSDUH)

c) ☒ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☒ Youth Risk Behavioral Surveillance System (YRBS)

e) ☒ Monitoring the Future

f) ☐ Communities that Care

g) ☒ State-developed survey instrument

h) ☒ Other (please list)

1. Kentucky Violent Death Reporting System
2. CDC Wonder
3. Kentucky State Police Data
4. Kentucky Center for School Safety
5. Kentucky Poison Control
6. Kentucky Injury Prevention & Research Center
7. County Health Rankings
8. Kentucky Kids Count
9. Kentucky Office of Drug Control Policy
10. Kentucky Office of Vital Statistics
11. Prevention Data System
12. Kentucky Incentives for Prevention (KIP)
13. Client Data, Community Mental Health Centers

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds?



Yes



No

a) If yes, (please explain in the box below)

b) If no, please explain how SUPTRS BG funds are allocated:

SUPTRS BG funds are allocated to the 14 regional prevention centers housed within Kentucky's community mental health centers (CMHCs), which serve all 120 Kentucky counties. Funds are allocated based on a historical formula that considers the population served by each CMHC.

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ☒ Yes ☐ No
 - a) If yes, please describe.

All RPC staff are required to become certified prevention specialists within three years of their hire date. The Kentucky Certification Board for Prevention Professionals (KCBPP) determines whether individuals have met the knowledge, training, and educational requirements for the individual to sit for the Certified Prevention Specialist (CPS) exam through the International Certification and Reciprocity Consortium (IC & RC). The Board is composed of representatives from the substance use 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 alcohol, tobacco and other drugs (ATOD) prevention experience, and a passing score on the IC & RC examination. Not only does certification enhance the field of substance use prevention, but it also assures the quality of service to the individuals and communities served by approximately 80 certified prevention specialists across the Commonwealth. Quality of services, competence, professional growth, ethical conduct, and continuing education are all benefits of certification. All state-level staff must meet the same certification requirements as contracted providers.
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ☒ Yes ☐ No
 - a) If yes, please describe mechanism used.

Training: The training needs of prevention providers are assessed on an annual basis, and a plan is developed to ensure that the training delivery matches the needs of the community-level providers. DBHDID accesses national-level technical assistance through the Prevention Technology Transfer Center, Community Anti-Drug Coalitions of America (CADCA), online courses, and webinars. Trainings are chosen or developed to promote evidence-based prevention, including utilizing the Strategic Prevention Framework (SPF),

DBHDID has developed an onboarding system that includes the Kentucky Substance Use Prevention Skills (KSUPS) training, a four-day comprehensive, hands-on prevention training adapted from the national Substance Abuse Prevention Skills

Training (SAPST) and facilitated by Branch staff as well as the Prevention Academy. Prevention Academy consists of a series of online training courses focusing on prevention topics, such as the history of prevention, substance-specific information, brain development, environmental strategies, and the six CSAP strategies. The trainings were developed specifically for Kentucky and feature national prevention experts as well as Branch subject matter experts. All new prevention staff members must complete both KSUPS and Prevention Academy within 18 months of hire.

DBHDID accesses national-level subject matter experts and technical assistance providers, such as the Prevention Training and Technical Assistance Center (PTTC), to support the delivery of training and technical assistance to prevention providers and their key stakeholders at the community level.

Kentucky Prevention Network Annual Conference is held in the fall of each year and focuses on evidence-based prevention strategies and emerging issues in substance use prevention. The statewide prevention network also offers virtual trainings in the spring to support prevention providers.

Prevention Ethics is delivered virtually twice a year to prevention providers to support certification. DBHDID has internal trainers for the curriculum. Trainers have completed Advanced Prevention Ethics training and began offering the training in FFY 2025.

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

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

a) If yes, please describe mechanism used.

All RPCs are required to assess community readiness for each community they serve. Each local provider completes a readiness assessment during the needs assessment process utilizing the Tri-Ethnic Community Readiness Model. REACH Evaluation provides additional analysis support is provided through the evaluation contract for the prevention portion of the Block Grant. RPCs include the readiness components in their work plans, which are monitored by state staff.

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? ☐ Yes ☒ No
If yes, please attach the plan in WebBGAS
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?
☐ Yes
☐ No
☒ Not applicable (no prevention strategic plan)
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
 - b) ☐ Timelines
 - c) ☐ Roles and responsibilities
 - d) ☐ Process indicators
 - e) ☐ Outcome indicators
 - f) ☒ Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ☒ Yes ☐ No
 - a) Does the composition of the Advisory Council represent the demographics of the State? ☒ Yes ☐ No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ☒ Yes ☐ No

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

Kentucky's prevention evaluation contractor worked with the evidence-based workgroup to develop criteria for determining if strategies are evidence-based, evidence-informed, or lack evidence of effectiveness. Workgroup members utilize evidence-based ratings from lists compiled by the Centers for Disease Control (CDC), Department of Justice (DOJ), etc. to determine effectiveness. They also compare similar strategies to those that have been found effective to determine if they are recommended. For example, strategies around limiting advertising for alcohol and nicotine products to reduce underage use might be recommended for locations that have legalized recreational cannabis.

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The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders on individuals families and communities.
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) ☐ SSA staff directly implements primary prevention programs and strategies.
 - b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) ☒ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) ☒ The SSA funds regional entities that provide training and technical assistance.
 - e) ☒ The SSA funds regional entities to provide prevention services.
 - f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
 - g) ☐ The SSA funds community coalitions to provide prevention services.
 - h) ☐ The SSA funds individual programs that are not part of a larger community effort.
 - i) ☐ The SSA directly funds other state agency prevention programs.
 - j) ☐ Other (please describe)
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
RPCs (contracted providers) utilize SUPTRS primary prevention funds to distribute information about substance use and potential consequences, information for parents on discussing substance use with youth, strategies to reduce substance use, and risk and protective factors related to substance use. They provide this information through media campaigns, including social media, tabling at local events, brief informational programs, etc.
 - b) Education:
SUPTRS funding helps promote and provide evidence-based programming, such as Too Good for Drugs, Prime for Life,

and Tobacco Retail Underage Sales Training (TRUST).

c) Alternatives:

SUPTRS funding is not generally used for alternatives, but contracted providers may utilize time for planning of community alternative events such as Project Prom and Project Graduation, mentoring programs, etc.

d) Problem Identification and Referral:

Prevention providers currently conduct the Zero Tolerance program – a screening and education program for youth who have a charge related to driving with a .02-.08 Blood Alcohol Level. If the screening reveals that a youth may need services beyond education, they are referred to treatment providers for assessment. Otherwise, the youth participate in the evidence-based program, Prime for Life. Contracted providers work with schools to promote screening for youth who have policy violations related to substance use, followed by referral to appropriate services.

e) Community-Based Processes:

Contracted providers and state-level staff provide technical assistance and training on coalition building, stakeholder engagement, policy development, military culture, and the strategic prevention framework to prevent or delay the initiation of substance use among youth and adults and reduce the consequences of all substances across the lifespan.

f) Environmental:

Contracted providers utilize SUPTRS funding to promote social host ordinances, smoke and vape-free communities, alcohol compliance checks, tobacco compliance checks, point of sales strategies for tobacco, sticker shock, responsible beverage server training, alcohol and tobacco environmental scans, Sources of Strength, and other environmental strategies.

- 3.** Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?



Yes



No

a) Yes (if so, please describe)

DBHDID employs a program administrator who regularly reviews all expenditures charged to prevention funds to ensure they are utilized for primary prevention not funded through other means. Any irregularities are identified, and the chief financial officer (CFO), who oversees the RPC, corrects any funding errors.

In addition, each provider contract includes the federal requirements for the use of block grant funds, and a specific funding code is used to designate ONLY primary prevention dollars.

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

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ☐ Yes ☒ No
If yes, please attach the plan in WebBGAS
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 prioritized benchmarks
 - b) ☐ Includes evaluation information from sub-recipients
 - c) ☐ Includes 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 describe):
 - g) ☒ Not applicable/no prevention evaluation plan
3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:
 - a) ☒ Numbers served
 - b) ☒ Implementation fidelity
 - c) ☐ Participant satisfaction
 - d) ☒ Number of evidence based programs/practices/policies implemented
 - e) ☒ Attendance
 - f) ☒ Demographic information
 - g) ☒ Other (please describe):

1. Activity Type
2. IOM intervention type (universal direct, universal indirect, selective, indicated)
3. Staff Time
4. Partners
5. CSAP strategy

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc
- b) ☒ Heavy alcohol use
- c) ☒ Binge alcohol use
- d) ☒ Perception of harm
- e) ☒ Disapproval of use
- f) ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- g) ☒ Other (please describe):

1. Risk factors (suspension, weapons, drug sales, car theft, aggression)
2. Age of onset
3. School safety
4. Problems at school
5. Mental health
6. Accessibility
7. Lifetime use
8. Bullying
9. Violence
10. Extracurricular activities/school connectedness
11. Sleep
12. Social media use

Footnotes:

Environmental Factors and Plan

6. 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, resilience-based, comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI), children, youth and transition aged youth, including those with serious emotional disturbance (SED) and their families, and adults and youth with co-occurring substance use disorders (SUD), through contracts with Kentucky's Regional Boards, also known as Community Mental Health Centers (CMHCs). DBHDID is Kentucky's designated State Mental Health Authority (SMHA). According to Kentucky Revised Statute (KRS) 194.030, DBHDID is designated as the primary state agency responsible for developing and administering programs to prevent, detect, and treat mental health disorders.

Kentucky is divided into 14 geographic regions for the purposes of planning and providing publicly funded community mental health, substance use and prevention services. Together, the 14 Community Mental Health Centers (CMHCs) serve all 120 Kentucky counties. A Regional Board has been established, pursuant to KRS 210.370 – 210.480, as the planning authority for behavioral health programs in each region and is an independent, non-profit organization governed by a volunteer board of directors that broadly represents stakeholders and counties in their region and is licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center."

CMHCs are charged, statutorily, with providing at a minimum the following services:

- a. Inpatient services (generally by referral);
- b. Outpatient services;
- c. Partial hospitalization or psychosocial rehabilitation services;
- d. Emergency services;
- e. Consultation and education services; and
- f. Services for individuals with an intellectual disability.

DBHDID works with Kentucky Department for Medicaid Services so that basic services, like outpatient and rehabilitation services, are available with similar service requirements for both Medicaid and non-Medicaid eligible individuals.

DBHDID contracts with 14 private, not-for-profit CMHCs to provide services to individuals in all 120 counties in the state. CMHCs are required to describe, in detail, their current system of care for children, youth, and transition-aged youth, including those with SED, and for adults with SMI, and to submit their plans for development regarding key system components, within the annual Plan and Budget process.

For adults with SMI, these key components include: individuals in recovery/family involvement; continuity of care; targeted case management; co-occurring M/SUD services; mental health and aging; mental health services for deaf and hard of hearing; housing options; physical health interface; rural outreach; rehabilitations services such as assertive community treatment, peer support, individual placement and support supported employment, comprehensive community supports, therapeutic rehabilitation programs, and supportive housing services; and behavioral health treatment services, including intensive outpatient programs for those with mental health disorders.

For children, youth and transition age youth, including those with SED, these key components based on the System of Care framework include: promotion of well-being/prevention of behavioral health disorders; supporting youth/family voices across the system of care; ensuring culturally responsive care, regional summary of the system of care; children and transition age youth service array; best practices; training needs; best practices; supportive services; early interventions for first episode psychosis; Service Members, Veterans and Family Members; integrated care, workforce development and youth/young adult engagement, support and leadership.

DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, service effectiveness and accountability.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a) Physical Health	☒ Yes ☐ No
b) Mental Health	☒ Yes ☐ No
c) Rehabilitation services	☒ Yes ☐ No
d) Employment services	☒ Yes ☐ No
e) Housing services	☒ Yes ☐ No
f) Educational services	☒ Yes ☐ No
g) Substance use prevention and SUD treatment services	☒ Yes ☐ No
h) Medical and dental services	☒ Yes ☐ No
i) Recovery Support services	☒ Yes ☐ No
j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	☒ Yes ☐ No
k) Services for persons with co-occurring M/SUDs	☒ Yes ☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Children with SED

In Kentucky, services for children, youth, transition age youth, and their families that are delivered through Kentucky's public behavioral health safety net (14 regional Community Mental Health Centers) have been provided in accordance with the system of care (SOC) framework since the late 1980s. A system of care is comprised of three equally important components: Philosophy, Infrastructure, and Services & Supports.

Kentucky operationalizes the System of Care philosophy including the definition, a set of core values, and guiding principles. Kentucky has adopted the recently updated SOC framework including the components of the philosophy as described in the 2021 report, The Evolution of the System of Care Approach 1.

SOC Philosophy

Definition - "A system of care is a comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life. A system of care incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults." 1

1. Core Values.

- "Family and Youth Driven Community Based
- Culturally and Linguistically Competent" 1

2. Guiding Principles.

- "Comprehensive array of services and supports
- Individualized, strengths-based services and supports
- Evidence-based practices and practice-based evidence
- Trauma-informed
- Least restrictive natural environment
- Partnerships with families and youth
- Interagency collaboration
- Care coordination
- Health/mental health integration
- Developmentally appropriate services and supports
- Public health approach
- Mental health equity
- Data driven and accountability
- Rights protection and advocacy" 1

SOC Infrastructure

Infrastructure includes but is not limited to processes and structures for:

- establishing a point of accountability for policy and system management and administration (governance);
- developing and implementing strategic planning, including for communications and social marketing;
- financing for infrastructure and services;
- building and sustaining partnerships among family organizations and leaders, youth organizations and leaders, child serving agencies, and community based organizations;
- coordinating outreach, information, and referral efforts; and
- recruiting and retaining a competent workforce.

Governance. Kentucky has a nearly four-decade long-standing governance structure in place. The State Interagency Council (SIAC) for Services and Supports to Children and Transition-Age Youth was established by statute in 1990 to serve as the governing body for Kentucky's system of care for children and youth with or at-risk of developing behavioral health (inclusive of mental health, substance use, and co-occurring mental health and substance use) challenges. In this role, the SIAC has served as the governing body for all past and present SAMHSA SOC and adolescent CSAT grants, as well as other federal grants (including suicide prevention, healthy transitions, Children's Bureau trauma, and others), and state-level initiatives focused on these populations and their families. The SIAC members include:

- Commissioner-level representatives from 12 state agencies (across five Cabinets) that serve children, transition-age youth, and their families;
- Non-profit family organization;
- Youth representative;
- Parent Representative; and
- Subcommittee for Equity & Justice for All Youth (SEJAY).

The SIAC was created and continues to serve as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs, as well as their families. This statutorily mandated group meets monthly and is engaged in Phase I of creating a comprehensive, multi-perspective Children's Behavioral Health Plan (CBHP) to support state agencies in developing services and supports that are available and accessible across the state and regardless of how or through what agency the child, youth, and family enter the system of care. In 2025, SIAC is focusing on three priority areas, which are organized into three workgroups that report their progress to SIAC quarterly. The output of these workgroups will drive Phase II of CBHP and guide SIAC in determining next steps for incorporating these efforts into its strategic plan. Eighteen Regional Interagency Councils (RIACS) with similar membership serve as regional loci of accountability for the system of care by:

- Conducting regional system of care planning and operations
- Coordinating system-level continuous quality improvement
- Identifying and developing system of care expansion opportunities
- Promoting system of care awareness
- Initiating and adopting interagency agreements as necessary for providing services & supports to children and transition-age youth with behavioral health needs by agencies on the RIAC
- Advising the SIAC regarding the system of care within the region

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

These statutorily mandated bodies craft policy aimed at providing services and supports with children, youth, and transition age youth with or at risk of developing a SED, and their families, that align with the system of care philosophy, comprised of a definition, core values, and guiding principles. This approach ensures that an individualized, collaborative, and integrated approach is taken to planning, coordinating, delivering, and evaluating services and supports for children, youth, and transition-age youth with or at risk of developing a SED, as well as their families.

Integration with Physical Health

The system of care framework is built around guiding principles that include the integration of physical and mental health, as well as the adoption of a public health model of care, prioritizing equitable access, services, and outcomes across the continuum of promotion, prevention, early intervention, treatment, and recovery so that services and supports can be put in place to ameliorate symptomology as early in the course of treatment as possible. The interface between the physical healthcare system and the behavioral healthcare system is of growing importance to service providers as well as families. A significant amount of behavioral healthcare is provided through the physical health provider network, particularly for children. Historically, data have indicated that of Kentucky's children with SED, approximately 50% have a co-occurring chronic physical health condition (i.e., asthma, diabetes, obesity). Given the complexity of these co-occurring conditions, screening, early identification, referral to treatment when indicated, and collaborative of care across the continuum and multiple systems is critical to ensure that providers are not working at cross purposes, and that children and families receive timely, appropriate, and effective care.

Community Mental Health Centers (CMHCs) are required to conduct physical health screening of all clients served.

Department staff assist contracted providers in improving tools used to screen for and identify potential physical health concerns and to encourage further assessment and integration of physical and behavioral healthcare, as well as referral for services elsewhere, when indicated. Four (4) of Kentucky's 14 CMHCs are participating in a Center for Medicaid and Medicare Services Certified Community Behavioral Health Clinic Demonstration (CCBHC) project. As part of the demonstration, demonstration sites are exploring best practices for integrating primary care screening and monitoring into their service arrays. Additionally, six additional CMHCs are expected to become certified as part of the demonstration expansion in January 2026.

Kentucky Strengthening Families

Kentucky is using a nationally recognized strategy, Strengthening Families: A Protective Factors Framework. This approach is coordinated nationally by the Center for the Study of Public Policy. Many state agencies, including DBHDID and others within the Cabinet for Health and Family Services (CHFS) support Kentucky Strengthening Families (KYSF). DBHDID staff serve on its Leadership Team, subcommittees, and training cadre. KYSF is a multi-disciplinary partnership of over 20 national, state, local, public, and private organizations dedicated to integrating six research-based Protective Factors into services and supports for children and their families. KYSF aligns with the system of care (SOC) framework, particularly with promotion and prevention efforts. Supporting families is a key SOC and KYSF strategy to promote school readiness, social-emotional well-being, and preventing child abuse and neglect. All families experience stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with stress in healthy, practical ways. KYSF protective factors have been integrated into CMHC contracts and DBHDID's approved Trauma-Informed Care training curriculum to support their adoption by provider agencies, programs, and staff.

SOC Services and Supports

Mental Health and Rehabilitation Services. All CMHCs have a designated Children's Service Director. These Directors, along with other leaders, seek to ensure that the mental health and substance use service and support needs of children and families within their regions are evaluated and addresses in a structured, yet flexible manner. Reflective of the system of care framework, services and supports are designed to meet the holistic needs of children with a SED, as well as those of all children served within their respective regions, and their families.

A review of the information from the CMHC Annual Plan and Budget applications submitted in May 2024 reveals that CMHCs strive to address barriers and meet the clinical service needs of children and families. Some examples include:

- All CMHCs offer off-site therapy services in home, school, other community settings;
- The CMHCs employ 182 Service Coordinators to provide targeted case management to children and adolescents with SED and another 24 Service Coordinators are trained and serve as High Fidelity Wraparound Facilitators;
- All CMHCs have positions for at least one designated Early Childhood Mental Health Specialist and at least one Early Childhood Consultant who provides therapeutic services for children birth to five years of age and their families. They also provide education and consultation to others working with this population. The regions reports employing 105 additional staff who have experience serving this population;
- All CMHCs employ clinicians who are trained to and routinely serve transition age youth, with a total of 539 staff trained for this subpopulation in the state;
- All regions employ clinicians who are trained and routinely serve youth with substance use concerns with a total of 235 staff trained;
- Twelve CMHCs employ Youth Peer Support Specialists (YPSS) with a total of 38 YPSS employed; and
- Twelve regions employ Family Peer Support Specialists (FPSS) with a total of 30 FPSS employed.

Kentucky's Medicaid State Plan includes the Rehabilitation Option for mental health and substance use, including statewide coverage for therapeutic rehabilitation and targeted case management for children with SED. Kentucky Interagency Mobilization for Progress in Adolescent and Child Treatment (IMPACT) programs within each CMHC offer targeted case management services that adhere to the values of wraparound, as well as the more intensive care coordinator approach of High Fidelity Wraparound to children with more complex needs, to ensure that children with SED and their families receive needed services and supports. More than \$5 million in state general funds is allocated to support the Kentucky IMPACT program. These funds are used to sustain program operations, including staff administrators, high-fidelity wraparound services, and flexible resources to meet the needs of children, youth, and families. Many CMHCs offer comprehensive community support services through their IMPACT programs as well as through traditional outpatient services. Community Support Associates serve as mentors and coaches who support children and youth in improving life skills such as organization, impulse control, socialization, coping strategies, job seeking, and budgeting. Services may occur on or off-site to allow for more practical experiences in natural environments. Peer Support Specialists, both Family and Youth, are also available through both IMPACT and traditional outpatient services. Most IMPACT services occur in the home, school, or community setting. Some regional IMPACT and outpatient programs also offer after-school and/or extended summer programs, during which children receive individual and group therapeutic services, as well as mentoring and other support, allowing for continued clinical and supportive services during less structured times.

The document that is attached to the application referencing Environmental Factor #6, Criterion 1, outlines community-based services available for children, youth, and families through the CMHCs. This grid is from SFY 2025 plan submissions and is updated annually based on required Plan and Budget submissions from the 14 CMHCs.

Employment Supports. Supported Employment services are a needed service for transition age youth. They are being addressed through several targeted initiatives, including the Transition Age Youth Launching Realized Dreams (TAYLRD) Drop-in Centers, the 10% block grant set aside for early serious mental illness/first episode psychosis (ESMI/FEP), the Kentucky Partners for Youth Transitions, and collaboration with Individual Placement and Support (IPS) supported employment training and coaching for the adult population. Recently, Kentucky was selected to participate in a National Institute of Disability, Independent Living, and Rehabilitation Research (NIDILRR) Field-Initiated Research Grant to evaluate the effectiveness of IPS Supported Employment for young adults aged 16-24 with behavioral health issues in five different states. This has led to the incorporation of specialized youth/young adult-focused IPS staff within two CMHCs. This model has continued to evolve in other areas of the state to better serve the employment and educational needs of youth and young adults.

The Kentucky Partners for Youth Transition (KPYT), an interagency group focusing on youth and young adults between 14 and 25 years old who have behavioral health issues, began meeting in 2008 in response to a need to address the gaps in services for these individuals. The KPYT's central focus areas include employment and career, education, living situation, and skills management. The goal is that youth and young adults with serious behavioral health issues will have earlier, faster, and easier access to the developmentally appropriate care that they need.

Housing Supports. The CMHCs offer community-based programs for children with SED, allowing them to remain in their own homes and communities, rather than in residential settings. They collaborate with the Department of Community Based Services (DCBS – child welfare agency) and the Department for Juvenile Justice (DJJ) to maintain children in their own homes and communities whenever possible and when in the best interest of the child.

TAYLRD Drop-in Centers for transition age youth and young adults are in operation in 7 of the 14 CMHCs. An array of behavioral health (both mental health and substance use) services is provided in an environment that is easily accessible, engaging, and inviting to transition-age youth (TAY) and includes open access hours. Supports are targeted to transition-age youth between the ages of 16 and 25 with or at risk of developing serious behavioral health issues (SED/SMI/SUD). This programming provides seamless services for this population to help minimize gaps between child, adolescent, and adult mental health and substance use programs.

KY River Community Care also operates the Youth Homeless Demonstration Program (YHDP), which supports homeless or at-risk youth through Community Support Associates (CSAs) and Housing Navigators, linking them to housing, employment, education, medical care, and behavioral health services. The Host Home Program at KY River provides housing for youth ages 14-24, along with fuel and grocery stipends. Meanwhile, two crisis homes in Letcher and Perry Counties offer immediate shared housing for individuals aged 18-24. Both serve the 8-county Promise Zone area in Kentucky.

Kentucky also operates Coordinated Specialty Care Programs called iHOPE (Helping Others Pursue Excellence) in eight of the 14 CMHC regions. Specialty services are provided to young people between 15-30 years old with First Episode Psychosis to prevent or minimize the full onset of illness for persons in a clinical high-risk state and improve long-term outcomes for those who have already had a First Episode of Psychosis. iHOPE Programs utilize the "iHOPE Practice Guidelines," which are based on the Early Assessment and Support Alliance (EASA) Coordinated Specialty Care best practice model. The Department contracts with the University of Kentucky/Human Development Institute to provide fidelity monitoring and data collection to ensure adherence to the Coordinated Specialty Care Model.

DBHDID does not assume custody of children within the state, nor does it operate a children's psychiatric hospital or any other residential program for children. The CMHCs, under contract with the DBHDID, do offer a limited amount of residential care. Therapeutic foster care is offered in two of the 14 regions.

DCBS, within the Cabinet for Health and Family Services, is responsible for investigating child dependency, abuse, and neglect, and making recommendations to the courts. When deemed necessary, DJJ, within the Justice Cabinet, also may assume custody of children. DBHDID collaborates with these two state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with CMHCs and private providers to meet the behavioral health needs of children in their custody.

Education Supports. (Including services provided by local school systems under IDEA)

DBHDID staff collaborate extensively with state and local educational agencies to support the Individuals with Disabilities Education Act (IDEA) and other initiatives aimed at simplifying access to and coordinating services for children and youth with behavioral health needs.

Currently, numerous school-based mental health initiatives are available across the state. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. The DBHDID has sponsored several training seminars featuring national presenters to educate personnel of both the CMHCs and school districts on approaches to school-based behavioral health delivery options and models. These events have been well-attended, and partnerships between school districts and CMHCs continue to grow statewide.

As in other states, Kentucky educators have reported an increase in the behavioral health needs of students. Kentucky has participated in two policy academies, which have allowed access to national experts in school-based behavioral health. Lieutenant Governor Jacqueline Coleman's office brought together a multi-disciplinary team, including students and CHFS staff, to work with experts provided by the National Governors Association to expand access to school-based behavioral health supports. The Comprehensive School Mental Health Policy Academy brought together a Kentucky team of partners from the Department of Education, the Division of Family Resource and Youth Services Centers, and the Department for Behavioral Health, Developmental and Intellectual Disabilities who, along with teams from three other states, learned from national experts on best practices in systemic supports for school-based behavioral health. The KY group is working to develop policy and programming to improve student access to appropriate behavioral health services in schools.

Kentucky's Department of Education (KDE) was awarded a Project AWARE (Advancing Wellness and Resilience in Education) grant to promote behavioral health in schools. This grant has led to efforts aimed at training school staff to identify students' behavioral health needs and enhance effective communication between school staff and behavioral health providers. KDE's Project AWARE is being implemented in three of the state's largest school districts. One Kentucky educational cooperative was also awarded a Project AWARE grant, and three additional counties are covered through that initiative. A state-level behavioral health program administrator, located within DBHDID, is staffed for both of these initiatives. Collaborative efforts are not limited to those six districts, however. Kentucky's programs include an emphasis on Trauma-Informed Care, Resilience Building, and educating school staff regarding Secondary Traumatic Stress, promoting these initiatives through learning collaboratives. The multi-disciplinary management team includes members from several different agencies, including DBHDID, and also includes young adults and family members with lived experience.

KY's Prichard Committee for Academic Excellence was the lead agency in Kentucky's work with Education Northwest to develop a plan regarding alternative education. The High School Alternatives State Action Collaborative was a cohort of eight states focused on developing or improving statewide policy for high school alternative education. The KY team included representatives from Prichard Committee, as well as DBHDID, KY Department of Education (KDE), KY Educational Collaborative for State Agency Children (KECSAC), and the Office of Educational Programs within the Education and Labor Cabinet. With technical assistance from Education Northwest, the KY team developed an action plan aimed at increasing access to behavioral health care for students in district-run alternative programs.

In 1998, the Kentucky General Assembly authorized the establishment of the Center for School Safety (KCSS). This center's mission is to serve as the central point for data analysis, research, dissemination of information about successful school safety programs, research results, and new programs, and in collaboration with the KDE and others, to provide technical assistance for safe schools. DBHDID partners with KCSS to provide Safe School Assessments for participating districts. DBHDID also provides information and resources to support the work of KCSS.

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

- Kentucky Department of Education
- Department for Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental and Intellectual Disabilities
- Local Education Agencies
- The State Agency Children School Administrator Association (SACSAA)

KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC is a partnership that links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with its partners and other associates.

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities comprises more than 22 state agencies, including DBHDID. Its mission is to facilitate the work of state, regional, and local agencies as they assist young persons with disabilities (of all types) in transitioning from school to community living and employment.

DBHDID's participation on the Council has offered a valuable forum for the sharing of program information and resources, as well as access to data to better address the needs of young people served by the various agencies. The council was at the forefront of meeting accessibility, using a hybrid (virtual and in-person) meeting format prior to the pandemic, which allowed more participation from a much broader audience.

Substance Use Prevention and SUD Treatment. CMHC clinicians often identify substance use among youth and their caregivers as a contributing factor to the poor mental health and overall well-being of individuals they serve. Funding for substance use treatment for youth has improved in recent years, and the use and misuse of nicotine, alcohol, inhalants, prescription, and illegal drugs are addressed in the treatment provided. While outpatient clinicians and case managers continue to collaborate with service providers, each CMHC also receives funding to support a full-time Youth Co-occurring Treatment Coordinator (YTC). The YTCs are tasked with partnering with local agencies, such as schools, courts, justice, child welfare, and other providers to identify, screen, refer, and treat youth with substance use disorders and co-occurring mental health and substance use disorders. The YTCs have more flexibility than outpatient clinicians as they are considered a hybrid of a direct service provider as well as a community-based employee. They are hired with the intention of maintaining their status as subject matter experts on youth co-occurring mental health and substance use, and evidence-based modalities to support these youth and their families.

Additionally, each CMHC includes a Regional Prevention Center that provides community-based promotion and prevention supports and works in collaboration with CMHC treatment staff to ensure a continuum of evidence-based/informed promotion, prevention, early intervention, treatment, and recovery services and supports is available.

Services and supports are provided primarily through contracts with CMHCs and their subcontractors, local governmental agencies, and other community-based organizations. The following are available:

- Prevention programming in communities offered through 14 Regional Prevention Centers;
- Juvenile diversion programs, under age 21 DUI assessment and education programs;
- Consultation with businesses on the development of a drug-free workplace and employee assistance programs;
- Social setting withdrawal management; residential treatment; intensive outpatient; outpatient treatment; targeted case management; peer support
- Specialized treatment services for pregnant women, youth; and persons who inject drugs; and
- Medications for Opioid Use Disorder (MOUD) for opiate dependent persons who are high-risk for HIV due to injecting drugs.

The DBHDID provides alcohol and other drug use/misuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is in accordance with KRS 431.100. Other statutes guiding DBHDID services include: KRS 189A (DUI assessment, education, and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of substance use has a significant impact on the health and well-being of every Kentuckian. From peer pressure of youth to use illicit substances to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for substance use-related problems. DBHDID has statewide responsibility for providing leadership and program direction for implementation of primary prevention, early identification (intervention), treatment, and recovery services and supports for children, youth, and adults with or at risk of developing substance use disorders.

Medical, Dental and Vision Care Physical Health Care.

A high rate of Kentucky's children and youth aged birth through 18 have health insurance, with only 3.4% uninsured. Forty-six percent of children and youth are covered by Medicaid or KCHIP. Despite this high rate of insurance coverage, Kentucky's children and youth continue to have health challenges, particularly in the areas of oral health, obesity, and exposure to secondhand smoke. The table below summarizes 2022-2023 data from the National Survey of Children's Health.

Kentucky Nationwide

Tooth decay/cavities age 1-17 (%)	14	12
Child Health Status (%)	91	90
Obesity age 6-17 (%)	19	17
Adolescent depression or anxiety age 12-17 (%)	23	18
Someone in household smokes (%)	22	12
Physical activity age 12-17 (%)	13	14
Forgone health care (%)	3	3

All CMHCs are required to complete physical health screenings for all new clients and to update this information at least annually. Additionally, four of Kentucky's 14 CMHCs are part of a Center for Medicaid and Medicare Services Certified Community Behavioral Health Clinic Demonstration (CCBHC) project. They are integrating primary care screening and monitoring into their service arrays. Additional CMHCs have expressed interest in becoming CCBHCs. Six additional CMHCs are expected to onboard as CCBHCs during and expansion of Kentucky's demonstration in January 2026.

The Kentucky Department for Medicaid Services (DMS) is engaging school districts to become certified as providers of School-Based Health Services (SBHS) through SHINE Kentucky. Certification for SBHS authorizes local education agencies in Kentucky, including the Kentucky School for the Deaf and the Kentucky School for the Blind, to enroll as Medicaid Health

service providers for children who are eligible under the Medicaid program and the Individuals with Disabilities Education Act (IDEA). The program is explicitly designed to allow school districts to act as health care providers and be reimbursed under Medicaid. District participation in SBHS will increase student access to physical health services, as well as services and supports aimed at treating mental health and substance use issues.

Funded by a grant from the Centers for Disease Control and Prevention to improve the health and educational outcomes of youth, the Kentucky Departments of Education and Public Health administer the Whole School, Whole Community, Whole Child (WSCC) initiative. The WSCC initiative is a comprehensive approach aimed at supporting learning and health by increasing the capacity of schools, districts, and communities to promote and support healthy behaviors and choices in school-age youth and reducing health disparities among school-age youth at disproportionate risk for chronic diseases, sexually transmitted infections, and unintended pregnancy.

DBHDID is collaborating with Medicaid to participate in the SAMHSA-CSAT Learning Collaborative "Integration of Physical Health, Substance Use Services, and Mental Health Care." Objectives center around learning about best practices and evidence-informed approaches, identifying state-specific barriers and challenges, collaborating within the Cabinet to formulate state goals, and implementing/monitoring progress towards those goals. Kentucky's cross-departmental work for integrated care currently centers around two key goals: 1) utilizing data to document and monitor the landscape of integration and identify gaps, challenges, and opportunities for increasing access to and quality of integrated care services and 2) promoting the collaborative care model within Kentucky to increase the number of primary care practices that are engaged in evidence-based integrated care. Additional partners include the Department for Public Health, who are currently administering the KY MARK Program.

The Kentucky Mental Health Care Access Program (KY MARK) is administered by the Division of Maternal and Child Health. KY MARK provides free psychiatric teleconsultation for pediatric primary care providers with the goal of meeting the increasing need for access to mental health care for Kentucky's pediatric population. This program is in year three out of five and is expanding capacity to increase enrollment statewide. Alongside participation in the board for this program, DBHDID and DMS are also exploring ways to collaborate with KY MARK to develop a sustainability plan for the program, as well as to develop integrated care training opportunities for enrolled primary care providers. These opportunities are placed on the University of Kentucky's CE Central website, a continuing education platform. Trainings center around behavioral health knowledge and skills, provider collaboration, and programmatic integrity.

Kentucky is a recipient of the 2023 SAMHSA PIPBHC (Promoting the Integration of Primary and Behavioral Health Care) grant. Through those funds, Kentucky has partnered with two CMHCs, LifeSkills and Pennyroyal, to integrate bidirectional primary and behavioral health services. In Warren County, LifeSkills has partnered with a Federally Qualified Health Center, Fairview Community Health Center, to provide services. LifeSkills co-locates therapists within the FQHC for short term intervention therapies. LifeSkills and Fairview engage in bidirectional screening and referral services, social care coordination, and health data integration practices to offer collaborative and coordinated care. In Christian County, Pennyroyal is exploring multiple integration pathways, including establishing their own primary care clinic to offer enhanced primary care to individuals with SMI, SUD, and SED, as well as co-locating therapists within a rural health clinic to increase access to behavioral health care. Preliminary success stories indicate that integrated care is leading to improved social health outcomes, better management of behavioral health conditions, and more coordinated whole person care. Across both counties, health outcomes of focus include physical health outcomes especially for chronic diseases, behavioral health outcomes, social health outcomes, symptom management, risk factor reduction, functionality, utilization of care, screening and connection to care, and quality of care.

Oral Health Care

As indicated above, Kentucky has a significant issue with child dental decay, with rates significantly higher than the national average, particularly among young children. Recently, the 2023 Kentucky Early Learner's Oral Health Survey found that dental decay rates for children aged 2-5 are higher than the national average and comparable to the highest-risk group in the US. This situation highlights the need for a greater emphasis on preventive dental care and increased access to dental services for Kentucky children.

Oral health can impact behavioral health in several ways. Discomfort from untreated dental issues can result in inattentiveness, anxiety, fatigue, and acting out among children and youth. Children and youth may be self-conscious of unhealthy teeth and smiles, leading to anxiety, embarrassment, and withdrawal. Finally, chronic pain may result in overuse of prescription pain medication or illicit substances, increasing the risk of substance misuse among youth. Thus, CMHCs and other behavioral health providers must strive to connect children and youth to accessible, affordable, high-quality oral health care.

Of equal importance is collaboration at the state level. Two agencies co-located in the Cabinet for Health and Family Services with DBHDID are working to improve oral health care for children, youth, and families. The Kentucky Department for Medicaid Services (DMS) contracts with managed care organizations to provide oral health care to Medicaid members. Kentucky has one of the worst oral health profiles for children of any U.S. state; the state lacks dental providers in poor and rural areas, and many of its providers historically have not accepted Medicaid. The Kentucky Oral Health Branch within

the Department for Public Health (DPH) Oral Health Program believes children's oral health is a foundation for a healthy lifetime. The Oral Health Branch provides the following initiatives to help children maintain good dental care: a fluoride varnish program, a sealant program, a community water fluoridation program, a rural school fluoridation program, a fluoride supplement program, oral health education, and Healthy Smiles Kentucky.

University Colleges of Dentistry are also committed to improving the oral health of Kentucky's children and youth. The University of Kentucky College of Dentistry, in coordination with other agencies, provides myriad dental services for children:

- Inpatient and outpatient specialized dental services for children at the University of Kentucky Children's Hospital and the UK Medical Center. This includes the provision of services for dental patients with special needs (physical, medical and other special needs);
- Primary dental services at an indigent care clinic serving north Lexington and a clinic in south Lexington;
- Seal Kentucky, a mobile dental sealant program providing on-site dental screening and preventive dental sealant services at eastern Kentucky elementary schools;
- East Kentucky Mobile Dental Program, that provides dental prevention and treatment services on-site at elementary schools in central and eastern Kentucky;
- Western Kentucky Mobile Dental Program, that provides dental prevention and treatment services on-site at nine elementary schools in three western Kentucky counties;
- Ronald McDonald Mobile Dental Program, in partnership with Ronald McDonald Foundation provides on-site services at underserved preschools and elementary schools in Fayette and surrounding counties; and
- School-Based Dental Clinics in rural Kentucky.

The pediatric dentistry program at the University of Louisville School of Dentistry provides services to patients between six months and 14 years of age. Patients with special needs of any age are accepted. The program focuses on preventive dentistry, including cleanings, x-rays, and fluoride treatments, as well as fillings, stainless steel crowns, and extractions. Emergencies or outpatient treatment is provided at Kosair's Children's Hospital for very young children with excessive decay or special needs of any age.

The Kentucky Oral Health Coalition is a statewide group of dental providers, public health professionals, advocates, educators, and others working together to improve the oral health of all people in Kentucky. The coalition began in March 2012 and is staffed by Kentucky Youth Advocates. The Coalition is focusing on two primary areas through 2025: enhancing oral health awareness and improving access to oral healthcare. Several faith-based organizations have provided the financial support necessary to initiate and sustain these services. In addition, some groups have established free clinics in church buildings, staffed by volunteer dentists who travel to the region from all over the state for week-long 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 who are aware of local resources and have well-developed relationships with local providers tend to lead to better access to dental services. In many communities, some dentists serve children in need who have no means to pay for dental care. However, overall access is generally considered poor.

In 2008, the General Assembly passed HB 185, which requires a dental screening for the first year that a child aged three, four, five, or six is enrolled in a public school, public preschool, or Head Start program. The law took effect for the 2010-2011 school year. Addressing dental health care needs has been found to reduce the number of school days that Kentucky's students miss due to pain associated with dental problems.

Vision Health Care. Kentucky Medicaid provides coverage for members of all ages for most examinations and specific diagnostic procedures performed by ophthalmologists and optometrists. Professional dispensing services, lenses, frames, and repairs are covered for individuals under the age of 21.

All Kentucky children are required to undergo an eye exam by a board-certified optometrist or ophthalmologist before entering school. This is in addition to the requirements for immunizations, dental, and hearing screenings. For children with vision problems, the Kentucky Lions Eye Foundation (KLEF) is an excellent resource for assistance with screenings, exams, and eyeglasses. Although located in Louisville, KLEF serves citizens across the state by operating the Vision Van, eye clinics throughout the state, and providing thousands of photo screenings at the Kentucky State Fair. The KLEF includes specialty services for children at its Pediatric Clinic.

Visually Impaired Preschool Services (VIPS) is a Kentucky nonprofit agency that provides assessments, early intervention services, childcare consultation, and playgroups/classes for infants, toddlers, and preschoolers who are blind or visually impaired. For parents and caregivers, VIPS offers various educational and support opportunities. 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 14 CMHCs offer consultation and education regarding behavioral health care and services for children, youth, and families within their communities, as well as connections to services and supports available through partner agencies. This is in addition to the ancillary support services that CMHCs directly provide as part of the children's

array and indicated in the service/support array grid provided above. These non-clinical supports include, but are not limited to:

- Respite;
- Intensive in-home;
- After school programs;
- Family peer support;
- Youth peer support;
- Specialized summer programs;
- Comprehensive community support;
- IPS Model of Supported Employment;
- Transition planning for transition-age youth; and
- Youth and Family Engagement and Leadership support.

Family and Youth Voice. Across all regions of Kentucky, parent and youth voices are most consistently heard through their membership on Local and Regional Interagency Councils (LIACs and RIACs) and through leadership opportunities provided by Kentucky's Statewide Family Network grantee, Kentucky Partnership for Families and Children Inc. (KPFC). DBHDID has maintained contracts from multiple funding sources with KPFC to elevate the voices of youth and families at all levels of the SOC. KPFC works to ensure "that all families raising youth and children affected by behavioral health challenges will achieve their fullest potential." KPFC's mission is to empower families affected by behavioral health challenges to initiate personal and systems change. The board of directors consists of 21 to 31 members: 12 parent representatives from various community mental health center regions, two transition-age youth representatives, seven representatives from child-family serving agencies, and 10 flexible positions to assist with identified needs. As a family organization, over 51% of KPFC's board of directors must be parent/primary caregivers raising children with behavioral health disabilities, and more than 50% of staff are also parents/primary caregivers who have raised, or are raising, children with behavioral health disabilities.

KPFC's programs and/or activities include:

- Disseminating a quarterly newsletter to more than 3,000 members;
- Participating in numerous committees with various child-family serving agencies to represent parent and youth voices and perspectives;
- Operating a website (www.kypartnership.org) and a toll-free phone number (800-369-0533) for parents and youth to access information about KPFC and resource information statewide;
- Providing an infrastructure for Kentucky Youth MOVE, a chapter of Youth MOVE National, comprised of 14-26 year olds who have a behavioral health challenge;
- Hosting of the Kentucky Family Leadership Academy and the Kentucky Family Peer Support Specialist Core Competency Training;
- Partnering with regional CMHCs to establish and support Regional Youth Councils and to assist in the identification of youth leaders;
- Offering youth and family peer support services across Kentucky;
- Creating opportunities for youth (13-26 year old) with behavioral health challenges and their parents to learn, connect, and network as part of the youth and parent movement; and
- Strengthening Kentucky's family- and youth-driven system of care.

Early Childhood Mental Health. DBHDID and the Department for Public Health (DPH) have co-administered Kentucky's statewide Early Childhood Mental Health (ECMH) Program since its inception in 2003. Funds are contracted to the CMHCs for regional program administration. The primary goals of ECMH are:

- To provide program and child level consultation to early care and education (childcare) programs regarding social, emotional, and behavioral issues;
- To provide training for child-serving agencies and individuals on working with young children with social, emotional, and behavioral needs and their families; and
- To provide evaluation, assessment, and therapeutic services for children from birth through the age of five and their families.

The ECMH program is funded with Master Tobacco Settlement Funds awarded to DPH for maternal and child health. These funds, in addition to a small portion of mental health block grant funds, support one full-time equivalent ECMH Specialist position in each of the 14 CMHC regions. The Specialists' time is devoted solely to their regional ECMH programs, which aim to build the capacity of regional providers to better meet the social, emotional, and behavioral needs of children from birth through age five and their families. Due to the high number of Kentucky babies and very young children who were exposed to opioids and other substances in utero and within their homes, State Opioid Response funds were utilized to establish Early Childhood Consultant (ECCs) positions in each CMHC. The ECCs work with infants, young children, and families impacted by opioid and other substance use disorders. ECCs provide training to families, child welfare, healthcare providers, treatment facility staff, and others, and provide collaboration with community partners on the impact of substance use on infants, early childhood development, healthy attachment, and building resilience in families affected by SUD. Consultant positions are being sustained with tobacco settlement funds for pregnant and parenting women.

Treatment Services for Youth with Co-occurring Mental Health and Substance Use Disorders. Services for youth with co-occurring mental health and substance use disorders are coordinated within the Children's Mental Health and Recovery Services Branch, which has a full-time position for a staff member who serves as the Youth Substance Use and Co-occurring Program Administrator. This position has been instrumental in facilitating infrastructure and service delivery efforts aimed at the population of focus. Since SFY 2022, DBHDID has supported a full-time Youth Substance Use and Co-occurring Treatment Coordinator staff position within each of the CMHCs. The coordinator is located within the CMHC's children's services division and serves as the regional subject matter expert in youth substance use and co-occurring substance use and mental health disorder treatment. The coordinator collaborates within and across other CMHC programs that have contact with individuals (children, adolescents, and adults) with or at-risk of developing SUD, and with youth and families. This position was created in response to information from CMHCs that they were not receiving referrals for youth with substance use issues and that there was a general lack of knowledge in communities regarding how to identify, screen for, and refer youth with substance use issues, as well as a lack of awareness of what services and supports are available for these young people. The coordinator is charged with providing community education and outreach and keeping an inventory of clinicians within their agency who are trained to serve youth with substance use disorders. Results from a recent survey of CMHC children's directors and substance use directors show that across all CMHCs, there is a total of 232 clinicians who are trained to and routinely serve youth with substance use disorders; thus, provider capacity in serving the population is not an issue. This further supports the need for community education and engagement around identifying, screening, and appropriately referring youth with substance use issues.

DBHDID has received a five-year, \$5 million Treatment for Individuals Experiencing Homelessness (TIEH) grant from SAMHSA to implement a street outreach initiative targeting unsheltered homelessness in the Louisville Metro area. The initiative, TEAM SOAR (Team-Engaged Assertive Mechanics for SSI/SSDI Outreach, Access, and Recovery), is a collaboration between DBHDID and Seven Counties Services, Louisville's Community Mental Health Center. In designing the TEAM SOAR (Team-Engaged Assertive Mechanics for SSI/SSDI Outreach, Access, and Recovery) initiative, DBHDID wrote specific outreach goals into the TIEH grant to address the needs of unsheltered transition-age youth (TAY). These goals reflect a deliberate effort to ensure that TEAM SOAR is responsive to the unique challenges faced by TAY experiencing homelessness, particularly those also living with serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring disorders. To operationalize these goals, the initiative features a dedicated team that focuses exclusively on outreach and engagement for TAY. This team functions alongside the core multidisciplinary SOAR team and is responsible for identifying transition-age youth in unsheltered settings, facilitating access to behavioral health services, and supporting the acquisition of benefits. By embedding these targeted goals into the grant's structure, DBHDID ensured that the specific needs of this vulnerable population would be addressed through tailored outreach, referral, and service linkage efforts as part of the broader implementation in the Louisville Metro area.

Resources.

1. Stroul, B.A., Blau, G.M., & Larsen J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.

Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2023 American Community Survey (ACS), Table S2701: Selected Characteristics of Health Insurance Coverage in the United States.
<https://www.childhealthdata.org/>

Adults with SMI

Kentucky's behavioral health system continues to expand and integrate Certified Peer Support Specialists (CPSSs) as key members of multidisciplinary teams supporting individuals with serious mental illness (SMI). Peer support services are offered statewide through Community Mental Health Centers (CMHCs), Consumer Operated Service Programs (COSP), and other provider networks as part of a comprehensive, recovery-oriented system of care.

Additionally, Kentucky continues to grow and diversify its peer support workforce through specialized training tracks and new service pathways. CPSSs are increasingly represented in settings focused on crisis response, forensic services, older adult mental health, and co-occurring disorders.

These efforts reflect the Commonwealth's ongoing commitment to building a robust, person-centered, and trauma-informed service system that empowers individuals with SMI to lead self-directed lives in their communities.

Kentucky's Assisted Outpatient Treatment (AOT) program is a court-ordered intervention aimed at improving treatment outcomes for individuals with serious mental illness (SMI) who have a history of non-compliance with voluntary treatment and are at high risk of hospitalization, incarceration, or self-harm or harm to others. AOT enables courts to require community-based treatment as a less restrictive alternative to inpatient hospitalization, intending to help individuals stabilize, engage with services, and avoid cycles of crisis and institutionalization.

AOT is more than a legal tool; it is a coordinated care model that integrates court oversight with comprehensive wraparound services. These can include outpatient psychiatric care, case management, medication oversight, peer support, housing assistance, and other personalized services that promote community integration and recovery.

Kentucky's AOT Program is deeply integrated into the state's behavioral health System of Care (SOC) and care coordination strategies, especially for adults with SMI. The SOC approach emphasizes person-centered, recovery-focused, trauma-informed services provided through integrated networks of providers and support. AOT enhances interagency collaboration by bringing together behavioral health providers, courts, law enforcement, and social service agencies to support individuals with complex needs. CMHCs play a crucial role in coordinating care, ensuring that those under AOT receive timely access to services such as case management, psychiatric care, crisis stabilization, and peer support. The program promotes service continuity and accountability through regular court oversight and personalized treatment planning, thereby fostering stability and reducing unnecessary hospitalizations and involvement in the justice system. Additionally, AOT aligns with Kentucky's data-driven approach to behavioral health by using outcome metrics—such as treatment adherence, reduced emergency service use, and increased housing stability—to guide system improvements. By serving individuals who are often the hardest to engage, AOT operationalizes the core values of Kentucky's System of Care and helps extend the reach and effectiveness of the state's coordinated service delivery system. DBHDID currently contracts with the UK School of Social Work for statewide evaluation of Kentucky's AOT program goals of reducing hospitalization, incarceration, and homelessness.

TEAM SOAR focuses on individuals experiencing homelessness who are also living with serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring disorders, including veterans and transition-age youth (TAY). TEAM SOAR deploys multidisciplinary teams trained in the SOAR model, comprising a therapist, case manager, and peer support specialist, to conduct outreach, screening, and referrals directly in encampments and on the streets. The program enhances access to eligible SSI/SSDI benefits, behavioral health services, and recovery supports, helping individuals navigate complex systems and engage in long-term care. By building on existing outreach efforts and utilizing evidence-based practices, TEAM SOAR aims to enhance service access, expedite benefit acquisition, and increase engagement among those most vulnerable to chronic homelessness. Lessons learned from the Louisville implementation will inform the development of a replicable model, with plans to expand this approach to other regions across Kentucky in the coming years.

Kentucky's InReach Program, which operates as part of the Direct Intervention: Vital Early Response System (DIVERTS) services, include transition planning activities such as engaging individuals living in personal care homes, psychiatric hospitals, or experiencing homelessness by providing education about community-based services and housing options, and by documenting these activities to ensure quality and adherence to designated visit schedules. To ensure effective transition planning, Regional Transition Committee (RTC)/Olmstead meetings are held monthly in each hospital catchment area to address individual needs, develop Person-Centered Transition Plans, and identify solutions to barriers for individuals ready for discharge from state psychiatric hospitals. These efforts promote person-centered transitions into the least restrictive community settings.

Physical Health and Oral Health

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. The interface between the physical healthcare systems and the mental health system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services is provided in the physical healthcare arena. Continuity of care across those systems is critical for individual recovery and success in establishing chosen roles in the community.

The National Diabetes Statistics Report, 2021, from the Centers for Disease Control (CDC), analyzed health data through 2018. This report acknowledges that 37.3 million Americans have diabetes, and 96 million American adults have prediabetes. The southern and Appalachian regions, which include some parts of Kentucky, had the highest proportion of diagnosed diabetes. Nearly 16% of adults diagnosed with diabetes were smokers, almost 90% were overweight, and more than 40% were physically inactive. These results are representative of some Kentuckians and many individuals with SMI in the state.

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

Kentucky's CMHCs are now able to provide Medicaid-reimbursable primary health care services to individuals who are eligible through the Medicaid program. The Medicaid state regulation that outlines the program requirements for delivering this level of care can be found here: 907 KAR 1:047. SFY 2025 Plan and Budget submissions indicated that nine of the 14 CMHCs are currently providing primary care services to individuals they serve in their programs, while three provide minimal services, such as physicals, or contract out to physical health providers. Four of those CMHCs are now credentialed as Certified Community Behavioral Health Clinics (CCBHC) and six additional CMHCs are expected to onboard as CCBHCs as part of the expansion effort in January 2026.

All 14 CMHCs reported having some formal agreement with at least one health care provider in their area. Many regions also reported numerous informal contracts with health care providers in their area, such as agreements with local medical

facilities to offer mobile health services, collaboration with private hospitals to provide assessments and healthcare for individuals being served through CMHCs, nutrition work with local health centers for individuals receiving treatment at CMHC, in addition to numerous agreements regarding screening and assessment.

One region in eastern Kentucky (Mountain) was awarded a grant in SFY 2013 regarding health care for individuals who are homeless. The first "Homeplace Clinic" is co-located in the lower level of the CMHC outpatient clinic in Johnson County, a very rural location in Kentucky, and provides services to individuals from surrounding counties. This project has made an integrated, holistic approach possible for individuals served in this area. Services provided thus far include preventative care, disease management, basic laboratory services, health education, medication management, patient assistance programs, mental health and substance use services (collaboration includes co-location of behavioral health providers), as well as referrals to other medical providers for dental, vision, and specialized medical care. Mountain has currently expanded to five Homeplace Clinics, one of which focuses specifically on individuals with SMI.

Another region in southeastern Kentucky (Kentucky River) manages a physical health clinic in Knott County. This healthcare center provides integrated care to clients and referrals to more intensive programs for those with more complex needs.

Northern Kentucky (NorthKey) operates three primary healthcare clinics in Covington, Florence, and Carrollton. NorthKey therapists and case managers make internal referrals to the clinics, providing clients with quick access to a health assessment. The clinics address the significant physical health needs of SMI and SUD clients, including high blood pressure, managing diabetes, and other illnesses and conditions.

For dental care, the University of Louisville and the University of Kentucky (in Lexington) provide access to low- or no-cost services through their dental schools. They serve individuals in the clinics located in Lexington and Louisville. The University of Kentucky also provides mobile dental services that reach out to uninsured families in eastern Kentucky (those who are not able to afford dental care but who earn too much money to qualify for Medicaid assistance). There are four dental vans from the University of Kentucky. Several faith-based organizations have provided the financial support necessary to initiate and sustain these services. In addition, some faith-based groups have established free clinics in church buildings, staffed by volunteer dentists who travel to the region from all over the state for week-long mission trips. Others hold dental events in Walmart parking lots, handing out free samples of toothpaste, dental floss, and toothbrushes to anyone who wants them. Still, targeted case managers and clinicians who are aware of local resources and have well-developed relationships with local providers tend to lead to better access to dental services. In many communities, some dentists serve individuals in need who have no means of payment. However, overall access to dental care is generally considered poor.

Mental Health

The document that is attached to the application referencing Environmental Factor #6, Criterion 1, demonstrates the availability of the vast array of services for adults with SMI in each of the 14 CMHCs. This grid is updated annually based on required Plan and Budget submissions. This grid is populated from SFY 2025 planning.

Mental Health Disorder Treatment

Each regional board provides a full array of outpatient services, including, but not limited to, screening, assessment, person-centered treatment planning, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, assertive community treatment, targeted case management, and peer support. Every effort is made to place these outpatient clinics in close geographic proximity to individuals, ensuring easy access to needed services. Additional areas of focus include:

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

Substance Use Prevention and SUD Treatment

Effective prevention and treatment of substance use has a significant impact on the health and well-being of every Kentuckian. From youth facing peer pressure to try alcohol or drugs, to adults at risk of overdose or impaired driving, substance use disorders (SUD) affect individuals and families across all age groups. DBHDID is responsible for providing statewide leadership in the implementation of primary prevention, early identification and intervention, treatment, and recovery services and supports for individuals at risk of or experiencing substance use disorders.

DBHDID supports a statewide continuum of substance use services for children, youth, and adults through contracts with

Community Mental Health Centers (CMHCs), their subcontractors, local government entities, and community-based organizations. Kentucky Medicaid reimburses a comprehensive array of SUD services, including screening, assessment, brief intervention and referral to treatment (SBIRT), individual, group, and family therapy, peer support, targeted case management, medications for opioid use disorder (MOUD), and a range of crisis services such as mobile crisis, crisis stabilization, and crisis intervention. Additional services include withdrawal management, residential treatment, intensive outpatient services, and other outpatient treatment modalities.

Each CMHC includes a Regional Prevention Center that provides community-based prevention and early intervention programming while also collaborating with treatment teams to ensure a continuum of care. These Regional Prevention Centers offer community education, youth-focused diversion programs, DUI education for individuals under 21, and consultation to businesses on creating drug-free workplaces and employee assistance programs.

For children and youth, each CMHC is funded to support a full-time Youth Co-occurring Treatment Coordinator (YTC), who serves as both a direct service provider and a community liaison. YTCs work closely with schools, juvenile justice, child welfare, and other youth-serving agencies to identify, screen, refer, and support youth experiencing co-occurring mental health and substance use disorders. They serve as subject matter experts on evidence-based interventions for youth and their families and are designed to be flexible and community-integrated in their role.

Adult services mirror the structure and intent of the youth services, with programming tailored to the unique needs of adult populations. Specialized treatment services are available for pregnant individuals, persons who inject drugs, and individuals involved with the criminal justice system. Within budget limitations, training, consultation, and individual evaluations are also available to criminal justice and other agencies within the Cabinet for Health and Family Services for individuals with substance use concerns.

These services are provided in accordance with statutory authority under KRS Chapter 222, which governs alcohol and drug education, treatment, and rehabilitation; KRS 431.100, related to alcohol intoxication fees; KRS 189A, which addresses DUI assessment, education, and treatment; and KRS 218A.410, concerning drug forfeiture. Together, this coordinated system of prevention, treatment, and recovery support ensures access to a robust array of services that promote wellness, reduce harm, and improve outcomes for Kentuckians of all ages.

Services for Adults with Co-Occurring Mental Health/Substance Use Disorders

It is well known that a large percentage of individuals with mental health disorders also have substance use disorders. Traditional silos have been challenging in the quest for integrated evidence-based care for these individuals. Efforts by Kentucky to support integrated care include:

- Restructuring the Plan and Budget process to include plans for all treatment, including substance use disorder treatment and individuals with co-occurring mental health and substance use disorders;
- Including language in required Plan and Budget forms that address having programming that is integrated for mental health and substance use disorders;
- Utilization of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and the Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools in reviewing local programming;
- Including administrative staff for co-occurring substance use and mental health disorders in both the Division of Substance Use Disorder and the Division of Mental Health;
- Requiring in contracts with CMHCs that all regions hire at least 2.0 full-time equivalents (FTE) peer support specialists with lived experience in substance use disorders or co-occurring substance use and mental health disorders;
- Supporting the creation and maintenance of support groups such as Double Trouble in Recovery (DTR) through advocacy organizations staffed by individuals with lived experience in co-occurring disorders;
- Encouraging the use of Integrated Dual Diagnosis Treatment (IDDT) with ACT teams and outpatient service settings;
- Providing training and consultation to Coordinated Specialty Teams regarding how to identify co-occurring substance use disorder, and how to treat it in tandem with first episode psychosis; and
- Providing workshops at Kentucky School (which has traditionally been designed for substance use disorders) that focus on integrated treatment and mental illness.

Through a department-wide technical assistance partnership with Zia Partners, Kentucky is fostering a culture of welcoming, person-centered, and integrated care for individuals with co-occurring mental health and substance use disorders. This collaboration supports system transformation by aligning policy, practice, and data strategies to improve identification, access, and delivery of evidence-based, integrated treatment across mental health and substance use systems. Division of Mental Health staff have begun reviewing service data for individuals with co-occurring disorders to identify intervention points that will assist with statewide implementation of integrated care. One data point identified is that although 11 CMHCs currently report providing integrated care through the mental health system (including individuals with SMI), there is no service code for "integrated treatment," thus treatment provided cannot be captured adequately. Treatment is shown as individual or group therapy, but it is unknown if evidence-based integrated treatment is truly being provided to individuals identified as having co-occurring disorders. Work continues in this area.

Rehabilitation Services (Includes Educational and Employment Services)

The Psychiatric Rehabilitation Association (www.psychrehabassociation.org) defines psychiatric rehabilitation as services

that help individuals with mental illness develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice. Psychiatric rehabilitation services are collaborative, person-directed, individualized, and evidence-based.

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 because it has been extensively documented, validated, and replicated in hundreds of different settings over the past two decades. This model also addresses the significant components of Community Support Services identified by DBHDID, with a focus on enhancing the lives of individuals with psychiatric disabilities by improving their use of skills and/or environmental supports to live, learn, work, and socialize in the community and the role of their choice.

DBHDID aligns its recovery framework with 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.

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

Currently, DBHDID, Kentucky Medicaid, the CMHCs, and other providers have not adopted a specific model of practice. Some programs have independently adopted a model but have struggled to implement and maintain a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

The DBHDID supports the provision of these key psychiatric rehabilitative services at the regional level:

- Therapeutic rehabilitation programs;
- Supported employment;
- Supported education;
- Illness, management and recovery;
- Peer support services;
- Comprehensive community supports;
- Permanent supportive housing; and
- Assertive community treatment.

While each relies on psychiatric rehabilitation foundations, each is supported in very different ways.

DBHDID supports psychiatric rehabilitation services through the CMHCs in a variety of ways:

- The Division of Mental Health coordinates the statewide Community Support Program (CSP) and designates the Adult Mental Health and Recovery Services branch program manager to provide statewide oversight;
- Contracts with CMHCs require designation of a regional Community Support Director and attendance at quarterly meetings;
- Technical assistance and training is provided for CSP Directors who coordinate services for the state's therapeutic rehabilitation programs (TRP). TRPs are goal-directed services designed to enhance skills in living, working, and socializing within communities of one's choice. Technical assistance is provided to regional programs on how to incorporate psychiatric rehabilitation technology into daily programming. At the end of SFY 2025, 12 CMHCs offered therapeutic rehabilitation services to individuals with SMI;
- The Division of Mental Health (DMH) designates a statewide Individual Placement and Support (IPS) Supported Employment Program Administrator;
- Collaboration between the DMH and several agencies (Office of Vocational Rehabilitation, Human Development Institute of the University of Kentucky, and others) has established implementation support for IPS Supported Employment for adults with SMI across the state. IPS in Kentucky began with a grant from Johnson & Johnson at Dartmouth in 2010. In addition to a DMH program administrator, a full-time IPS coordinator, and several additional fidelity reviewers, coaches, and trainers are available to support IPS implementation within an infrastructure developed in collaboration with a steering committee.
- Kentucky has significantly expanded its Individual Placement and Support (IPS) Supported Employment program, now serving 78 of the state's 120 counties. This initiative is delivered through 14 Community Mental Health Centers (CMHCs) and seven additional community providers. The program has also broadened its scope to include individuals with intellectual and developmental disabilities, as well as those experiencing substance use disorders, ensuring more comprehensive support for diverse populations. The DMH, in collaboration with the Office of Vocational Rehabilitation, hosts an annual IPS conference, inviting IPS supported employment specialists and their supervisors, vocational rehabilitation counselors, and others from across the state to participate in learning opportunities and to discuss barriers and strategies to address those barriers;
- Supported Education is now a Medicaid-reimbursable service through the 1915 (i) Medicaid State Plan Amendment for

eligible individuals with SMI. Supported Education services are provided in tandem with IPS Supported Employment services.

- Contracts with the CMHCs require all regions to provide access to ACT, IPS-supported employment, and Peer support services for adults with SMI. At the end of SFY 2025, all CMHCs across the state are providing ACT services, IPS-supported employment, and adult peer support services to adults with SMI;
- Eight CMHCs are providing access to Illness, Management and Recovery (IMR) services, an evidence-based practice for adults with SMI;
- Twelve CMHCs are providing Comprehensive Community Supports to individuals with SMI, a service designed to offer skill-building services in community settings to assist with independent living, and;
- While not widely utilized at the moment, all CMHCs provide access to educational services to adults with SMI. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills to compete in the workforce. A lack of literacy skills hinders the personal advancement of an additional 656,000 Kentuckians. The lack of available educational services can significantly hinder individuals with SMI in accessing and maintaining employment and can negatively impact their quality of life. In addition, young adults experiencing their first episode of psychosis require supported education programming to navigate school successfully and/or explore higher education opportunities with good outcomes. The 1915 (i) RISE initiative offers eligible individuals with SMI access to supported education services in Kentucky.

One of the key components of rehabilitation services is housing. It isn't easy to focus on anything except where you will live if you do not have a place to live. DBHDID requires, via contract, that CMHCs provide supportive housing services in accordance with the SAMHSA Permanent Supportive Housing Toolkit and conduct an annual self-assessment of supportive housing services using the SAMHSA Permanent Supportive Housing fidelity scale. Additionally, DBHDID contracts with other community partners to provide supportive housing services.

Ten of the 14 CMHCs have developed housing units covering the wide range of those they serve. As of the plans submitted for SFY 2025, the total number of units owned and operated by CMHCs across the Commonwealth is 1,058. Many of these units are embedded in local mainstream housing that is owned and/or operated by the CMHC.

Although adult rehabilitation services are widely available, access to services is often inconsistent and inadequate to meet the needs. Only a fraction of the estimated adults with SMI in the state participate in rehabilitation programs offered through the CMHCs.

Quality, timely service delivery remains challenged by several factors including:

- Kentucky Medicaid reimbursement rates for TRP, ACT, and peer support are low and significantly below the reimbursement rate for outpatient treatment services;
- Although Kentucky Medicaid reimburses for ACT and TRP services, reimbursement is inconsistently applied across the state when a client is enrolled in both programs concurrently. Providing coverage through Kentucky Medicaid for a client to attend TRP in conjunction with receiving ACT services ensures a comprehensive, recovery-oriented approach for individuals with serious mental illness. Together, these services reinforce one another- ACT promotes stability and engagement, and TRP cultivates independence and resilience.
- Most funding sources other than Medicaid do not reimburse for TRP, ACT or peer support services, so individuals without Medicaid have difficulty accessing this service;
- Some rehabilitation services are inconsistent and do not have a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Medicaid 1915(i) State Plan Amendment now reimburses supported employment for those who qualify, but there is limited funding for the long-term employment supports needed by adults with SMI who may not qualify;
- The advent of Managed Care and Kentucky's contracts with five separate Managed Care Organizations (MCOs) have led to numerous difficulties with authorizations for TRP, ACT, and other rehabilitation services. Each CMHC must have contracts with each of the five MCOs and negotiate for each service;
- Difficulties with transportation, especially for individuals who do not qualify for Medicaid benefits.

3. Describe your state's case management services

Targeted Case Management (TCM) for adults with SMI or children with SED is a covered service in Kentucky's Medicaid state plan. TCM for individuals with SUD is also a covered service. DBHDID also provides funding to cover this service for individuals without insurance or those with 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. 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. Most credentialing activities occur through an online portal and are managed by the Division of Program Integrity within DBHDID. Both Kentucky Medicaid and DBHDID have promulgated regulations for TCM that outline credentialing and service provision requirements. These regulations are as follows:

- DBHDID regulation for TCM: Eligibility and Training Requirements <https://apps.legislature.ky.gov/law/kar/titles/908/002/260/>
- Medicaid regulation for TCM: Coverage provisions and requirements regarding TCM for individuals with SMI and children with SED. <https://apps.legislature.ky.gov/law/kar/titles/907/015/060/>
- Reimbursement provisions and requirements regarding TCM for individuals with SMI and children with SED. <https://apps.legislature.ky.gov/law/kar/titles/907/015/065/>
- Coverage provisions and requirements regarding TCM for individuals with SUD.

<https://apps.legislature.ky.gov/law/kar/titles/907/015/040/>

- Reimbursement provisions and requirements regarding TCM for individuals with SUD.

<https://apps.legislature.ky.gov/law/kar/titles/907/015/045/>

- Coverage provisions and requirements regarding TCM for individuals with a co-occurring SMI or SED or SUD and a Chronic Physical Health Condition. <https://apps.legislature.ky.gov/law/kar/titles/907/015/050/>

- Reimbursement provisions and requirements regarding TCM for individuals with a co-occurring SMI or SED or SUD and a Chronic Physical Health Condition. <https://apps.legislature.ky.gov/law/kar/titles/907/015/055/>

As explained in Criterion 2, Kentucky's statutory definitions for SMI and SED are more stringent than the federal definitions; therefore, the prevalence rates are lower than those most used nationally. Based on an estimated prevalence rate of 2.6% of the adult population in Kentucky, the CMHCs served approximately 54% (42,986 of 79,196) of the estimated number of individuals with SMI. 7% (5,567) of individuals with SMI received TCM services, during SFY 2024. Based on an estimated prevalence rate of 5% of the child (under age 18) population in Kentucky, the CMHCs served approximately 40% (19,940 of 49,756) of the estimated number of those individuals with SED, and 6.8% received TCM (3,386) services, during SFY 2024 (unduplicated counts).

4. Describe activities intended to reduce hospitalizations and hospital stays.

In response to higher census which has sometimes strained capacity at the four state-operated or state-contracted psychiatric hospitals, a steering committee composed of the psychiatric hospital facility directors and DBHDID leadership staff was organized. Four focused work groups under the oversight of this steering committee were formed to address the following issues:

1. Data trends - This group has undertaken a comprehensive short- and long-term analysis of admission numbers, counties of residence, legal status upon admission and at discharge, length of stay, and other relevant factors. The goal of the work group is to better understand factors which increase hospital census in order to determine needed system adjustments to better regulate facilities' census by reducing inappropriate admissions and promoting the use of less restrictive alternatives to hospitalization.

2. Hospital referrals - This group was formed to address referrals to one of the state psychiatric hospitals from a free-standing private psychiatric hospital, since the private hospital sends a large number of patients to the state facility on a regular basis. Analysis of diagnostic and length of stay data on these referrals suggests that a subset of the patients without serious mental illness who do not require extended hospital treatment could potentially be diverted to local outpatient treatment. Next steps will include coordinating care between the two facilities to develop a more consistent referral algorithm to make sure each patient is served in the most appropriate setting.

3. Involuntary commitment training - This group, comprised of community mental health center crisis managers and state hospital facility staff, is working to create a standard training curriculum regarding civil commitment processes for qualified mental health professionals who conduct clinical certifications of individuals referred for involuntary hospital treatment. A standardized training program will increase clinicians' competency in conducting these evaluations as well as promoting more uniformity in processes and procedures throughout the state.

4. Alternative transportation models - This group is exploring models from other states to supplement law enforcement transportation of individuals being evaluated for civil commitment with contracted private transportation vendors. A budget proposal to develop and implement a pilot alternative transportation project in selected community mental health center regions is being prepared for submission to the next state biennial budget.

Additionally, The Kentucky Judicial Commission on Mental Health, in partnership with DBHDID, is hosting a series of 14 virtual regional meetings (one for each community mental health center region) with court, behavioral health and law enforcement leadership to support improving the Kentucky Revised Statutes (KRS) Chapter 202A civil commitment process. These interactive forums provide an opportunity to identify challenges, share best practices, and develop localized solutions to better serve individuals in crisis. DBHDID executive staff also regularly communicate with all of these community partners to offer immediate consultation and technical assistance around case-specific concerns arising in the 202A process.

DBHDID provides 24/7 access to the crisis continuum for all Kentuckians through the 988 Suicide & Crisis Lifeline network. All 14 CMHCs operate a 988 call center, one provides 988 chat/text services on a limited schedule, and one center will provide 24/7 access to 988 chat/text services by November 2025. The statewide 988 workforce receives extensive training on triage and screening, crisis de-escalation, working with high-risk populations, and providing appropriate referrals. All individuals who contact 988 are offered a follow-up contact within 72 hours by their preferred method of contact. Through the 988 network, individuals have access to the most local and least restrictive care tailored to their specific crisis.

In addition to 988 providing early access to crisis services in Kentucky, significant efforts are underway to engage emergency services at both the local and state levels. Each center has long-standing relationships with 911 centers and local law enforcement, which are being formalized around 988. The Kentucky 988 centers are developing Memoranda of Understanding (MOU) with local 911 centers for warm handoffs between the centers. Awareness and education about 988 as an entry point to crisis services are being promoted alongside 911, law enforcement, fire, and Emergency Medical Services (EMS). Materials have been created for distribution by emergency services encountering an individual in crisis. Through ongoing engagement with emergency services, individuals experiencing behavioral health issues can be connected to services via 988, thereby reducing the need for emergency services involvement and hospitalizations.

DBHDID believes that addressing the issue of continuity of care through a well-planned aftercare process is crucial to ensuring a successful transition from psychiatric hospitals and other facilities to the community. Providing appropriate aftercare following a hospital stay or transition from a higher level of care is critical to reducing hospital readmission rates, enhancing community housing tenure, and ultimately improving quality of life.

DBHDID addresses continuity of care for adults with SMI through several avenues. Through contracts with 14 CMHCs, DBHDID requires each region to provide an outpatient appointment for adults with SMI within 14 calendar days of discharge from a state psychiatric facility. DBHDID also requires the assignment of a targeted case manager and provision of targeted case management services to adults with SMI who are discharged from a state psychiatric facility within 14 calendar days. Since SFY 2013, CMHC contract language has also included a requirement that individuals within the Department for Corrections' Psychiatric Treatment Unit (CPTU), an all-male unit within Kentucky State Reformatory, and individuals within the Psychiatric Care Unit (PCU), an all-female unit within Kentucky Correctional Institute for Women, who have SMI and are serving out or being paroled, have an outpatient appointment within 14 calendar days of release.

The CMHCs and state-operated or state-contracted psychiatric hospitals work closely together to ensure continuity of care. All contracts with these entities address continuity of care issues, including medications, discharge plans, case management, and outpatient referrals. There are also a series of various meetings designed to assist with continuity of care planning:

- Continuity of Care meetings occur at least quarterly within each state-operated or/contracted psychiatric hospital and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, to facilitate collaboration between the hospitals and the CMHCs. System-wide issues, including admission and discharge processes, follow-up procedures for outpatient appointments, medication access, strategies to reduce readmission rates, and general communication concerns, are also on the agenda.
- Olmstead Committee and Regional Transition Committee meetings are held monthly within each state-operated or state-contracted psychiatric hospital catchment area. Beginning in 2022, following COVID-19 pandemic adaptations and in recognition of overlapping goals and stakeholders, DBHDID formally merged the previously separate Olmstead Committee and Regional Transition Committee meetings. The goal is to streamline coordination, reduce redundancy, and enhance cross-agency collaboration to support timely and appropriate community transitions for individuals with serious mental illness (SMI).

Participants include DBHDID staff, Community Mental Health Center (CMHC) staff, Kentucky Protection and Advocacy, the Department for Community Based Services (DCBS), the Kentucky Long Term Care Ombudsman, Managed Care Organizations (MCOs), hospital discharge planners, and other key community stakeholders. The combined structure allows for more efficient planning and oversight of both Olmstead-related transitions and those connected to the state's broader system transformation and Settlement Agreement efforts.

Key Functions of the integrated meetings include:

- Reviewing individuals currently hospitalized who meet the Olmstead criteria:
 - o Hospitalized for 90+ days.
 - o Experiencing frequent readmissions within one year.
 - o Determined by clinicians to be appropriate for community-based care.
 - o Have chosen community placement through fully informed decision-making.
 - o Have a placement option that can be reasonably accommodated.
- Identifying and planning transitions for adults with SMI who:
 - o Are currently residing in or at risk of admission to a personal care home (PCH).
 - o Are hospitalized and meet criteria for the state's Settlement Agreement population.
- Coordinating the use of Olmstead Flexible Funds, which DBHDID allocates to each state hospital's CMHC catchment area. These funds, managed by a designated CMHC, are used to secure essential goods, services, and supports to help eligible individuals remain in or transition to integrated community settings.
- Facilitating cross-system accountability and problem-solving to reduce unnecessary institutionalization and increase access to permanent housing, supported employment, wraparound services, and peer support.

In alignment with national best practices, Kentucky has entered the discovery phase of implementing the Peer Bridger model, in partnership with the Alliance for Rights and Recovery. The Peer Bridger model is designed to embed peer specialists within inpatient and community settings to support individuals with SMI as they prepare for discharge from psychiatric hospitals and transition back into the community. While full implementation logistics are still being developed, the model is expected to strengthen Kentucky's continuum of care by improving engagement, reducing readmission rates, and supporting recovery through consistent peer relationships.

Psychiatric inpatient facilities are encouraged to refer individuals to ACT to reduce the likelihood of repeat hospitalizations. ACT team leaders assess individuals onsite before discharge and, when appropriate, initiate the onboarding process before the individual leaves the facility. A statewide ACT referral form has been developed to streamline and standardize this process. Additionally, new contract language with all 14 Community Mental Health Centers (CMHC) requires that all ACT referrals from inpatient facilities be assessed, with a response provided within 72 hours of submission. This language ensures that referrals are

addressed promptly and that essential services are in place prior to discharge. DBHDID has worked with each of the state-operated/contracted psychiatric hospitals and their assigned CMHCs to assist with the development of a Memorandum of Agreement (MOA) between the two entities. To ensure a seamless system of care, the need was identified to strengthen the relationships between hospitals and CMHCs. The MOAs include the contractual responsibilities each entity has to the DBHDID but also define and clarify roles and responsibilities for the hospital and CMHC to ensure continuity of care for the individuals they both serve.

DBHDID strategies to reduce unnecessary psychiatric inpatient utilization also include the development of residential crisis stabilization programs, additional behavioral health crisis services, such as mobile crisis, continued development of other community support services as effective alternatives to inpatient services for individuals, as well as opportunities for community partners to discuss pertinent strategies for creating "warm hand-offs."

DBHDID, through contracts with CMHCs, has been strengthening the system of care for adults with SMI by enhancing billable services such as ACT, peer support, and comprehensive community supports, as well as building better infrastructure for outpatient and residential crisis services for all individuals, including those with co-occurring substance use disorders. Continuity of care is a significant priority for the DBHDID. With the implementation of the 1915 (i) RISE initiative, additional fee-for services Medicaid reimbursement will now be available for 10 services, including supervised residential care, independent living supports, housing and tenancy services, supported employment and education, transportation, medication management, planned respite for caregivers, assistive technology, and case management for eligible individuals with SMI. Challenges include:

- Limited 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, and other resources.
- Lack of consistency in beliefs about the reality of recovery for individuals with SMI, and subsequent lack of adoption of the recovery mindset by all providers.

5. Please indicate areas of technical assistance needs related to this section.

None at this time.

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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	79,196	42,986
2.Children with SED	49,756	19,940

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Estimate of Prevalence – Serious Mental Illness (SMI)

In 1962, as Kentucky was writing statutes and regulations for the creation of the Community Mental Health Centers, the first Kentucky statute was written that outlined a definition for chronic mental illness (CMI) as serious mental illness was first known in Kentucky. That statute, KRS 210.005, still exists and includes the following broad definition for SMI for Kentucky:

"Chronic" means that clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two years, or that the individual has been hospitalized for mental illness more than once in the last two years, and that the individual is presently significantly impaired in his ability to function socially or occupationally, or both.

In 1992, with the passage of P.L. 102-321, the federal law that governs 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 federal definition, and states were also encouraged to create their own definitions. The federal definition for "adults with a severe mental illness" was originally published on May 20, 1993.

After that, later in the 1990s, a work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of "chronic mental illness" and assisted in creating Kentucky's definition of adult with SMI, as currently operationalized. This definition utilizes the following age, diagnosis, disability, and duration criteria:

1. Age 18 or older

AND

2. Diagnosis of a Major Mental Illness (Schizophrenia Spectrum and Other Psychotic Disorders; Bipolar and Related Disorders; Depressive Disorders; Trauma and Stressor Related Disorders)

AND

3. Clear evidence of functional impairment in two or more of the following domains (Societal/Role Functioning; Interpersonal Functioning; Daily Living/Personal Care Functioning; Physical Functioning; Cognitive/Intellectual Functioning)

AND

4. One or more of these conditions for duration (Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two years; The individual has been hospitalized for mental illness more than once in the last two years; OR There is a history of one or more episodes with marked disability and the illness is expected to continue for a two year period of time)

The 1999 federal methodology for estimating adults with serious mental illness required states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness, and an estimated rate of 2.6 percent for adults with severe and persistent mental illness (SPMI). Kentucky's definition for SMI aligns more closely with the federal SPMI definition. For this reason, Kentucky uses the 2.6 percent formula to obtain prevalence estimates.

Using the 2.6% state prevalence estimate and the 2020 Census data for Kentucky, prevalence rates are established. These data shown below are based on adults with SMI served by CMHCs across the state during the last few state fiscal years.

2020 Adult (18+) Census – 3,045,985

Estimated number of adults with SMI (2.6% of Kentucky's adult population) – 79,196

Number of Adults with SMI served in SFY 2020 – 43,410 or 50% (of the 2.6% SMI population)

Number of Adults with SMI served in SFY 2021 – 43,326 or 55% (of the 2.6% SMI population)

Number of Adults with SMI served in SFY 2022 – 44,178 or 56% (of the 2.6% SMI population)

Number of Adults with SMI served in SFY 2023 – 44,353 or 56% (of the 2.6% SMI population)

Number of Adults with SMI served in SFY 2024 – 42,986 or 54% (of the 2.6% SMI population)

By utilizing these data for planning purposes, CMHCs are aware of the number of adults with SMI in their service area that may be in need of services. DBHDID staff also analyze these numbers by CMHC region for planning purposes in order to determine which areas are in more need of training and/or technical assistance regarding this population. It should be noted that a few CMHCs serve 100% or more of the adults with SMI estimated for their region. However, other CMHCs serve a much lower percentage of their estimate.

Estimate of Prevalence – Serious Emotional Disturbance (SED)

In Kentucky, criteria for determining whether a child is experiencing SED were included in the enabling legislation (KRS 200.503) for the Kentucky Interagency Mobilization for Progress in Adolescent and Child Treatment (IMPACT) program in 1990. These criteria are still relevant and utilized today and 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.

Using 2020 census data and the state's agreed upon estimate of five percent, prevalence rates are established. The data shown below are based on children with SED served by the CMHCs across the state during the last few state fiscal years.

2020 Child (under aged 18) Census – 995,111

Estimated number of Children with SED (5% of Kentucky's child population) – 49,756

Children with SED Served SFY 2020 – 24,094 or 47% (of the 5% SED population)

Children with SED Served SFY 2021 – 20,082 or 40% (of the 5% SED population)

Children with SED Served SFY 2022 – 21,441 or 43% (of the 5% SED population)

Children with SED Served SFY 2023 – 21,079 or 42% (of the 5% SED population)

Children with SED Served SFY 2024 – 19,940 or 40% (of the 5% SED population)

By utilizing these data for planning purposes, CMHCs are made aware of the number of children in their serve area in potential need of services. The CMHCs also rely heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also utilized for program planning. (www.kyouth.org.)

3. Please indicate areas of technical assistance needs related to this section.
None at this time.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?^[1]

a)	Social Services	☒ Yes	☐ No
b)	Educational services, including services provided under IDEA	☒ Yes	☐ No
c)	Juvenile justice services	☒ Yes	☐ No
d)	Substance use 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 systems	☒ Yes	☐ No

2. Please indicate areas of technical assistance needs related to this section.

None at this time.

^[1] A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

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 tailored services to rural population with SMI/SED. See the federal [Rural Behavioral Health](#) page for program resources.

Children with SED and their families

Kentucky is a primarily rural state. According to the 2020 Census, 93 of Kentucky's 120 counties are predominantly (more than 50 percent) rural, with 54 of these counties classified as entirely rural, having no designated urban areas within their boundaries. Rural counties are disproportionately impacted by poverty. According to the 2024 Kentucky Kids Count data, 21% of Kentucky's children are living in poverty, and 44% in households with low income (below 200% of the federal poverty level). An added risk for becoming unhoused is the large number of children (44%) in Kentucky households with a high rental cost burden.

Transportation in rural areas poses a considerable challenge, as families often lack access to reliable transportation, and with few exceptions, public transportation is non-existent. As a result, many children are unable to travel to service providers, and service reimbursement rates do not account for travel time, resulting in inconsistent availability of home-based services across the state.

Finally, 105 of Kentucky's 120 counties are designated as health professional shortage areas by the Health Resources and Services Administration (HRSA), and 111 counties are explicitly identified as mental health shortage areas by the Rural Health Information Hub. These workforce shortages create further barriers to families seeking mental health services for their children.

Kentucky Client and Event data indicates that in SFY 2023 and SFY 2024, the Community Mental Health Centers (CMHCs) served 49% and 44%, respectively, of youth estimated to have SED living in rural areas, despite identified challenges. In addition to the challenges faced by families, provider agencies in rural areas also encounter difficulties in serving children and families within their respective communities. Rural county offices often have a minimal number of staff, with clinicians who serve all ages of service recipients; access to clinicians who specialize in services for children and families is often limited. To better meet the needs of children and their families, CMHCs employ targeted case managers, high fidelity wraparound facilitators, community support associates, and family and youth peer support specialists to assist with outreach to and engagement of families in rural areas. These staff members have more flexibility in their schedules, which allows them to travel to meet families in locations that are easily accessible for them. These staff members can access limited amounts of state flexible funding available to children with SED and their families to provide necessary goods and services for which there is no other source of payment. They also collaborate closely with other community agencies and non-profit organizations that may offer transportation, childcare, and other types of assistance to families. School-based clinicians and supportive staff collaborate with local education district Directors of Pupils and Personnel, district homeless coordinators, and Family Resources/Youth Services Center staff to identify children with SED. They work together with families and other community and natural supports to identify and prioritize needs, including mental health and substance use issues, and connect with those who can support the safety, health, and well-being of children with SED and their families.

Adults with SMI

Three of the most common barriers to mental health services in rural areas of Kentucky for adults with SMI are isolation, transportation issues, and a limited workforce. Isolation can be partially attributed to the geographical distance between neighbors and/or amenities. Still, it may be 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 approach to tackling the ongoing problem of isolation in rural areas has been to intentionally recruit, train, and integrate family and peer support staff. These individuals bring lived experience and community trust, helping to reduce stigma, build relationships, and expand the reach of behavioral health services to those who might otherwise stay disconnected from care.

Adult peer support specialists serve as a crucial link across the behavioral health spectrum in rural communities. They foster genuine engagement, promote sensitive and trauma-informed approaches, and assist individuals in navigating complex systems. Their presence not only improves access but also boosts retention in services and leads to better recovery outcomes, especially in areas where traditional workforce shortages and social isolation pose significant barriers.

Transportation barriers remain one of the most significant concerns among providers, service recipients, and family members. The Human Service Transportation Delivery (HSTD) program pools existing public transportation funds, including Medicaid non-emergency transportation. HSTD services are coordinated by the Kentucky Transportation Cabinet and provide non-emergency, non-ambulance medical transportation services to eligible recipients of Medicaid, Medicare, Vocational Rehabilitation, and the Department for the Blind. Twelve transportation regions statewide operate 24 hours a day, seven days a week, with a single broker or broker/provider established in each area. Service recipients access transportation services through a toll-free phone number. Eleven of the 14 CMHCs report engaging in initiatives to better coordinate transportation services for adults with SMI in

their regions. When no other source of funding is available, state flexible funding for individuals with SMI eligible for targeted case management services may be used to cover transportation costs.

Rural communities often have fewer workers and limited resources to provide behavioral health services. It is crucial for rural behavioral health agencies to establish collaborative agreements with primary care physicians, senior citizen centers, church groups, government agencies, and other organizations. Rural case managers have been resourceful in helping individuals with serious mental illnesses meet their needs by identifying and developing local resources, serving as vital links to both formal and informal services and supports in rural Kentucky. Over the years, Kentucky law has introduced licensure categories for additional professionals to offer mental health services. DBHDID will continue working with rural communities and other groups to address funding, training, and to bring all stakeholders together at the state and local levels to strategize best practices.

The benefits of implementing telehealth in rural areas are widely recognized. Because recruiting qualified medical and clinical staff to work in rural regions is challenging, telehealth helps extend staff coverage from a central location to remote clinics and other service sites. Access to these services has significantly increased across the state due to the pandemic, and all 14 CMHCs now report delivering or accessing services through the telehealth network. Telehealth is used statewide to improve access to providers offering therapy, medication management, case management, and peer support, based on individual preferences. However, internet connections in rural areas of the state can be limited, reducing access even further. Detailed examples are available under MHBG Criterion 5 of this application.

While the problems of isolation, transportation, and workforce are common to rural areas in Kentucky, each rural community has its unique issues because of geographical and social differences. Thus, the strategies to address them must be collaborative among local, regional, and state-level stakeholders.

- b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal [Homeless Programs and Resources](#) for program resources¹

Children with SED and their families

For the 2023-2024 school year, the Kentucky Department of Education (KDE) reported that 22,362 unduplicated children and youth, aged 3-21, enrolled in public schools met the definition of being homeless. Using a 5% estimated prevalence rate, an estimated 1,118 children and youth experiencing homelessness and served by Kentucky public schools met criteria for a serious emotional disturbance (SED). However, this likely underestimates the actual need, as children with unstable housing face significantly higher risk factors for mental health challenges. Further limitations of these data are that only children enrolled in public school are included. Children under age five who do not qualify for public preschool and youth who drop out of school (who may be at higher risk for mental health challenges) are omitted. In addition, there are nearly 65,000 students in private schools in Kentucky, bringing the estimated total to 3,250 more children and youth who meet the criteria for SED. Finally, children and youth who are homeschooled are also excluded from the count. More than 38,000 school-age children in Kentucky are homeschooled, increasing the estimated prevalence of SED among this population by 1,900. While homeschooling can be a deliberate choice for some families, for others, especially those facing housing instability, it may be a necessity due to barriers in accessing public education. Challenges such as a lack of transportation, documentation, or a stable address can make public school enrollment difficult, leading some homeless families to opt for homeschooling.

The KDE adheres to the United States Department of Education (USDE) Homeless Non-Regulatory Guidance that defines homeless children and youths as individuals who lack a fixed, regular, and adequate nighttime residence. The term includes:

- Children and youth who are:
 - o sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason (sometimes referred to as doubled-up);
 - o living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations;
 - o living in emergency or transitional shelters; or
 - o abandoned in hospitals;
- Children and youth who have a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;
- Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
- Migratory children who qualify as homeless because they are living in the circumstances described above.

DBHDID Client/Event data show that the CMHCs served 285 youth with SED who experienced homelessness in SFY 2023, and 268 in SFY 2024, indicating that approximately 1% of youth with SED who were served by the CMHCs reported experiencing homelessness. This is likely an underestimate, as information about housing stability is updated infrequently and may be underreported by families.

Each CMHC prioritizes services and supports to individuals experiencing homelessness, including children who have SED and their families. Children's mental health staff follow the system of care framework and take a whole child/family approach to their work, coordinating efforts to locate and secure safe housing for children and youth with SED and their families. In Kentucky, children experiencing homelessness can be found in both "traditional" locations, such as cities and larger metropolitan areas, and in rural parts of the state, where they often stay with friends and family members for short periods, in other non-home locations, and are usually transitory. Connecting with children who frequently move is challenging. Identification, outreach, and engagement

strategies for children and youth experiencing homelessness are similar to those described above for those living in rural areas. CMHC staff also rely on teachers, child welfare staff, and community influencers to assist with the location and engagement of children who are experiencing homelessness, with priority being given to ensuring the children's safety and basic needs.

A Transition Age Youth (TAY) cross-branch implementation team was established within DBHDID. This team consists of key liaisons from the Adult Mental Health and Recovery Services Branch, the Children's Behavioral Health and Recovery Services Branch, the Mental Health Promotion, Prevention, and Preparedness Branch, the Adult Substance Use Treatment and Recovery Services Branch, and the Substance Use Prevention and Promotion Branch. This state-level TAY cross-branch team is charged with enhancing the seamless coordination of behavioral health services for transition-age youth across child and adult services, as well as substance use prevention and treatment.

To support this work at the local level, DBHDID established a Transition Age Youth (TAY) Coordinator within each of the 14 CMHCs. This position is responsible for collaborating across local programming to enhance supports that are developmentally appropriate and evidence-informed for youth, young adults, and their families who are affected by serious behavioral health issues (mental health and substance use), including SED and SMI. The TAY Coordinator serves as the regional expert on transition-age youth best practices and works to build the capacity within the region to provide excellent supports and services for the TAY population (14-26 years old).

Thirteen counties across Kentucky operate TAYLRD (Transition Age Youth Launching Realized Dreams) Drop-in Centers for transition age youth and young adults. Behavioral health support, including peer support and clinical services, as well as assistance with finding housing and other resources, is offered in an appealing environment for young people (16-25 years old) and includes open access hours.

Kentucky River Community Care, a CMHC in southeastern Kentucky, operates a Youth Homeless Demonstration Program (YHDP), which supports homeless or at-risk youth through community support associates and housing navigators, linking them to housing, employment, education, medical care, and behavioral health services. The Host Home Program at Kentucky River provides housing for youth ages 14-24, along with fuel and grocery stipends. Meanwhile, two crisis homes in Letcher and Perry Counties offer immediate shared housing for individuals aged 18-24.

Adults with SMI

DBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to Kentucky's population experiencing homelessness, including adults with SMI. At the state level, DBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, individuals with lived experience, and government officials, established to develop statewide systems and policies that forge partnerships among state agencies that allow communities to achieve local solutions to homelessness, in addition to establishing targets for permanent supportive housing production. The KICH Plan to Prevent and End Homelessness is an expression of a collective commitment to actively seek long-term and sustainable solutions to homelessness, rather than continuing to manage episodes of homelessness as they occur. The primary focus of this plan is on investing local resources in a manner that better serves individuals experiencing homelessness, ultimately eliminating homelessness in Kentucky. Some areas addressed in this plan include:

- Access to mainstream services;
- Access to health insurance, including Medicaid;
- Assistance with disability application processes 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.

DBHDID, the Kentucky Interagency Council on Homelessness (KICH), and the Kentucky Housing Corporation (KHC) continue to collaborate on the SSI/SSDI Outreach, Access, and Recovery (SOAR) initiative to improve service access for individuals experiencing homelessness. As part of this effort, work is underway to develop a case management manual for service providers and a homelessness rights manual to support individuals navigating housing instability and institutional discharge. These resources, once finalized, will be housed on the KICH website and integrated into provider training efforts. Additionally, the partners continue to promote education and technical assistance related to effective discharge planning from public institutions. The partners are advancing strategies to expand access to housing through the implementation of the "Housing First" model.

Most CMHCs offer individualized services designed to alleviate homelessness as well as to provide mainstream mental health treatment to persons who are experiencing homelessness and have SMI. Of the 14 CMHCs in Kentucky:

- All CMHCs give service priority to individuals experiencing homelessness;
- Ten CMHCs do consultations with local shelters;
- Ten CMHCs have staff dedicated to individuals experiencing homelessness;
- Ten CMHCs have staff that regularly visit local homeless shelters;
- Fourteen CMHCs have walk-in clinics; and
- Six CMHCs that receive Projects for Assistance in Transition from Homelessness (PATH) funding do street outreach.

DBHDID has continued PATH grant funding to the CMHCs that received contracts in the prior year. The six CMHCs that receive PATH funds are:

- New Vista - subcontracts and works with the HOPE Center, a private non-profit shelter and homeless service provider, to provide outreach, screening, and diagnostic services, case management, mental health treatment, rehabilitation, and staff training in the Lexington/Fayette County area.
- LifeSkills, Inc. - provides outreach, case management, and training in the Bowling Green/Warren County area.
- NorthKey Community Care - utilizes a multidisciplinary outreach team to provide screening, treatment, and case management. 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 urban areas.
- Seven Counties Services - provides outreach, assessment, 24-hour crisis intervention, case management, referral, and linkage to community resources and supportive services through their Homeless Outreach Team. The program is located in Jefferson County, Kentucky (the largest urban county in the Commonwealth).
- Cumberland River Behavioral Health - provides outreach, case management and housing support services in Laurel County, a rural county in southeast Kentucky.
- Kentucky River Community Care - provides outreach, case management, housing support services, and support for six emergency apartments for individuals experiencing homelessness who have a mental illness located in Hazard/Perry County, but also includes individuals from Breathitt, Knott, Lee, Leslie, Letcher, Owsley, and Wolfe Counties in southeast Kentucky.

By combining PATH and other McKinney funds (which support specialized housing services) with state and federal funds (that fund community support services), DBHDID and the CMHCs aim to create a statewide system of outreach, community support, and mental health services for individuals with serious mental illness experiencing homelessness. DBHDID employs a full-time housing services program administrator. This person is located in the Adult Mental Health and Recovery Services Branch within the Division of Mental Health, and coordinates statewide housing services as well as manages the PATH program. The role of the State PATH Contact (SPC) is key in supporting local PATH providers across Kentucky. The SPC collaborates with local providers to prepare the annual PATH application, ensures that annual data collection requirements are fulfilled, and ensures that fund allocation and contracts are in place. Support is also given through notifications of relevant training, updates on homeless issues, and on-site technical assistance as needed.

DBHDID is also engaged with other homeless initiatives including:

- The Homeless Prevention Project helps people discharged from state psychiatric facilities find housing and access mainstream services, aiming to reduce discharges to homeless shelters. Community partners include the Lake Cumberland Regional Board, Seven Counties Services, Adanta, LifeSkills, New Vista, the Housing and Homeless Coalition of Kentucky (HHCK), the Department of Corrections, the Department for Community Based Services, and the Louisville Coalition for the Homeless. This project supports individuals leaving the prison system, those being discharged from psychiatric institutions, and youth aging out of foster care.
- Collaboration with Kentucky Housing Corporation (KHC) in the operation of local homeless planning boards (Continuum of Care Committees) in Kentucky's area development districts (which correspond to the 14 CMHC regions). CMHCs are encouraged to participate in this process for the benefit of individuals with serious mental illness who are experiencing homelessness or who may become homeless in their regions.
- A Rural Homeless Outreach program in the Mountain Comprehensive Care Center CMHC area, funded by mental health block grant funds. The goal of this program is the identification of individuals with serious mental illness who are experiencing homelessness and linkage with mainstream mental health services. Consultation and training are also provided to service providers for individuals experiencing homelessness under this initiative.
- A collaboration between DBHDID and Seven Counties, Services, the CMHC in Louisville, Kentucky, to implement an awarded five-year, \$5 million Treatment for Individuals Experiencing Homelessness (TIEH) grant from SAMHSA. Plans are to implement a street outreach initiative targeting unsheltered homelessness in the Louisville Metro area. The initiative, TEAM SOAR (Team-Engaged Assertive Mechanics for SSI/SSDI Outreach, Access, and Recovery), focuses on individuals experiencing homelessness who are also living with SMI, SED, or Co-occurring Disorders (COD), including veterans and transition-age youth (TAY). TEAM SOAR deploys multidisciplinary teams trained in the SOAR model—comprising a therapist, case manager, and peer support specialist—to conduct outreach, screening, and referrals directly in encampments and on the street. A second team provides dedicated support to transition-aged youth. The program enhances access to eligible SSI/SSDI benefits, behavioral health services, and recovery supports, helping individuals navigate complex systems and engage in long-term care. By building on existing outreach efforts and using evidence-based practices, TEAM SOAR aims to improve service access, accelerate benefit acquisition, and expand engagement among those most vulnerable to chronic homelessness. Lessons learned from the Louisville implementation will inform the development of a replicable model, with plans to expand this approach to other regions across Kentucky in the coming years.

- c. Describe your state's tailored services to the older adult population with SMI. See the federal [Resources for Older Adults](#) webpage for resources²

Using the federal formula for severe and persistent mental illness, it is estimated that approximately 2.6% of adults in Kentucky, aged 60 and older, are estimated to have a serious mental illness. Based on the 2020 Census population numbers and utilizing the 2.6% formula, there are an estimated 26,493 Kentuckians over the age of 60 with SMI. In SFY 2024, Kentucky's CMHCs served 7,226 individuals over the age of 60 with a serious mental illness (SMI), accounting for 27% of the state's total estimate.

The diagnosis and treatment of serious mental illness can be more complex in older adults due to the presence of other health diagnoses. Additionally, there is an ongoing concern regarding healthcare providers underdiagnosing depression and other mental illnesses in older adults, due to a long-standing belief and practice that a decline in mental health is a natural part of the aging process. Many older adults have not been adequately treated for their mental health issues due to a lack of recognition of the problem, ageism, stigma, and a lack of trained professionals who can identify and treat these mental health disorders.

Another issue affecting care for older adults with SMI is that they often have Medicare insurance coverage only, and many of the behavioral health services they need are not part of that benefit package. For reimbursable services, Medicare will not frequently reimburse all available professional provider types. This is especially challenging in areas where workforce shortages and staff turnover have limited the availability of provider types. Mental health block grant and state general funds can support services for individuals who may not have a payor for a needed service. However, there the availability of these funds is limited. There is a need for additional flexible funding to support the behavioral health services required for older adults.

Kentucky is home to 15 Area Development Districts (ADD), which cover all 120 counties and serve as key access points for older adult and other services. These agencies operate under the Department for Aging and Independent Living (DAIL), a sister agency to the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and include Area Agencies on Aging. DAIL and DBHDID have a longstanding history of collaboration on initiatives such as public education campaigns, statewide conferences, settlement agreement implementation, and grant proposals related to aging.

In partnership with DAIL, the University of Kentucky Sanders-Brown Center on Aging, the Kentucky Counseling Association, the Department for Community Based Services, and older adults with lived experience, DBHDID helped establish the statewide Mental Health and Aging Coalition (MHAC). This Coalition catalyzed the formation of regional coalitions supported by DAIL and each Community Mental Health Center (CMHC). Over time, DBHDID has provided mini grants to the regional mental health and aging coalitions to support educational events, provider manuals, suicide prevention initiatives, and certification training such as Mental Health First Aid for Older Adults.

Like many programs, the MHAC experienced setbacks during the pandemic, including staff turnover, decreased participation, and reduced activity. Recognizing the continued and growing need to support older adults with serious mental illness, DBHDID remains committed to revitalizing this essential work. A dedicated program administrator position has been filled, and an interdisciplinary team has already begun implementing a revitalization strategy for the MHAC.

As Kentucky's older adult population grows and becomes more diverse, the revitalized MHAC will aim to address statewide emerging needs and long-standing service gaps. These include improving integration of behavioral and physical health care, particularly in rural primary care and geriatric settings; supporting caregivers not only as stakeholders but also as recipients of behavioral health services; and addressing transportation and telehealth access barriers that disproportionately affect rural seniors. Additional needs include better support for older adults with co-occurring cognitive decline and behavioral health needs, those facing housing instability, and justice-involved older adults transitioning from incarceration.

Additionally, DBHDID is collaborating with DAIL on a suicide prevention project for older adults that is embedded in DAIL's implementation of the Innovations in Nutrition grant (INNU). This project equips service providers for older adults, especially home-delivered meal (HDM) drivers and senior citizen center staff with evidence-based suicide prevention training including Question, Persuade, and Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST), as well as training in referral protocols and media literacy and education. In the first two years of this project, 910 of these providers were trained in QPR, 120 were trained in ASIST, 67 crisis interventions were completed, and 11 educational videos were launched. Over 28,000 HDM and congregate meal participants are now supported by staff trained in suicide prevention. Plans for SFY 2026 are to expand to include Lethal Means Safety and Safe TALK training, host a post-training "What Now" session, develop a directory of ASIST-trained responders, launch a train-the-trainer series, and create three additional educational videos.

DAIL also is working with DBHDID in the creation of the Western Kentucky Senior Suicide Prevention Network (WKSSPN), an initiative stemming from the Kentucky Strategic Suicide Prevention Project (KYSSPP) that focuses on the high-risk region of the Pennyroyal Area Development District (ADD) in western Kentucky. The WKSSPN supports regional coordination and upstream suicide prevention strategies for older adults and is led by DBHDID in partnership with DAIL/Pennyroyal ADD, Pennyroyal Center Regional Prevention Center, and REACH of Louisville. The goals for WKSSPN include building sustainable, cross-sector suicide prevention partnerships, understanding risk factors for suicide among older adults to guide data-informed strategies, promoting lethal means safety through education, campaigns, and resource mapping, and providing evidence-based training for clinical and non-clinical providers.

The following goals for SFY 2026/2027 have been identified:

1. Revitalize the state Mental Health and Aging Coalition, ensuring diverse representation from state and local agencies, higher education, health care providers, caregivers, persons with lived experience, faith-based organizations, and community leaders.
2. Develop a five-year strategic plan to guide the MHAC priorities and partnerships.
3. Leverage federal and state data to inform state and local planning, with a focus on behavioral health outcomes for older adults with SMI.
4. Sponsor and host trainings and learning events (e.g., Mental Health First Aid for Older Adults, Question, Persuade, Refer (QPR), Whole Health Action Management (WHAM), Wellness Recovery Action Planning (WRAP), Trauma-Informed Care, and The ABCs of

Working with Older Adults and Caregivers).

5. Increase the MHAC digital and social media presence, including the production of short films and video content to promote wellness and reduce stigma for older adults with SMI.
6. Develop and disseminate Kentucky-specific educational materials to promote understanding of aging and behavioral health.
7. Provide technical assistance, training, and mini grants to support current and prospective local Mental Health and Aging Coalitions and to encourage regional innovation for this population.

Through this revitalization effort, Kentucky aims to build a more inclusive, connected, and responsive system of behavioral health supports for its older adult population, ensuring that no one is left behind.

Additionally, as part of strategic efforts to address service gaps among rural, homeless, and older adult populations with serious mental illness (SMI), Kentucky has entered into the discovery and planning phase of implementing the Peer Bridger model, in partnership with the Alliance for Rights and Recovery (ARR). This peer-led model is designed to support individuals as they transition from inpatient psychiatric hospitals and personal care homes back into the community, an especially critical need for people in remote areas, those experiencing housing instability, and older adults who often face fragmented services. Peer Bridgers, who have lived behavioral health experience, will provide consistent, relational support to help individuals navigate complex systems, reengage with natural and clinical supports, and regain a sense of autonomy. The model's development in Kentucky emphasizes cultural responsiveness and geographic adaptability to ensure it meets the diverse needs of underserved populations while strengthening continuity of care and promoting long-term community integration.

- d.** Please indicate areas of technical assistance needs related to this section.

None at this time.

¹ <https://www.samhsa.gov/homelessness-programs-resources>

² <https://www.samhsa.gov/resources-serving-older-adults>

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**1. 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. Offered below is discussion about the status of the three key management components for Kentucky.

Component 1: Financial

Kentucky implemented 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 enrolled in the expansion of Medicaid. Additionally, during the same time period, a new Kentucky Medicaid State Plan Amendment (SPA) was approved by the Center for Medicare and Medicaid Services (CMS) that impacted Kentucky's behavioral health system by opening the network of available providers in the state, adding additional services to the Medicaid reimbursement list, and making all services available in the community as well as in the office, due to the Rehabilitation Option. Through this SPA, substance use disorder services, an array of crisis services, and many additional evidence-based practice options became Medicaid reimbursable for the first time. As a result of these changes, DBHDID evaluated purchasing options, redesigned CMHC contracts and implemented performance-based contracting.

The Cabinet for Health and Family Services (CHFS) contracts with Managed Care Organizations (MCOs) to coordinate behavioral health services for individuals with Medicaid across the state. As of SFY 2025, there are five MCOs coordinating these services. Providers must negotiate services and reimbursement rates and provide authorization requirements for each service with each separate MCO. Some providers are more successful at this process than others. During the pandemic, some authorization requirements from MCOs were relaxed temporarily to make services more readily available for those in need. Providers are adjusting to the rollback of some of those relaxed requirements.

As described earlier in this grant application, CMHCs are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators but are given some autonomy in how funds are distributed based on regional priorities.

DBHDID is awarded state general funds for community mental health services as a result of an annual allocation from the state General Assembly. The funding amounts are a result of a biennium budget proposed and ultimately passed by the General Assembly in the form of a budget bill. DBHDID also enters into contracts with other state agencies to provide specific behavioral health services. DBHDID also applies for and receives other federal grant funds to support the systems of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

Per Section 1911 of the Title XIX Block Grants, the state will expend the block grant funds only for the following purposes:

- Carrying out the plan submitted for the fiscal year;
- Evaluating programs and services carried out under the plan; and
- Planning, administration and educational activities related to providing services under the plan.

DBHDID allocates mental health block grant funds as well as substance use prevention, treatment, and recovery services block grant funds, to CMHCs and to agencies that are either public or not-for-profit entities in accordance with Federal block grant requirements. No funds are used to satisfy any requirement for expenditures of non-Federal funds. The mental health block grant funds are utilized by DBHDID to provide direct services for adults with SMI and children with SED, to support direct programming, for data collection and analysis and for the operation of the Kentucky Behavioral Health Planning and Advisory Council. The draft allocation sheet uploaded in attachments for this environmental factor outlines the mental health block grant planned expenditures for SFY 2026. State allocations work on an annual basis, so the exact allocations for SFY 2027 will be determined at a later date.

Component 2: Staffing

DBHDID contracts directly with each CMHC to provide direct services and each CMHC employs staff who deliver the services at the local level. Thus, DBHDID involvement in human resource development activities for the CMHCs and their staff have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers. The Medicaid State Plan includes staff requirements for various services. Most Medicaid reimbursable services require an independently licensed professional or an individual under supervision to obtain their license. A billing supervisor must manage all non-licensed providers.

With a broader array of behavioral health services reimbursable by Medicaid, and with the expansion of Medicaid provider types in Kentucky to others beyond CMHCs, staff retention remains an important issue for most CMHCs. In addition, the pandemic led to staff shortages and additional challenges in staff retention. Those challenges remain. DBHDID has supported CMHCs in efforts

to assist with staff issues.

Component 3: Training

DBHDID strives to provide access to ongoing training and technical support for all central office staff as well as partner agencies and providers statewide. DBHDID seeks to utilize available technology to provide educational/training and consultation opportunities. When the pandemic shut down offices, DBHDID staff quickly adapted to Zoom technology and virtual connection software packages (Zoom, Teams, etc.) were purchased for DBHDID staff. Since early 2020, most meetings and staff trainings have occurred utilizing virtual means, which has allowed for broader audiences and enhanced attendance.

DBHDID provides or sponsors and participates in a variety of training initiatives. This includes many opportunities for central office staff, as well as contracted and private behavioral health service providers, to increase their knowledge and skill level in various best practices. Many offerings include sessions necessary for continuing education requirements for professional board certification or licensure. During the pandemic all training efforts became virtual. Providers from all over the state can and do participate from their local venues. These efforts are designed to strengthen the service system for individuals with SED and SMI.

DBHDID contains a Program Integrity Division to assist with contract monitoring, technology support, legislative support, and training support. This Division includes a Program Support Branch that works to streamline procedures that assist all DBHDID staff in providing training events. A Central Help Desk was created through the Program Support Branch, where information can be uploaded to assist with continuing education approval for various offerings. The Program Support Branch also manages the database for all certified Targeted Case Managers, Peer Support Specialists, and Comprehensive Community Support Providers across the state, as well as tracking required continuing education for those paraprofessionals. Additionally, this branch approves submitted training curricula for these three service types, which allows entities to provide certification trainings within quality guidelines.

The Department makes a wide variety of trainings, technical assistance, and coaching available, free of charge, to CMHC staff and other contracted providers. The DBHDID also provides scholarships (as funding allows) for individuals with lived experience, parents/family members, and CMHC staff, to attend training events. Funds are also used to support technical assistance for the development and maintenance of adult and children's programming. (e.g., Targeted Case Management for SED/SMI).

DBHDID also makes a wide variety of training available, free of charge, to individuals and/or organizations that may interact with individuals with SED or SMI but are not direct behavioral health providers, such as laypeople, support staff, and administrative staff. Trainings are also provided to individuals/organizations that may provide a direct service to individuals with SED or SMI but not necessarily as a behavioral health provider, including first responders, personnel responding to natural/mental health emergencies, and law enforcement.

The listings below show mental health training and technical assistance initiatives for both mental health service providers and emergency providers.

3a. Training/Technical Assistance for Mental Health Service Providers and DBHDID staff:

DBHDID provides the following trainings and technical assistance opportunities to providers and departmental staff.

Advancing Wraparound: Training to identify the essential elements of quality Wraparound implementation, develop an increased understanding of the role of the supervisor in quality Wraparound implementation, learn how to manage quality throughout the phases of Wraparound implementation, learn how to utilize supportive tools to develop quality Wraparound practitioners, individualized and strength-based service plans and team processes, and learn how to transfer knowledge and skills to the workforce.

American Sign Language Interpreter workshops 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. Done in partnership with the Kentucky Registry of Interpreters for the Deaf (KyRID).

Assertive Community Treatment (ACT) team leader technical assistance: DMH program administrator for ACT meets monthly with ACT team leaders. During these peer group meetings, participants discuss fidelity issues, receive targeted training, share team updates, and engage in general education relating to serious mental illness (SMI) and the ACT evidence-based model. Each year, a statewide conference is hosted by the DMH ACT Program Administrator for ACT team leaders, providing training and support. An ACT Trainer through University of Kentucky Human Development Institute collaborates with the ACT Program Administrator to provide annual fidelity reviews, training, and technical assistance.

Behavior Institute: A two-day conference sponsored by the Kentucky Council for Children and Behavior Disorders, the Kentucky Department of Education, Kentucky's System of Care Five grant through DMH, Kentucky Autism Training Center and the Central Kentucky Special Education Cooperative.

Child and Adolescent Needs and Strengths (CANS): Functional assessment used for children with child welfare involvement through the Department for Community Based Services (DCBS). It is the outcomes management tool for High Fidelity Wraparound.

Cognitive Behavior Therapy for Psychosis (CBTp): Training for clinicians, regarding building skills to provide CBT with individuals

experiencing psychosis, in particular with those experiencing their first episode of psychosis. This intense training includes follow up coaching and consultation with national experts for teams serving individuals with early psychosis.

Community Support Program (CSP) meetings: These meetings are hosted by DMH and held quarterly and are open to all CMHC CSP directors as well as other community partners who serve adults with SMI.

Creating a Welcoming Environment Individuals with Hearing Loss: Training made available by DBHDID Deaf and Hard of Hearing Services staff to all providers as needed regarding communication access options. Emphasis on ensuring that all points of contact know how to establish communication and rapport. Options for in-person and virtual services are offered.

Crisis Director's meetings: DMH program administrators for adult and youth crisis services host a quarterly peer group meeting for directors of adult and youth crisis programs across the state. These meetings give an opportunity to share information, discuss issues and network with peers across the state.

DBHDID Orientation: Provided to all new staff hired by DBHDID. Enhances staff knowledge of the mission and vision of the agency, programs and services administered by the agency, and staff who lead those initiatives.

Deaf and Hard of Hearing Services Provider Symposia: Trainings that are offered quarterly to bring together Deaf and Hard of Hearing service specialists as well as other CMHC staff who serve these individuals. Private practice therapists and other providers are also invited to build the professional network of specialists and increase capacity.

Deaf Service 101: An overview of cultural and linguistic issues in serving individuals with behavioral health challenges who are Deaf or Hard of Hearing. Includes information on establishing effective communication and connecting to resources in the community.

Deaf Services 102: Additional training on how to adapt clinical practices to be culturally and linguistically affirmative for individuals with behavioral health challenges who are Deaf or Hard of Hearing. Exact content is adapted to the needs of the requesting agency.

Early Interventions for First Episode Psychosis: A set of eleven online modules that provide an overview of prevalence, signs and symptoms of psychosis-risk and first episode psychosis in youth and young adults, as well as provides information on best practices for this population, including Coordinated Specialty Care (CSC).

Engagement in the Wraparound Process: Training to identify barriers to engagement, develop skills around engaging team members and the family, and utilize research-based strategies of engagement for increased positive outcomes for youth and their families.

Forensic Assertive Community Treatment (FACT): Kentucky has launched early implementation of FACT teams in three regions to operate in coordination with existing ACT teams, with plans for statewide expansion. This initiative is led by the DBHDID ACT Program Administrator, in collaboration with guidance from subject matter experts, Community Forensic Initiatives.

First Episode Psychosis (FEP) Consultation: Monthly calls with national experts for each FEP team across the state to offer implementation support for CSC and guidance in serving this population. DBHDID in collaboration with Yale University and Dr. Barbara Walsh provided Structured Interview for Psychosis Risk Syndromes (SIPS) training June 2-4, 2025, for KY's FEP providers. On June 6, 2025, DBHDID in collaboration with Yale University and Dr. Barbara Walsh provided a SIPS refresher training for all providers who have been certified in the SIPS assessment and wish to continue to hone their skills.

Hearing Voices that are Distressing: Training based on curricula developed by Patricia E. Deegan, Ph.D., consists of activities designed to simulate auditory hallucinations. The goal is to foster understanding and empathy for those working with this populations. This training is provided by request.

Individual Placement and Support (IPS) Supported Employment: Quarterly IPS supervision meetings are held with IPS supervisors led by state IPS training/fidelity/coaching staff, regarding IPS services for adults with SMI and other populations. In addition, state IPS training staff offer IPS training regarding education and technical assistance with topics such as documentation, career profiling, recovery and self-care. Once a year, a statewide conference is held that includes IPS employment specialists, supervisors, the Office for Vocational Rehabilitation (OVR) staff, DMH staff, and others who seek information on IPS in Kentucky.

Introduction to Wraparound: Training provided to gain an understanding of the critical components of the Wraparound process in order to introduce the High Fidelity Wraparound process and to practice skills needed to elicit the family story from multiple perspectives, engage team members, identify underlying needs, establish outcomes, brainstorm strategies, create a plan of care that represents the work of the team, develop a crisis plan, and learn basic facilitation skills for running a wraparound team meeting.

InReach: DMH offers a weekly virtual office hour/drop-in session for InReach Coordinators to ask questions, discuss challenges, and receive real-time technical assistance. In addition, a monthly InReach Coordinator meeting is held to provide program

updates, share best practices, review data trends, and offer peer-to-peer learning opportunities. Participation in these sessions is strongly encouraged to promote collaboration, skill-building, and continuous quality improvement.

Kentucky Behavioral Health Planning and Advisory Council Member Orientation: An annual orientation is provided for all new Council members, including state agency representatives and other interested parties. Led by members of the Council.

Kentucky Registry of Interpreters for the Deaf (RID): KyRID offers fall and spring workshops as well as online events throughout the year. DBHDID collaborates for the conferences to ensure that behavioral health information is interwoven into professional development.

Kentucky School of Alcohol and Other Drug Studies: An annual, weeklong event, sponsored by DBHDID, providing education from national and state experts regarding up and coming theories of practice in the field of behavioral health. This training has been held for over 40 years until the pandemic but is on track to occur again. Traditionally, this conference has had very large (over 800 people) attendance, and providers from Indiana and Ohio have attended. This event includes a track focused on services and supports for youth with SUD and co-occurring MH/SUD and their families, as well as additional sessions on co-occurring mental health disorders for adults.

Kentucky- System Transformation Advocating Recovery Supports (KYSTARS) conference: Annual statewide conference provided by DMH via contract with local NAMI affiliate. This conference provides an opportunity for peer support specialists, targeted case managers, and community support associates to receive annual education on recovery issues related to individuals with SMI/SED/SUD. This event is low cost/no cost and provides continuing education credits to these providers. An annual award ceremony recognizing outstanding peer specialists in the community, is part of this event.

Multi Family Group Therapy: An evidence-based family psychoeducational/therapy model, particularly effective when working with families of individuals experiencing their first episode of psychosis. This training is offered virtually, several times each year, through national FEP partners. In addition, FEP programs in Kentucky also participate in monthly consultation calls with the national experts, specifically focused on implementing this practice.

Olmstead Housing Initiative (OHI) and Supported Housing training: DMH offers regularly scheduled office hours to provide individualized and targeted technical assistance (TA) to Community Mental Health Center (CMHC) housing coordinators and related staff. These TA sessions are intended to:

- Address tenant-specific and site-specific housing concerns,
- Clarify OHI program processes and eligibility requirements,
- Support problem-solving around complex housing cases, and
- Assist new or transitioning staff in understanding the OHI framework and expectations.

Targeted TA is tailored to the specific needs of each CMHC or provider site and is a key component of DMH's commitment to ensuring effective implementation of housing supports consistent with the principles of the Olmstead decision.

Olmstead meetings: Monthly Regional Transition Committee/Olmstead meetings are held virtually in each of the four hospital catchment areas. These meetings bring together providers to discuss individual consumer needs and review budgets for individuals who have been in care longer than 90 days. The DMH provides education and technical assistance during these meetings to support providers delivering DIVERTS services to individuals with SMI.

In addition, smaller group meetings are scheduled monthly as needed to review specific barriers and develop solutions for individuals who meet Olmstead criteria and are ready for discharge from a state psychiatric hospital.

Parent and Youth Cafes: Based on Kentucky's Strengthening Families initiative, the Parent and Youth Cafes are offered by DMH in collaboration with Kentucky Partnership for Children and Families (KPFC). These offerings focus on the protective factors specific to families with children and behavioral health challenges. Cafes for families with children who have hearing loss are facilitated in partnership with Kentucky Hand and Voices.

Peers In the Know training series: Virtual training series designed to build peer knowledge and capacity, provided by DMH via a contract with an agency that houses the Center for Peer Excellence and provides education and support to all peer support specialists across the state, through these training events, newsletters and regular calls.

Projects for Assistance in Transition from Homelessness (PATH) briefings: Quarterly meetings hosted by DMH with all PATH recipients to strengthen collaboration efforts to assist individuals with SMI experiencing homelessness. An annual conference brings together PATH grantees from across the state and collaborative partners who serve individuals experiencing homelessness to share and learn about best practices.

Regional Interagency Council (RIAC) learning series: A learning series that supports the regional system of care efforts. Topics are drive by RIAC and training is free and open to all RIAC members and system of care partners. This series came to an end in June 2025.

Structured Clinical Interview for Diagnostic and Statistical Manual 5 (SCID-5): This is an assessment tool used to more accurately

diagnose behavioral health conditions as categorized in the DSM-5. Virtual trainings are offered several times per year through national First Episode Psychosis (FEP) partners, and FEP team staff receive this training.

Supported Housing Coordinator briefings: Quarterly meetings hosted by DMH with all CMHC housing coordinators providing a forum for statewide collaboration on efforts to attain and maintain housing for individuals with SMI.

System of Care Academy: Event sponsored by DBHDID that brings all child serving agencies together to discuss System of Care development across the state and across all agencies. A theme is generally developed around a topic that emerges throughout the year and is the focus of the plenary session.

System of Care Framework: Provides an overview of the history and development of the System of Care framework at the national level as well as Kentucky's implementation.

Targeted Case Management (TCM): Quarterly meetings hosted by DMH with all CMHC TCM supervisors, providing a forum for statewide collaboration, best practices, regulation discussions, billing issues and workforce training needs. Provide face to face TA after the annual Person-Centered Planning Fidelity reviews. DBHDID in collaboration with Yale University and Dr. Janis Todora provided two separate six (6) hours trainings on Person-Centered Planning (PCP) in SFY 2025 for all providers.

TEAM SOAR Learning Collaboratives: Bimonthly, all-day learning collaboratives are provided in person and virtually for Community Mental Health Center staff involved in outreach and service provision for individuals experiencing homelessness who have serious mental illness, serious emotional disturbance, or co-occurring disorders. Provided through Kentucky's TEAM SOAR grant, the collaboratives focus on strengthening best practices, sharing resources and strategies across regions, and building connections among case managers, clinicians, and outreach specialists.

TEAM SOAR Motivational interviewing: The TEAM SOAR grant provides continuing education opportunities at no cost for Community Mental Health Center and Continuum of Care staff. Offerings include a six-hour intermediate to advanced motivational interviewing workshop led by a national subject matter expert. These offerings are designed to enhance clinical skills and promote best practices in outreach and service delivery.

TEAM SOAR State Summit: A two-day state summit is held annually through the TEAM SOAR grant to provide training and professional development opportunities for Community Mental Health Center and Continuum of Care staff. The summit focuses on enhancing knowledge, sharing innovative practices, and supporting collaboration across agencies serving individuals experiencing homelessness with serious mental illness, serious emotional disturbance, or co-occurring disorders.

Transition Aged Youth Launching Realized Dreams (TAYLRD): A training that provides an overview of barriers, developmental issues, cultural issues and best practices when providing services and supports to transition age youth.

Trauma Informed Care: An overview of trauma and the necessary components that support the provision of care that recognizes the trauma that individuals have experienced in their life.

Trauma Informed System of Care Training for Trainers: A cross agency training that creates community partner trainers that will be able to provide general overview training on Trauma Informed Care for their local agencies.

Suicide Prevention Training/Technical Assistance Provided to the General Public and/or Providers:

Applied Suicide Intervention Skills Training (ASIST): Training to learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone alive.

Assessing and Managing Suicide Risk Outpatient (AMSR OP) : Teaches best practices in suicide risk assessments and how to determine the level of suicide risk for individuals. Focuses on clinicians and other healthcare professionals in outpatient settings.

Assessing and Managing Suicide Risk Direct Care (ASMR-Direct Care): Prepares non-clinical staff working in outpatient settings to provide confident and empathetic care to individuals at risk of suicide.

Assessing and Managing Suicide Risk Substance Use Disorder (AMSR SUD): Teaches best practices in suicide risk assessments and how to determine the level of suicide risk for individuals. Focuses on clinicians and other healthcare professionals in substance use disorder care settings.

Brief Cognitive Behavioral Therapy (BCBT): BCBT is a short-term, evidence-based treatment designed to reduce suicidal thoughts and behaviors by helping individuals develop coping strategies, increase emotional regulation, and build hope. It is particularly effective for individuals at high risk of suicide and is often delivered in outpatient or primary care settings.

Code RED: Code RED is an evidence-informed universal safety tool aimed at helping individuals, especially youth, prepare for potential mental health crises. It provides embedded strategies for identifying a trusted contact to reach out to, delaying risky

decision-making, relaxing, and distracting from thoughts of suicide. As a universal prevention tool, Code RED is intended for everyone, promoting proactive measures to be taken before a crisis arises. It follows the upstream prevention model, enabling individuals to identify and practice effective strategies and healthy coping skills that build resilience. Additionally, Code RED includes access information about the 988 crisis line, ensuring that everyone knows how to access these vital services for themselves or someone in need. This tool promotes understanding, empowering individuals to take action when it matters most. Code RED was developed by University of Kentucky Professor Dr. Julie Cerel, a psychologist in the College of Social Work at the University of Kentucky. Dr. Cerel is a national suicide subject matter expert in suicide prevention, treatment, and postvention. Collaborative Assessment and Management of Suicidality – Educational (CAMS): Provides an overview of data and theories regarding suicide rates, information about the field of suicidology and suicide prevention. Used for large audiences of healthcare providers and administrators, as well as school districts.

Collaborative Assessment and Management of Suicidality (CAMS): Evidence-based assessment and treatment model regarding individuals at risk of suicide. Can be applied across treatment settings and with various clinical populations.

CONNECT Postvention: This evidence-based model equips community leaders and service providers with the skills to coordinate a safe, timely, and supportive response following a suicide or other sudden traumatic death. The training covers best practices for reducing risk of contagion, supporting loss survivors, and promoting healing across communities. Participants learn to create comprehensive postvention response plans that address immediate, short-term, and long-term needs and emphasizes cross-sector collaboration.

Crisis Response Planning (CRP): CRP is a brief intervention that helps individuals at risk of suicide create a personalized, written plan outlining specific coping strategies and support resources to use during a crisis. It emphasizes collaboration and empowers individuals to manage future suicidal urges safely.

Lethal Means Counseling (LMC): Lethal Means Counseling involves working with individuals and families to reduce access to firearms, medications, and other potentially lethal means during times of suicide risk. This strategy is a critical component of safety planning and has been shown to save lives.

LifeLines Trilogy: The Lifelines Trilogy is a comprehensive, school-based suicide prevention program consisting of three sequential components—Prevention, Intervention, and Postvention. Designed for middle and high schools, it equips educators, students, and parents with the knowledge, skills, and protocols to identify risk, respond effectively, and support recovery after a suicide-related crisis.

Mental Health First Aid (MHFA): MHFA is a skills-based training that teaches participants how to identify, understand, and respond to signs of mental health and substance use challenges, including suicide risk. The course increases confidence in providing initial support and connecting individuals to professional help.

Question, Persuade and Refer (QPR): A basic community-oriented presentation designed to create greater awareness, recognition of warning signs, and knowledge of what to do if someone is struggling with a potential suicide crisis. This program is 90 minutes in length and each participant receives a booklet containing the basic program information.

Psychological First Aid (PFA): PFA is an evidence-informed approach for assisting people in the immediate aftermath of trauma or disaster, focusing on safety, stabilization, and connection to support. It includes strategies for addressing acute stress and preventing long-term psychological harm.

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.

Sources of Strength: A peer-led, upstream suicide prevention program that promotes protective factors such as connection, resilience, and help-seeking behaviors through youth-adult partnerships. The program shifts culture by empowering young people to be agents of change in their schools and communities.

3b. Training for Emergency Providers:

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), serves as a support agency for the Kentucky Emergency Support Function (ESF) 8 – Public Health and Medical Services group. ESF 8 is led by the Department of Public Health, a sister agency to DBHDID, within the Cabinet for Health and Family Services (CHFS). The ESF 8 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 8 is the Kentucky Community Crisis Response Team (KCCRT). This team is managed by DBHDID per statute approved during the 2022 legislative session and was created under Kentucky Revised Statutes Chapter 36 and Chapter 42. In the case of natural or manmade disasters, KCCRT is activated by a Governor's Disaster Declaration to provide psychological first aid to survivors. KCCRT also deploys Rapid Assessment and Response Teams upon request to first responders and communities to mitigate stress reactions to critical incidents and traumatic events. In the past, the responsibilities for these services have been housed outside DBHDID. The movement of the entity in 2022 to the Department for Behavioral Health, where it operates organizationally in most other states, allows for a synergistic response with other services provided through DBHDID, as well as

the leveraging of additional resources to support survivors, including individuals with serious emotional disturbance (SED) and serious mental illness (SMI).

DBHDID oversees and coordinates all behavioral health training efforts for emergency service providers across Kentucky. This includes centralized planning, resource development, and alignment of curricula with evidence-based practices such as Psychological First Aid (PFA), Mental Health First Aid (MHFA), and Crisis Intervention Team (CIT) training. DBHDID collaborates closely with regional and local partners—including Community Mental Health Centers (CMHCs), law enforcement agencies, 988 centers, and other emergency service entities—to implement these trainings based on local needs. Regional partners are responsible for executing trainings and reporting key metrics such as participation, completion rates, and local feedback, which DBHDID uses to inform ongoing planning, quality improvement, and resource allocation at the state level. PFA trainings are offered across the Commonwealth. PFA is a SAMHSA-endorsed program teaching first responders and others how to deal with individuals experiencing traumatic events, including those with SED or SMI. Individuals trained in Psychological First Aid learn to promote environments of safety, calmness, connectedness, self-efficacy, empowerment, and hope, in times of crisis. The trainings are offered online, free of charge through the National Child Traumatic Stress Network (NCTSN).

DBHDID, through KCCRT, is the state's designated entity to apply for and implement the SAMHSA/FEMA Crisis Counseling program. In SFY 2022 and SFY 2023, DBHDID managed the Immediate Services Program (ISP) and Regular Services Program (RSP) for Western Kentucky (KY-4630; record strong tornadoes) and the ISP and RSP for Eastern Kentucky (KY-4663; 1,000-year flooding). DBHDID currently has ISP and RSP grants submitted for approval for three separate disasters that have occurred in 2025; flooding in the eastern and central parts of the state, and tornadoes in southeastern Kentucky. In addition, both locations impacted by the SFY 2022 and SFY 2023 tornadoes and flooding also received the Disaster Case Management (DCM) grant. In the case of the DCM grant for Eastern Kentucky, DBHDID wrote and submitted the grant in a single day and the grant represented the first for FEMA using "the new modern approach" for DCM services that ensures that disaster case management services are available to survivors, including individuals with SED or SMI, early in the disaster period.

DBHDID has hired three staff members to oversee the Disaster Services Implementation. In addition, a team of five staff across the department are being trained to provide on-call services to support the KCCRT when volunteers are deployed to the community. KCCRT is staffed by a multi-disciplinary team of trained individuals who volunteer their time to assist others, including individuals with SED or SMI, who encounter a critical incident. Many of these volunteers are behavioral health professionals, and some are current or retired CMHC staff. Others are first responders, including law enforcement, firefighters, emergency medical services and dispatchers. Policies, processes, and procedures were updated to reflect the new structure within DBHDID, and volunteers have been retrained, recertified, reactivated, and recruited to increase capacity of the team. After the devastating tornado outbreak in Kentucky in 2021, DBHDID hosted virtual PFA for over 500 individuals. Due to the increasing need for this training, a "Train the Trainer" session was conducted in 2024 in partnership with NCTSN, which prepared 20 individuals to deliver PFA training. Several staff are now certified NCTSN PFA trainers and have led six trainings in 2025 with more than 50 individuals trained. DBHDID requires the 14 CMHCs via contract, to maintain a community-level behavioral health disaster plan and a Continuity of Operations Plan (COOP plan). The statewide Disaster Behavioral Health Plan outlines the expected regional response in the event of a crisis or disaster, ensuring that survivors' behavioral health needs are met. It also ensures collaboration with local community partners. The COOP plan ensures that the CMHC has a roadmap for the continuation of services to its clients during an emergency. Each CMHC is required to review its plans annually with DBHDID and submit its plan electronically. In addition, each CMHC has designated an individual to serve as the point person for emergency preparedness in the region.

DBHDID was also required by 2022 legislation to develop and convene a public safety peer task force and offer recommendations on best practices related to the development of peer counseling groups for first responders. The team met throughout the winter and spring of 2023 and released its report to the General Assembly in July 2023. The report provides overall guidance on the definition of a public safety peer support team, steps in creating a new team within a first-responder or public safety agency, guidelines on ethics, confidentiality, and appropriate interventions; as well key trainings that should be utilized to equip members.

DBHDID also offers MHFA training to first responders, emergency health service providers, emergency dispatchers, state guardians, police officers and other community members to increase capacity to meet the needs of individuals in the community with behavioral health issues. MHFA is a public education program that provides members of the community with skills, knowledge, and abilities to help identify, understand, and respond to signs of mental illness and substance use disorders. It is managed by national entities and has rigorous requirements, including a weeklong training session, to be certified as a MHFA instructor. At the state level, each MHFA training is eight hours and includes education on an action plan consisting of five steps, where participants gain the knowledge and skills to assist an individual experiencing a mental health crisis by connecting them with the appropriate professional, peer, social or self-help care. The number of MHFA instructors in Kentucky has grown over the last few years. DBHDID collaborates with Community Mental Health Centers and other entities that have trained providers to offer Adult MHFA trainings across the state, and to track both the number of persons approved to provide the training and the number of actual trainings occurring across the state. (In SFY 24, there were 54 community partners trained in MHFA which included 35 adults and 19 youth.)

DBHDID also provides Youth Mental Health First Aid training through a partnership with Kentucky Partnerships for Families and Children (KPFC), an advocacy organization for children with behavioral health issues and their families as well as through CMHCs and internal trainings. In addition, DBHDID has provided funding over the years, through the statewide Mental Health & Aging

Coalition, to train instructors in Mental Health First Aid for Older Adults.

Core trainings such as MHFA, Applied Suicide Intervention Skills Training (ASIST), and Question, Persuade, Refer (QPR) are explicitly designed to improve recognition, de-escalation, and referral for individuals experiencing serious mental illness (SMI), serious emotional disturbance (SED), or behavioral health crises related to co-occurring conditions. Each training emphasizes the need for compassionate, non-judgmental engagement and helps emergency service providers respond effectively in high-stress situations. (In the last year and a half, 7,650 community partners received training in QPR and ASIST.)

Training participation is tracked through attendance rosters, participant sign-in sheets, and digital registration systems managed by DBHDID and its partners. For select programs such as MHFA, Applied Suicide Intervention Skills Training (ASIST), and Crisis Intervention Team (CIT) training, pre- and post-training assessments are used to measure knowledge gains and changes in confidence related to identifying and responding to behavioral health crises. Some trainings also include follow-up surveys to gather participant feedback on relevance, applicability, and use of skills in the field. For 988-specific and Public Safety Answering Point (PSAP)-focused trainings, metrics include the number of emergency service agencies reached, number of referrals to behavioral health services made post-training, and anecdotal reports of improved coordination between 988 centers and emergency response teams. These evaluation strategies help DBHDID monitor training quality, inform refinements, and guide future technical assistance.

Effective June 16, 2021, the Community Behavioral Health Training Program was established through DBHDID. This program was mandated by legislation (908 KAR 2:270) in response to increased numbers of substance overdose deaths and suicides in Kentucky. However, it was not funded. DBHDID continually seeks to increase access to appropriate behavioral health services, and this requires the assistance of all Kentucky citizens to identify individuals and families who may be struggling and help them find adequate care. Through this program, DBHDID staff coordinate additional MHFA trainings, as well as QPR training and ASIST. Added to the Community Behavioral Health Training Program in October 2024 was CONNECT Postvention. The NAMI New Hampshire's CONNECT Postvention Training equips community leaders and service providers with the skills to coordinate a safe, timely, and supportive response following a suicide or other sudden traumatic death. The training covers best practices for reducing risk of contagion, supporting loss survivors, and promoting healing across communities. Participants learn to create comprehensive postvention response plans that address immediate, short-term, and long-term needs. This evidence-based model aligns with national standards and emphasizes cross-sector collaboration. Since October 2024, three Postvention Trainings have taken place along with two Postvention Training for Trainers. (108 community partners have been trained in CONNECT Postvention and 14 community leaders and providers have been trained to provide postvention intervention services in the aftermath of a death by suicide.)

Through a partnership with a retired police lieutenant, DBHDID provides Crisis Intervention Team (CIT) training across the state. This training is based on the Memphis Model and Kentucky trains law enforcement officers in behavioral health specifics, as well as assists local communities in the creation of CIT Advisory Committees. The Advisory Committees assist with gathering local leaders from relevant stakeholders to build relationships and work to problem-solve local issues related to law enforcement and behavioral health. Crisis Intervention Team (CIT) 2 is a class offering that provides refresher training for law enforcement officers who have already received CIT training. This refresher training focuses on training needs that are identified through the regional Advisory Committees and includes current trends for law enforcement. During SFY 2024, 10 CIT trainings occurred across the state, and one CIT 2 class.

DBHDID in collaboration with The Department of Criminal Justice Training (DOCJT) began a new twenty-four (24) hour behavioral health training at the police basic academy in June 2017. The new program provides new police recruits with a basic knowledge of mental health, developmental disabilities, intellectual disabilities, and substance use disorders. The training block consists of two days (16 hours) of instruction and scenarios presented by two CIT "Train the Trainer" instructors. The remaining day (eight hours) consists of behavioral health professionals instructing new recruits about the clinical side of mental health disorders, substance use disorders, autism, brain injuries, developmental, and intellectual disorders. The new behavioral health training at DOCJT will provide all new Kentucky police officers a basic understanding of individuals with behavioral health issues and how best to communicate and work with them in the community. This block of training will be conducted about once per month and will reach about 350 new police officers per year.

This training block ensures that every new police officer in Kentucky enters the field with foundational knowledge of how to recognize and respond to individuals experiencing SMI, SED, or the combined impacts of mental health and substance use conditions. By embedding this content early in the training pipeline, Kentucky is building a more informed and trauma-sensitive public safety workforce. A revised CIT curriculum is currently in development, with an anticipated rollout in SFY 2027. This curriculum will provide updates on best practices in working with individuals in crisis, as well as further educating officers on regional treatment options as alternatives to hospitalization.

In July 2022 the 988 Suicide and Crisis Lifeline launched to provide 24/7 access for individuals in crisis through phone, chat, and text. Since the launch, Kentucky has provided access to the crisis continuum through 988 centers, housed within the 14 CMHCs. Each CMHC has an assigned geographic region to provide mental health and substance use services, serving as the behavioral health safety net.

implementation of 988 has highlighted the need for relationships with other emergency services to provide the least restrictive and local care for individuals experiencing a behavioral health crisis.

Since 2022, DBHDID has been educating emergency services on 988. These educational opportunities have been provided as general 988 education and awareness, accessing services for individuals experiencing a behavioral health crisis, and developing partnerships between 988 and emergency services. The trainings have occurred both in-person and virtually, for specific agencies and at conferences.

These training efforts are part of Kentucky's strategy to ensure that emergency services providers can recognize and appropriately respond to individuals experiencing behavioral health crises, including those with SMI, SED, and co-occurring substance use disorders. By equipping first responders with the skills and awareness needed to navigate these complex presentations, Kentucky enhances early intervention, reduces unnecessary emergency room utilization, and promotes safer outcomes for high-risk individuals.

Between 2022 and 2024, DBHDID utilized a single staff person to implement, promote, and advance 988. In 2024, two additional staff were added to further advance partnerships between 988 and emergency services (988-911 Liaison) and provide relevant trainings for both the 988 workforce and community partners (988 Workforce Liaison).

While the 988 centers/CMHCs generally have strong relationships with law enforcement and PSAPs for suicidal individuals, relationships with other emergency services agencies and 988 has become a priority. The addition of a 988-911 Liaison enables DBHDID to better support the 988 centers in educating emergency services and community partners on the state level, while providing resources for regional partnerships.

Each year since the 988 launch, DBHDID has provided trainings at the Kentucky Emergency Services Conference (KESC), focused on 988. These trainings have evolved from general 988 awareness to developing partnerships to assist individuals in crisis. More than 50 individuals from PSAPs, Emergency Management, and other community partners have attended the trainings to learn how to connect individuals with appropriate services.

Building on the KESC trainings, a partnership with the Kentucky 911 Services Board was forged for a series of virtual trainings on 988 for Kentucky's PSAPs. Two sessions have been provided to PSAP staff to educate on 988 services, partnerships, and assisting individuals in a mental health crisis. More than 80 individuals attended the live session, which was recorded and made available through the 911 Services Board. The total number of individuals reached is not known as the recordings are accessible through the training portal on the 911 Services Board website.

Over the last two years, both virtual and in-person regional training sessions have been held for PSAPs. The virtual sessions, held in 2022, brought Kentucky's 988 centers together with the PSAPs in their respective regions. Approximately 31 PSAP representatives attended the 14 sessions. These sessions served as an introduction to 988 and provided information on accessing services for individuals in crisis. Starting in 2024, with the hiring of a 988-911 Liaison, the in-person sessions were implemented. These educational sessions, provided in all 14 regions, were intended to bring together all emergency services and 988 centers. Each regional session focused on 988 awareness and addressing the needs of individuals in crisis who contact 911. Attendees were provided information on how 988 can assist with emergency calls for individuals with mental health crises, SMI, SED, or substance use issues. More than 100 emergency services representatives attended the in-person sessions.

The inclusion of SMI, SED, and co-occurring disorder content in 988 regional trainings reflects Kentucky's commitment to ensuring that all emergency response agencies can identify high-risk behavioral health presentations and connect individuals to appropriate care. Emergency services professionals are equipped not just with referral pathways but with the understanding necessary to safely manage behavioral health crises.

A 988 Workforce Liaison was added also to the DBHDID team in 2024 to focus on building 988 capacity and training needs. In 2025, a virtual 988 learning series was launched for the 988 workforce and community partners. Each monthly session focuses on a distinct topic and is open to the public. The first virtual training was "Assisting Individuals Experiencing Psychosis" and provided strategies for recognizing, responding to, and effectively supporting individuals experiencing psychosis. Of the 40 individuals attending this session, eight reported being in emergency services. The second virtual training was "Autism and Its Relation to Suicide" and provided practical strategies for effectively supporting individuals with autism. This virtual training had 82 participants, with 13 from emergency services. Two additional trainings on the crisis continuum and first responder mental health were provided and attended by 49 individuals from emergency services.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious

disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#).

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

The advantages of establishing telehealth capability are well known. Due to ongoing challenges in recruiting qualified medical and clinical staff in rural areas, telehealth continues to serve as a critical tool for extending staff coverage from central sites to outlying clinics and service locations. Kentucky has maintained regulations governing the use of telehealth for many years, initially focused on prescribers and certain licensed clinicians. Since the pandemic, those regulations have been significantly broadened to support a permanent statewide infrastructure. Today, all 14 Community Mental Health Centers (CMHCs) report delivering or accessing services through the telehealth network. Telehealth is now fully integrated into behavioral health service delivery and is utilized across Kentucky to increase access to therapy, medication management, case management, and peer support—based on individual choice and clinical appropriateness. Examples of how the CMHCs utilize telehealth equipment for providing services to individuals with SMI/SED are outlined below:

- Four Rivers Behavioral Health currently utilizes the telehealth network for psychiatric screening and services in three counties and has hired an Advanced Practice Registered Nurse (APRN) who is dedicated 100% to the provision of telepsychiatry services.
- Pennyroyal Center utilizes telehealth for psychiatry services from all outpatient clinic locations. In addition, emergency services can be provided via telehealth to all clinic locations, all local hospitals that have Memoranda of Agreement (MOAs) with Pennyroyal Center, and all regional police departments that have MOAs with Pennyroyal Center.
- River Valley Behavioral Health utilizes telehealth via psychiatrists from the University of Louisville, as well as APRNs and other psychiatrists for medication management. Since the pandemic, outpatient therapy services have been offered and delivered via telehealth or telephonic platforms, in addition to traditional service methods. Involuntary psychiatric hospitalization petition evaluations are also being conducted in conjunction with regional hospitals via telehealth. Telehealth is used on an as-needed basis to contact clients for supported employment services.
- LifeSkills utilizes the telehealth network to increase access to psychiatric services and offers telehealth services in all 10 counties to improve access to providers with therapy services, medication management, case management, and peer support. They use a dedicated HIPAA-compliant Zoom connection for these appointments to ensure a higher level of security for private health information.
- Communicare uses telehealth for psychiatry services and therapy services in all eight rural counties in their region on an as-needed basis
- Seven Counties Services sites all have a telehealth room for clients who walk in and need to be seen by providers at other sites. Telehealth is used on an as-needed basis to contact clients for supported employment services.
- NorthKey utilizes telehealth for all clinical services and supported employment when needed or requested. Clients are contacted by phone and asked if they would like to be seen via telehealth.
- Comprehend utilizes telehealth services on an as-needed basis for outpatient therapy, clinical services, medication management, and adult and children case management services.
- Pathways provides intake and assessment, medication evaluation and follow-up, and individual therapy via telehealth for individuals who are referred to a prescriber or specialty provider outside of their geographic area.
- Mountain Comprehensive Care Center utilizes telehealth for outpatient psychiatry and medication management services in addition to crisis stabilization unit services and residential children's programs. During the pandemic, they provided telehealth services to as many clients as possible for all of their services. Additionally, an Accessing Telehealth Through Local Area Stations (ATLAS) site has been recently established to facilitate telehealth access during times of natural disasters.
- Kentucky River Community Care, Inc., (KRCC) utilizes telehealth services with individuals in all offices across their region, as well as in Lexington, Louisville, and London. They can provide individual therapy, medication management, and crisis services via this technology. Additionally, an ATLAS site has been recently established to support telehealth access during times of natural disasters. KRCC also recently launched Better Together, their telehealth-based Consumer Operated Service Program (COSP), designed to bring peer-led support groups directly into homes via Zoom. Open to both existing clients and community members, these daily virtual sessions offer a safe and stigma-free environment for shared experiences and mutual encouragement. By leveraging telehealth technology, KRCC ensures consistent outreach and engagement, particularly in rural counties such as

Breathitt, Knott, Perry, and Wolfe, helping individuals stay connected, supported, and on track with their wellness journeys.

- Cumberland River has telehealth available in each outpatient clinic across its region and offers telehealth between sites. All services can be accessed through telehealth. Telehealth crisis services are also provided to local law enforcement, hospitals, and other community partners. They recently established an ATLAS site at the Whitley County Health Department to provide individuals with access to telehealth, mental health, and substance use treatment through their affiliated clinics.

- Adanta provides telehealth psychiatry services to rural counties in their region and provides telehealth psychiatry services via contract with the University of Louisville as well. They are utilizing the telehealth network to provide psychiatric and therapy services to counties within the agency that lack onsite prescribers or Medicare-billable behavioral health providers.

- New Vista offers telehealth as a delivery method for most services, available based on clinical need or individual request.

3. Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

ADULT SERVICES ARRAY SFY 2025 REGIONAL AVAILABILITY OF COMMUNITY SUPPORT SERVICES														
SERVICES	REGIONS													
	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Consumer and Family Support														
Consumer Support Groups	X			X	X	X	X	X	X	X		X		
Consumer Operated Services Program (COSP)	X			X	X	X	X			X	X			X
Social-Club Drop-In	X		X		X				X			X		
Local NAMI Kentucky Affiliates	X	X				X	X	X	X	X		X		X
Consumer Conferences									X		X			X
Crisis Services														
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Crisis Intervention Services		X			X	X		X	X	X		X	X	X
Mobile Crisis Services		X	X	X	X	X	X	X	X	X	X	X		X
Residential Crisis Stabilization	X		X	X	X	X			X	X	X	X	X	
Mental Health Treatment														
Community Medications Support Program	X	X	X		X	X	X	X	X	X	X	X		X
Specialized Co-Occurring Disorders Services		X	X		X	X	X		X	X	X	X	X	X
Intensive Outpatient Program for MH			X											X
Targeted Case Management (TCM)														
TCM for Adults with SMI	X	X	X	X	X	X	X	X	X	X	X	X	X	X
TCM for SMI + Physical Health		X		X	X	X			X	X	X	X		X
Flexible Funds for SMI (Wraparound Funds)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Payee Services		X	X	X				X	X		X	X		X
Rehabilitation Services														
Therapeutic Rehabilitation		X	X	X		X	X	X	X	X	X	X	X	X
IPS Supported Employment (IPS)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Educational Services (Supported Education)					X						X			
Illness, Management and Recovery (IMR)					X	X	X		X	X	X	X		X
Adult Peer Support Services	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
Assisted Outpatient Treatment	X	X	X	X	X	X	X	X			X			X
Comprehensive Community Supports	X		X	X	X	X	X		X	X	X	X	X	X
Housing Options														
Supportive Housing Program	X	X	X	X	X		X		X	X	X			X
Residential Support		X			X			X	X	X	X	X		X
Housing Development		X		X	X					X				X

DRAFT

Contracted
07/01/25

MENTAL HEALTH REGULAR BLOCK GRANT (TPAV) ALLOCATIONS FOR FISCAL YEAR 2026

CONTRACTED TO THE REGIONS FOR SERVICES:

<u>Region</u>	<u>Crisis Services</u>	<u>Adults with SMI</u>	<u>Children with SED</u>	<u>988 Implementation/ Follow-up</u>	<u>Consumer Operated Programs</u>	<u>ECMH Specialist</u>	<u>FEP/ MHBG 10% Set Aside</u>	<u>IPS Supported Employment MH America</u>	<u>IPS Supported Employment</u>	<u>Reintegration Services</u>	<u>SMI/SED Deaf & HoH</u>	<u>TOTAL</u>
1 Four Rivers	11,819	209,936	101,016	100,000	70,000	25,000	150,000					667,771
2 Pennyroyal	10,574	252,530	76,933	100,000		25,000	3,000				6,000	474,037
3 River Valley	10,944	260,569	78,028	100,000		25,000	3,000					477,541
4 LifeSkills	16,480	265,171	107,531	100,000	50,000	25,000	150,000					714,182
5 Communicare	14,485	212,444	99,919	100,000	50,000	25,000	150,000					651,848
6 Seven Counties	29,609	677,556	183,032	100,000	50,000	25,000	150,000			100,000	84,900	1,400,097
7 North Key	13,893	309,375	129,260	100,000	50,000	25,000	3,000	200,000			12,000	842,528
8 Comprehend	5,306	81,795	74,548	100,000		25,000	3,000					289,649
10 Pathways	14,641	254,434	115,634	100,000		25,000	150,000					659,709
11 Mountain	13,940	198,952	75,906	100,000	50,000	25,000	150,000		50,000			663,798
12 Kentucky River	8,574	124,842	70,619	100,000	50,000	25,000	3,000					382,035
13 Cumberland River	13,446	288,263	96,891	100,000	50,000	25,000	150,000		50,000		12,000	785,600
14 Adanta	11,571	175,183	76,835	100,000		25,000	3,000					391,589
15 New Vista	22,108	252,988	158,082	100,000		25,000	150,000				33,500	741,678
TOTAL	197,390	3,564,038	1,444,234	1,400,000	420,000	350,000	1,218,000	200,000	100,000	100,000	148,400	\$9,142,062

STATEWIDE PROJECTS:

<u>Region</u>	<u>Program or Service</u>	<u>Amount</u>
4 LifeSkills	IPS Supported Employment Initiative	25,000
4 LifeSkills	Access Planning Training and TA	10,000
4 LifeSkills	Adult MH Training and TA	100,000
4 LifeSkills	Children's Training and TA	100,000
4 LifeSkills	First Episode Psychosis	85,000
4 LifeSkills	KCCRT Trainings	10,000
4 LifeSkills	Peer Bridger Initiative	50,000
5 Communicare	Crisis Intervention Team (CIT) / Annual Conference	110,000
6 Seven Counties	Mental Health and Aging	20,000
15 New Vista	SIAC Support	5,000
15 New Vista	Statewide Deaf & Hard of Hearing Services (DHHS)	40,000
		\$555,000

OTHER:

Behavioral Health Planning Council	6,850
Bridgehaven (\$34,500 of this allocation is for Deaf & Hard of Hearing)	177,500
Center for Accessible Living - Replaces Independence Place (IPS SE)	25,000
Kentucky Partnership for Families & Children (KPFC)	268,000
Mental Health Association of KY (MHA KY)	60,000
NAMI Lexington	175,190
NAMI Louisville	55,000
University of Connecticut	167,000
University of Kentucky - Human Development Institute (HDI)	898,592
University of Kentucky - Institute for Biomedical Informatics (IBI)	105,626
Wellspring	50,000
	\$1,988,758

TOTAL MH BLOCK GRANT ALLOCATIONS

\$11,685,820

Audit Reserve

\$0

TOTAL MH BLOCK GRANT AVAILABLE

\$11,685,820

Statewide Service Array Totals

Services X=Available N=Not Available	Four Rivers	Pennyroyal	River Valley	LifeSkills	Communicare	Seven Counties	NorthKey	Comprehend	Pathways	Mountain	KY River	Cumberland	Adanta	New Vista	# of Service Statewide
Screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
Psychological Testing	X	N	X	N	X	X	N	X	X	X	X	X	X	N	10/14
Outpatient Clinical: Individual	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
Outpatient Clinical: Collateral	X	X	N	X	X	X	X	X	X	X	X	X	X	X	13/14
Outpatient Clinical: Group	X	X	N	X	X	X	X	X	X	N	X	X	X	X	12/14
Outpatient Clinical: Family	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
Medication Management Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
School-Based Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
Intensive In-Home Services	X	N	X	N	N	X	N	N	N	N	X	N	N	X	5/14
Intensive Outpatient Program	X	N	X	N	N	X	X	N	X	X	X	N	N	N	7/14
After School Program	N	N	N	N	N	X	N	N	X	X	X	X	N	N	5/14
Day Treatment Program	X	N	N	N	N	X	N	X	X	X	X	N	N	N	6/14
Partial Hospitalization	N	N	N	N	N	N	N	N	N	N	X	N	N	N	1/14
Mental Health/Substance Use Integrated Clinical Services	X	X	X	X	X	N	X	X	X	X	X	X	X	X	13/14
Specialized Summer Program	N	N	N	X	N	X	X	N	N	X	X	X	X	X	8/14
Comprehensive Community Support Services	N	N	X	X	X	X	X	X	X	X	X	X	X	N	11/14
Youth Peer Support: Individual	X	N	X	X	X	X	X	N	X	X	X	X	X	X	11/13
Youth Peer Support: Group	X	N	X	N	X	X	N	N	X	N	X	X	X	X	9/14
Parent/Family Peer Support: Individual	X	N	X	X	X	X	X	X	X	X	X	X	X	X	13/14
Parent/Family Peer Support: Group	N	N	X	N	X	X	N	X	X	N	N	X	X	X	8/14
Respite Care	N	N	N	N	N	N	N	X	N	N	N	N	X	N	2/14
Service Planning	X	X	X	X	X		X	X	X	X	X	X	X	X	13/13
Targeted Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
High Fidelity Wraparound	X	N	N	X	X	X	X	X	X	X	X	X	N	X	11/14
Therapeutic Foster Care	N	N	N	X	N	N	N	N	N	X	N	N	N	N	2/14
Recovery Supports	X	N	X	X	N	X	X	N	X	X	X	X	N	N	8/13
Supported Employment (IPS)	X	N	X	X	X	X	X	X	X	X	X	N	X	X	12/14
Drop-In Center for TAY	X	N	X	N	X	X	N	N	X	X	X	N	N	N	7/14
Early Childhood Consultation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14/14
Other, please specify: Early Psychosis	X	N	N	X	X	X	N	N	X	X	N	X	N	X	8/14

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i) Screening	☒ Yes ☐ No
ii) Education	☒ Yes ☐ No
iii) Brief intervention	☒ Yes ☐ No
iv) Assessment	☒ Yes ☐ No
v) Withdrawal Management (inpatient/residential)	☒ Yes ☐ No
vi) Outpatient	☒ Yes ☐ No
vii) Intensive outpatient	☒ Yes ☐ No
viii) Inpatient/residential	☒ Yes ☐ No
ix) Aftercare/Continuing Care	☒ Yes ☐ No
x) Recovery support	☒ Yes ☐ No

b) Services for special populations:

i) Prioritized services for veterans?	☒ Yes ☐ No
ii) Adolescents?	☒ Yes ☐ No
iii) Older Adults?	☒ Yes ☐ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☐ No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ Yes ☐ No
3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☐ No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling? ☒ Yes ☐ No
 - b) Establishment of an electronic system to identify available treatment slots? ☒ Yes ☐ No
 - c) Expanded community network for supportive services and healthcare? ☒ Yes ☐ No
 - d) Inclusion of recovery support services? ☒ Yes ☐ No
 - e) Health navigators to assist clients with community linkages? ☒ Yes ☐ No
 - f) Expanded capability for family services, relationship restoration, and custody issues? ☒ Yes ☐ No
 - g) Providing employment assistance? ☒ Yes ☐ No
 - h) Providing transportation to and from services? ☒ Yes ☐ No
 - i) Educational assistance? ☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Kentucky's behavioral health system of care has incorporated multiple programs to address the needs of pregnant and parenting individuals. These programs address substance use disorder by developing a continuum of care that includes screening, assessment, outpatient, intensive outpatient, and residential treatment services, along with recovery supports including case management, peer support, recovery housing, and other community-based recovery supports. DBHDID has a Division of Program Integrity that includes a Program Support Branch that monitors provider compliance with all contract deliverables and contract performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Support Branch coordinates reviews of all PWWDC contract deliverables with specific program administrators in the Division of Substance Use Disorder that oversee the PWWDC programming. Monitoring reports are created during the third quarter of each fiscal year for the DBHDID Commissioner. Any issues are discussed with contracted entities, and plans of correction are developed and monitored through the Program Support Branch.

Kentucky continues to expand its Plan of Safe Care (POSC) initiative with pilot sites at 11 of the 14 CMHCs, with plans for further expansion as funding allows. This initiative aims to improve access to evidence-based, quality services for PWWDC and to develop a coordinated and collaborative community-based system of care that supports the needs of families served.

Senate Bill 192 provides funding for the Kentucky Justice and Public Safety Cabinet to combat heroin and substance use disorder in the Commonwealth. The Office of Drug Control Policy within that cabinet works in tandem with the Kentucky DBHDID to assist with the selection of provider agencies to receive funds for programs focusing on Neonatal Abstinence Syndrome (NAS). Qualified providers receive funding to develop or expand comprehensive, evidence-based residential treatment services, and increase access to recovery housing, and other recovery supports for pregnant and parenting individuals and their families. From SFY 2016 to SFY 2022, it is estimated that more than 5,000 individuals and their children/families have received treatment and utilized services from over 22 selected providers across the state supported by these funds.

As part of the KY-Moms Maternal Assistance Towards Recovery (Moms MATR) the Adult Substance Use Treatment & Recovery Services Branch, within the Division of Substance Use Disorder, is implementing a statewide effort to improve the health of all babies in Kentucky by decreasing the use of alcohol, tobacco, and other substances during pregnancy and postpartum periods. This program is currently operating in all 14 CMHCs across Kentucky where collaborative outreach services seek to identify and

engage pregnant and postpartum individuals who are at risk for substance use and/or present with a substance use disorder. KY-Moms MATR services are focused on providing universal, selective, and indicated prevention services to educate an at-risk population of pregnant and postpartum individuals. Pregnant and post-partum individuals that are diagnosed with a substance use disorder can receive case management services during their pregnancy and up to 12 months after delivery. Prevention and case management services are designed to reduce harm to Kentucky children from maternal substance use during and after pregnancy.

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) 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 as at risk for diseases associated with intravenous drug use. Each CMHC is required to have written policies for screening individuals and referring them for appropriate treatment services. DBHDID has a Division of Program Integrity that includes a Program Support Branch that monitors provider compliance with all contract deliverables and contract performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Support Branch coordinates reviews of all PWID contract deliverables with specific program administrators in the Division of Substance Use Disorder that oversee the PWID programming. Monitoring reports are created during the third quarter of each fiscal year for the DBHDID Commissioner. Any issues are discussed with contracted entities, and plans of correction are developed and monitored through the Program Support Branch.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
- a) Business agreement/MOU with primary healthcare providers? ☒ Yes ☐ No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment? ☒ Yes ☐ No
 - c) Established co-located SUD professionals within FQHCs? ☒ Yes ☐ No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
- Contractual requirements include guidelines for providing education and referral services for individuals identified at risk for diseases associated with tuberculosis. Each CMHC is required to have written policies for screening individuals and referring them for appropriate treatment services. DBHDID has a Division of Program Integrity that includes a Program Support Branch that monitors provider compliance with all contract deliverables and contract performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Support Branch coordinates reviews of all TB contract deliverables with specific program administrators in the Division of Substance Use Disorder that oversee the TB programming. Monitoring reports are created during the third quarter of each fiscal year for the DBHDID Commissioner. Any issues are discussed with contracted entities, and plans of correction are developed and monitored through

the Program Support Branch.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ☐ Yes ☐ No
2. Has your state identified a need for any of the following:
- a) Establishment of EIS-HIV service hubs in rural areas? ☐ Yes ☐ No
- b) Establishment or expansion of tele-health and social media support services? ☐ Yes ☐ No
- c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? ☐ Yes ☐ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances [\(42 U.S.C. § 300x-31\(a\)\(1\)\(F\)\)](#)? ☒ Yes ☐ No

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, persons experiencing homelessness)? ☒ Yes ☐ No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ☒ Yes ☐ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered 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 system, adult criminal justice system, 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

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements? ☒ Yes ☐ No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients? ☐ Yes ☒ No
 - c) Updating written procedures which regulate and control access to records? ☐ Yes ☒ No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ☐ Yes ☒ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act ([42 U.S.C. §300x-52\(a\)](#)) and [45 CFR 96.136](#) require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.
- a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
- Kentucky contracts with 14 CMHCs for MH/SUD services. Of the 14 CMHCs, seven currently have CARF accreditation and four are currently accredited by the Joint Commission, resulting in 79% of the CMHCs have independent peer reviews by these two external accreditation bodies. In addition, four of these CMHCs are also Certified Community Behavioral Health Clinics. As of January 2026, an additional six CMHCs will also be Certified Community Behavioral Health Clinics.
3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan? ☒ Yes ☐ No
 - b) Establishment of policies and procedures related to independent peer review? ☐ Yes ☒ No
 - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ☒ Yes ☐ No
4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ☐ Yes ☒ No

If Yes, please identify the accreditation organization(s)

- i) ☐ Commission on the Accreditation of Rehabilitation Facilities
- ii) ☐ The Joint Commission
- iii) ☐ Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ☒ Yes ☐ No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ☐ Yes ☒ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state? ☒ Yes ☐ No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ☒ Yes ☐ No
 - c) Performance-based accountability? ☒ Yes ☐ No
 - d) Data collection and reporting requirements? ☒ Yes ☐ No

If the answer is No to any of the above, please explain the reason.
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^[1] (TTCs)?
 - a) Prevention TTC? ☒ Yes ☐ No
 - b) SMI Adviser ☒ Yes ☐ No
 - c) Addiction TTC? ☒ Yes ☐ No
 - d) State Opioid Response Network? ☒ Yes ☐ No
 - e) Strategic Prevention Technical Assistance Center (SPTAC) ☒ Yes ☐ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C. § 300x-22(b), 300x-23, 300x-24, and 300x-28 (42 U.S.C. § 300x-32(e))**.*

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women (300x-22(b)) ☐ Yes ☒ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23)

☐ Yes ☒ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis

☐ Yes ☒ No

b) Early Intervention Services Regarding HIV

☐ Yes ☒ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements ([42 U.S.C. § 300x-28](#))

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.
Kentucky Revised Statutes Chapter 210 - <https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38158>

DBHDID Kentucky Administrative Regulations - <https://apps.legislature.ky.gov/kar/titles/908/>

Medicaid Kentucky Administrative Regulations - <https://apps.legislature.ky.gov/kar/titles/907/>

KRS 194A.030 - <https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=55830>

^[1] <https://www.samhsa.gov/technology-transfer-centers-ttc-program>

Footnotes:

Kentucky is not a HIV-designated state. Thus, responses to HIV Criterion 6, question 1 and Questions 2a 2b and 2c are Not Applicable.

Environmental Factor # 7

Criterion 1 – Substance Use Prevention and Treatment Services

Additional Information

Kentucky's behavioral health system of care includes 14 Community Mental Health Centers (CMHCs) as well as multiple licensed and credentialed private providers as specified on the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) provider directory. These programs provide access within the state to a full continuum of services, including education, screening, brief intervention, assessment, outpatient, intensive outpatient, residential, withdrawal management, and recovery supports. Kentucky is continuously identifying specific populations of need and works to provide targeted services to those populations. Those populations include Service Members, Veterans, and their Families (SMVF), adolescents, pregnant and parenting persons, individuals experiencing homelessness, older individuals, individuals with co-occurring substance use and mental health disorders and others as identified. Kentucky promotes the use of Medications for Opioid Use Disorder (MOUD) by providing this evidence-based treatment via 36 state-certified Narcotic Treatment Programs that dispense buprenorphine and/or methadone in conjunction with treatment services. Kentucky also maintains comprehensive legislative regulations to support access to all formulations of buprenorphine. For example, Kentucky has removed prior authorizations for extended-release buprenorphine injections. Additionally, Kentucky has established an online treatment locator website called FindHelpNowky.org. It works with hundreds of facilities across the state including CMHCs, private, non-profit, faith-based treatment providers, and providers of Medication for Opioid Use Disorder (MOUD) to bring consumers up-to-date and accurate information about their treatment offerings and availability. Providers are encouraged to update their treatment availability and facility information daily. FindHelpNowky.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, and recovery resources. FindHelpNowky.org was created by the Kentucky Injury Prevention and Research Center (KIPRC) as an agent for the Kentucky Department for Public Health in partnership with the Kentucky Office of Drug Control Policy, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities, and Operation Unlawful Narcotics Investigations, Treatment and Education (UNITE).

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use 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. Title XIX, Part B, Subpart III of the Public Health Services Act ([42 U.S.C. §300x-52\(a\)](#)), mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

[42 U.S.C. §300x-53\(a\)](#) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMS) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are 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-owned and state-operated facilities. The community-based data and facility data share common data elements thus serve DBHDID on project-based analyses.

The monthly data DBHDID collects from the Community Mental Health Center (CMHC) providers supports DBHDID's efforts to monitor client-level demographic and diagnostic statistics, service utilization, and provider & staffing used to provide direct care

behavioral health services (including services for Mental Health, and Developmental & Intellectual Disabilities). DBHDID also uses these data to aid reporting for the federal Block Grants, National Outcome Measures (NOMs), 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.

DBHDID collects data daily from its state-owned and state-operated facilities, which for behavioral health include three state psychiatric hospitals and a state psychiatric unit within a medical facility. The data collected includes client-level admission and discharge information, demographics, diagnoses, and living arrangement (housing) status at admission and discharge. DBHDID uses this data to inform service delivery decisions and to meet federal reporting requirements, including National Outcome Measures (NOMs), Client-Level Data (CLD), and the Uniform Reporting System (URS). It also supports other uses such as State Mental Health Authority (SMHA) profiles and national surveys.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is 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.).

DBHDID's community-based data collection and reporting system is specific to mental health services. It also includes the collection of CMHC Substance Use Disorder Treatment Episode Data Set (SUD-TEDS). Additionally, substance use identifiers and service codes as well as intellectual and developmental disabilities identifiers and service codes are included. However, DBHDID's data collection system is not connected to other broad data bases, such as Medicaid.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

DBHDID currently links its community-based and facility-level data. Although Kentucky does not maintain integrated mental health data systems across state agencies, DBHDID collaborates with partners such as the Department for Medicaid Services (DMS), Department of Corrections (DOC), and Department for Public Health (DPH) through data-sharing agreements. These partnerships support correlational analyses that help the department better understand and plan for the capacity needs of the state's mental health system.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

DBHDID primarily uses client- and event-level data from community-based services to report on the use of evidence-based practices, informed by client profiles, diagnoses, and the services delivered by Community Mental Health Centers. With regards to Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), several specific EBPs are included in the DBHDID client/event data set (e.g., assertive community treatment; supported employment; peer support) In addition to analyzing these service data, Kentucky conducts fidelity assessments to ensure evidence-based practices are delivered in alignment with established models and to promote service quality.

For Early Serious Mental Illness (ESMI), there is currently no specific marker in the DBHDID client/event data set for either ESMI or First Episode Psychosis (FEP). In addition, there is currently no event code for Coordinated Specialty Care (CSC). While the CMHCs providing the EBP of CSC are entering overall client/service data for those individuals through the data system, there is no current method of extracting data with specificity for this population. For that reason, DBHDID partners with an external evaluator and uses a third-party application into which ESMI providers directly enter service data. This information is reviewed by the evaluation team, and technical assistance is provided to support effective implementation of evidence-based services.

For Behavioral Health Crisis Services (BHCS) the DBHDID client/event data set does include codes for crisis intervention services, community-based mobile crisis intervention services, and residential crisis stabilization services (adult and child). However, call center services are not currently represented in the DBHDID client/event data set. For this reason, DBHDID relies on data captured through the Vibrant unified platform for 988/call center data (e.g., call, text, and chat services). DBHDID accesses the Vibrant Exchange to analyze contact data by demographics, geography, presenting issues (e.g., suicide, mood disorders, family conflict), and time of contact. To maintain caller anonymity, specific data is only collected when individuals voluntarily disclose information during their interaction.

Additional 988 contact-related data is entered into a separate third-party application maintained by the evaluation team and used to inform service delivery and resource allocation. Providers also submit supplementary data to DBHDID on a quarterly basis via standardized Excel spreadsheets. Additional crisis service system data specifics are collected through quarterly department periodic reports maintained by crisis services program administrators.

DBHDID remains committed to expanding its capacity to monitor, evaluate, and report on the use and effectiveness of evidence-based practices across the behavioral health system.

5. Briefly describe the limitations of the SMHA 's existing data system.

DBHDID mental health data system consists of multiple applications designed to collect, manage, analyze, and report data across a range of behavioral health programs and initiatives. While these applications serve important program-specific functions, most operate independently and are not integrated with one another. As a result, data housing within individual systems often cannot be easily compared, aggregated, or linked.

Furthermore, the current structure limits the ability to integrate DBHDID's mental health data with data systems maintained by

other state agencies or external partners, such as Medicaid, Corrections, or Public Health. This lack of interoperability creates challenges in generating a comprehensive, cross-system understanding of service utilization, outcomes, and population needs.

DBHDID recognizes the need for a more connected and interoperable data infrastructure and continues to explore opportunities to modernize its systems, improve data linkages, and support data-informed decision-making across the behavioral health continuum.

6. What strategies are being employed by the SMHA to enhance data quality?

DBHDID is increasing communication and coordination among all department divisions for projects to improve software and data operations, etc. Our state hosts three data-related standing teams that involve state and community partners. Each committee has a key role in defining data elements, processes to ensure accurate, complete and timely data collection and defining indicators measures of quality. Contributions from all three teams often lead to successful implementation of data collection, issue resolution, and outcomes measure development.

The Data Users Group (DUG) 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 data and 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.

Recommendations by the Quality Management & Outcomes Team (QMOT) provide direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across the department. The team evaluates outcomes that support the provision of quality services and explores areas for improvement. The Joint Committee for Information Continuity (JCIC) 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 an information system to manage a public behavioral health system.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

Federal and state level funding cuts could present barriers. Additional reporting requirements would also present barriers to collecting and reporting data to SAMHSA.

8. Please indicate areas of technical assistance needs related to this section.

DBHDID would benefit from targeted technical assistance to strengthen its capacity to aggregate and integrate data both within the agency—across programs and divisions—and externally with partner agencies such as Medicaid, Public Health, Corrections, and Education.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

.....to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system has 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. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include [Crisis Services: Meeting Needs, Saving Lives](#), which consists of the [National Guidelines for Behavioral Health Coordinated System of Crisis Care](#) as well as an [Advisory: Peer Support Services in Crisis Care](#). There is also the [National Guidelines for Child and Youth Behavioral Health Crisis Care](#) which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act ([P.L. 116-172](#)) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Kentucky offers 24/7 Crisis Hotline and Walk-In Crisis During Business Hours in all 14 regions for both adults and children, showing the strong emphasis placed on strong access for initial crisis contact. In addition, there's broad availability of mobile crisis assessment via telehealth. Access to a Qualified Mental Health Professional (QMHP), and psychiatric consults are widely available across regions, though slightly more consistently for adults than children.

peer-based and non-clinical crisis support. Virtual crisis support via chat or text is available in some regions, increasing accessibility for youth and young adults. Kentucky is expanding its text and chat capacity for 988 as well, with statewide coverage expected before the end of the year.

Kentucky does have limited or uneven availability for services like Behavioral Health Crisis Respite, Withdrawal Management, 23-Hour Observation/Living Room, and Behavioral Health Urgent Care highlighting regional disparities in higher-intensity or specialty crisis services. Additionally, Intensive In-Home Services and Law Enforcement Drop-Off Sites for children are more limited and scattered.

CMHCs are engaged in the following initiatives to enhance crisis services in their region:

- Expansion of Mobile Crisis Services: Kentucky's 988 network is embedded in the Commonwealth's 14 CMHCs. All 988 centers have access to mobile response teams (MRTs), though the response varies by region. Kentucky is working with Certified Community Behavioral Health Centers (CCBHCs) on connections to 988 centers and MRTs.
- Expansion of Crisis Continuum: CMHCs are expanding mobile crisis services, 23-hour crisis receiving facilities, co-occurring capable crisis stabilization units, behavioral health urgent care centers, call center services such as 988 calls/texts/chats, and placing crisis staff at more community locations to meet clients where they are, such as in schools and drop-in centers.
- High Acuity Youth: DBHDID has enhanced its focus on meeting the needs of youth with complex needs who are boarding in hospitals and non-traditional placements. Within the Kentucky Cabinet for Health and Family Services, DBHDID, and Department for Community Based Services are partnering with Myers & Stauffer to create a children's 1915(c) Waiver application. The waiver, named Community Health for Improved Lives and Development (CHILD) is intended to serve children with the highest acuity needs and require intensive behavioral health and residential services and supports. It will provide home and community-based waiver services to Kentucky children and youth ages birth through twenty-one who have a serious emotional disturbance; intellectual disability; developmental disability, or autism spectrum disorder and who meet level of care for Psychiatric Residential Treatment Facility or Intermediate Care Facility for Intellectual Disability. Priority enrollment will be granted to those children who are unhoused, are at risk of being unhoused, or transitioning out of an institution. The following services will be included in the 1915(c) application: Case Management; Respite- including in-home, community, and facility-based options, Community Living Supports, Environmental and Minor Home Modifications, Step-Down and After Care Support (includes parental and family support), and Supervised Residential Care.
- Adults and Youth with Justice Involvement: Collaboration to increase services for adults and youth with justice involvement is at an all-time high. DBHDID has an Executive Advisor position to focus on forensic services and specialized workgroups are meeting to:
 - o Educate court staff, behavioral health providers, and community partners on adult civil commitment law and process. Trainings have been developed and forums are being scheduled in each CMHC region for late summer/early autumn 2025.
 - o Develop Kentucky's new, less restrictive adult competency evaluation and restoration options.
 - o Enhance transportation services for adults who need inpatient care.
 - o Enhance DBHDID's forensic data collection and analysis for use in enhancing delivery of services to the forensically involved population.
 - o Discover opportunities for programs to collaborate.
- Staff Capacity: DBHDID and contracted providers have increased staff capacity by developing additional crisis positions, hiring more staff at all levels, offering more competitive wages, advancing staff into leadership roles, and consolidating crisis programs within their agencies. In SFY 2024, CMHCs reported the following number of full time equivalents (FTEs) per position: mobile crisis clinicians (95.5), office-based crisis clinicians (126), crisis stabilization unit clinicians (44), crisis call center staff (148); Certified Peer Support Specialists working in crisis services (92), crisis case managers (79), crisis prescribers (30), Community Support Associates working in crisis services (55.5), and crisis stabilization techs (104).
- Substance Use Crises: DBHDID has enhanced focus on serving individuals in crisis experiencing a substance use disorder through starting more Quick Response Teams (QRTs), collaborating more with QRTs/local providers/agency programs, and medication assisted treatment same-day inductions. This is achieved through blended funding.
- Transportation Services: Staff from Kentucky's four state hospitals and DBHDID are meeting monthly to review other states' models of secure transportation for adults needing an inpatient level of care. The group plans to draft budget recommendations for the next biennium budget request.
- Community Partnerships: DBHDID has created two new 988 positions to develop state and local partnerships and capacity. The 988/911 Coordinator position facilitates collaboration between 911 Public Safety Answering Points (PSAP) and emergency response agencies, such as Emergency Medical Services (EMS), fire, and law enforcement, and 988 call centers to establish a care pathway and connect individuals in crisis to the appropriate care. The 988 Workforce Coordinator position aids in workforce development across CMHCs by planning and delivering ongoing trainings specific to the 988 workforce, as well as to those working across the crisis continuum.
- Disaster Response: DBHDID has three designated staff positions to oversee Disaster Services Implementation. These roles are responsible for managing the Kentucky Community Crisis Response Team (KCCRT), which provides Psychological First Aid to survivors of natural or manmade disasters, as well as first responders and communities that have been affected. KCCRT is a multi-disciplinary team of trained volunteers, many of whom are mental health professionals and first responders. DBHDID oversees the training provided to KCCRT members, as well as Mental Health First Aid training to first responders, emergency health service providers, state guardians, dispatchers, and other community members in order to help meet the needs of the community. Additionally, DBHDID, through KCCRT, coordinates federal grants, which facilitates the application for three separate grants for disasters that occurred in 2025 (flooding in the central and eastern parts of the state, and tornadoes in southeastern Kentucky). Approval for those grant dollars is pending from federal agencies.
- Intra-Agency Collaboration: DBHDID hosts collaborative meetings and trainings to improve service coordination. Program Administrators coordinate meetings with CMHC Adult Crisis Directors, CMHC Children's Crisis Directors, and 988 Call Center Directors. DBHDID collaborates with community stakeholders to enhance services by coordinating the Kentucky 988 Coalition, 988 Quality Assurance Team, 988 Workforce Team, and 988 Emergency Services Team. These teams meet monthly to share updates and develop plans to enhance services. DBHDID has developed the Forensic Advisory Group and subgroups focused on civil commitment, secure transportation, forensic data. These groups also include community stakeholders to help guide service development.
- CCBHC Alignment and Expansion: There is coordinated work being done to increase the number of CCBHCs in Kentucky and to enhance services to align with CCBHC requirements. Four CMHCs are operating as CCBHCs as part of Kentucky's demonstration, with six CMHCs and two Behavioral

Health Service Organizations (BHSOs) planning to onboard as CCBHCs in January 2026.

- **Best Practices:** DBHDID coordinates trainings and works to build local training capacity. Trainings include topics specific to the workforce along the crisis continuum, including both in-person and virtual training options. In 2025, the 988 Virtual Learning Series featured topics about Kentucky's continuum of crisis services, responding to callers with autism, and supporting individuals experiencing psychosis. Seven in-person trainings are being held across the state.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.

c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.

d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☒
Someone to respond	☐	☐	☐	☒	☐	☐
Safe place to be	☐	☐	☐	☒	☐	☐

3. Briefly explain your stages of implementation selections here.

Someone to Contact

Program Sustainment: Kentucky has 14 CMHCs that operate 24/7 regional crisis call centers. Those regional crisis call centers responded to more than 161,000 crisis contacts in SFY 2024 from 988 and local crisis lines. Five CMHCs provide warmline services for children and five provide warmline services for adults. NAMI Lexington's Participation Station, a local mental health advocacy organization, provides peer-operated warmline services seven days a week.

Fourteen CMHCs are 988 call centers and provide coverage to all 120 counties. In 2024, Kentucky's 988 centers answered 33,722 calls to 988, a 40.1% increase over 2023. Kentucky improved the answer rate from 84% in January 2024 to 91% in December. The national goal for states is 90%.

One 988 call center, Pennyroyal Center, responds to 988 chats and texts three-hours per day on weekdays. During the past year they responded to 707 texts and 276 chats. In December 2024, Kentucky issued a Notice of Funding Opportunity (NOFO) for additional 988 chat/text services. One grant was awarded to RiverValley, an existing 988 call center, to provide 24/7 access to 988 chat/text, with full implementation expected by November 2025. The addition of a 24/7 center with a dedicated workforce will increase access to 988 through chat/text for Kentuckians.

Kentucky has 14 locally based Crisis Call Centers in the state, all participating in the 988 Suicide and Crisis Lifeline network. All 14, 100%, have follow up protocols in place. The Kentucky 911 Services Board does not collect the percent of 911 calls that are dispatched as behavioral health related on a statewide basis, and there are 117 certified 911 call centers in Kentucky that use different methods to capture this data. Only one state agency, the Kentucky Board of Emergency Medical Services (KBEMS), collects statewide data on emergency calls. Kentucky is working with KBEMS to collect annual data on mental health and substance use calls responded to in the commonwealth. This data will be used to identify trends related to behavioral health calls to 911 and call disposition when known, and to develop partnerships with Emergency Medical Services (EMS) agencies to avoid unnecessary emergency department visits.

Someone to Respond

Early Implementation: Kentucky's regional mobile crisis services are at varying levels of implementation. Programs are working to revitalize mobile crisis teams that dwindled during the pandemic. CMHC mobile crisis providers report that recruitment and retention is challenging due to safety concerns, low pay, lack of fleet vehicles, and evening/weekend work hours.

Mobile crisis is a required service for Certified Community Behavioral Health Clinics (CCBHCs). There are currently four CMHCs that are operating as a CCBHC as part of Kentucky's demonstration project, with six additional centers and two BHSOs planning to onboard as CCBHCs in January 2026. In SFY 2024, CMHCs provided mobile crisis services to 5,191 adults (2,028 with serious mental illness) and 987 youth (557 with serious emotional

disturbance). This is 21.4 adults per 10,000 population and 3.7 youth per 10,000 population (2020 census).

Kentucky's 14 CMHCs provide mobile crisis services for adults in 75 out of the state's 120 counties and for children and adolescents in 112 of 120 counties, with varying access. Ten CMHCs have staffed mobile crisis teams during business hours and nine during evenings and weekends. Mobile crisis teams provide services in homes and designated safe community locations, such as schools and workplaces.

The following local communities have invested in developing community crisis response programs within police or paramedic services: Lexington Fire Department (paramedic team); Louisville Metro Police Department West Division (behavioral health staff embedded in dispatch plus social worker deflection teams); Perry County Community Paramedicine Program (paramedic team in unmarked vehicle); Boyle County Emergency Medical Services (paramedic team); City of Alexandria (social worker embedded in police department); City of Erlanger (social worker embedded in police department); Bowling Green Police Department and LifeSkills Co-Response Program; Mt. Sterling Police Department and Pathways Co-Response Program; Rowan County and Pathways; Kentucky River Community Care Co-Response Program; and the City of Frankfort Police Department (Community Policing Advocate/Social Worker). The Kentucky Judicial Commission on Mental Health is developing a report about these programs.

DBHDID is unaware of any first responder structures that employ behavioral health peer specialists; however CMHCs report the following number of Certified Peer Support Specialists designated for crisis services: 14 CMHCs employ 100.75 FTE Adult Peer Support Specialists; 10 CMHCs employ Youth Peer Support Specialists; 11 CMHCs employ Family Peer Support Specialists; eight CMHCs employ Peer Support Specialists for mobile services; 10 employ Peer Support Specialists for walk-in crisis services; and eight employ Peer Support Specialists for residential crisis services.

Safe Place to Go or To Be

Partial Implementation: Kentucky CMHCs operate 11 adult crisis stabilization units (92 beds) and five children's crisis stabilization units (46 beds) across the state. In SFY 2024, CMHCs provided residential crisis stabilization to 1,811 adults (1,223 with serious mental illness) and 854 youth (668 with serious emotional disturbance). These service numbers represent a rate of 6.2 adults per 10,000 population and 2.5 youth per 10,000 population (2020 census).

CMHC crisis receiving and stabilization programs have increased in the last two years. Five CMHCs are providing 23-hour services for adults and two are providing services for children and adolescents. In Kentucky, this service is provided to clients who consent to services and includes assessment, observation, intervention, peer support, and linkage to ongoing care and community resources.

CMHCs provide walk-in crisis services at local clinics in 110/120 counties. In SFY 2024, CMHCs provided walk-in services to 12,511 adults (5,441 with serious mental illness) and 3,498 youth (2,405 with serious emotional disturbance). This is 34.2 adults per 10,000 population and 11.4 youth per 10,000 population (2020 census).

As of December of 2024, Kentucky had 110 emergency departments. Kentucky has two emergency departments that operate with a specialized behavioral health component. In Louisville, Emergency Psychiatric Services (EPS) is a partnership between the University of Louisville Hospital and Seven Counties Services, the local CMHC. In SFY 2024, EPS served 4,114 adults (850 with a serious mental illness), admitting 684 individuals to the 23-hour holding bed unit and 398 to the state hospital.

In Lexington, the state's first Emergency Psychiatric Assessment, Treatment, and Healing (EmpATH) Unit opened in July 2024. It is operated by University of Kentucky HealthCare, on the grounds of Eastern State Hospital, in partnership with New Vista, the local CMHC. The unit accepts all voluntary and involuntary adults experiencing a mental health crisis. When inpatient care is needed, staff coordinates admissions with Eastern State Hospital and local private hospitals. When individuals have co-occurring physical health needs, the EmpATH Unit coordinates medical care with University of Kentucky Hospital. New Vista coordinates ongoing outpatient and follow-up care.

In Spring 2025, New Vista opened the state's first Behavioral Health Urgent Care Center in Lexington. The center is currently serving adults during extended business hours.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the [National Guidelines for Child and Youth Behavioral Health Crisis Care](#), explain how the state will develop the crisis system.

988 Projects

Kentucky's 988 program has a designated 988 Program Administrator at DBHDID and an active coalition that meets monthly to collaborate on improving access for Kentuckians with high acuity needs and continual system improvement. It has five committees (Marketing, Quality Assurance, 988 Training Workgroup, Crisis Directors, and Emergency Services) that meet on a regular basis and one committee (Policy and Advocacy) that meets as needed. Kentucky's 988 program is working on the following projects:

- 988 Workforce: The 988 Program Administrator and partners are standardizing and expanding 988 call counselor capacity. In 2024, a 988 Workforce Liaison position was added to support the centers in building capacity through recruitment, retention, and training. A 988-specific training plan has been developed and implemented through monthly virtual learning sessions and the first in-person training academy for the 988 workforce. Based on feedback from the frontline 988 workforce, trainings are being offered to equip crisis staff in assisting individuals with SMI and SED, and working with populations with unique needs, such as children. The virtual training sessions are offered twice to allow for maximum attendance of the workforce on different shifts and are recorded for future viewing. The in-person training sessions are offered multiple times at different locations across the Commonwealth. These sessions utilize subject matter experts in various topics to educate and engage the workforce through information and simulations. The in-person trainings also provide the workforce opportunities to meet individuals from other centers and discuss strategies for handling common challenges. Through a partnership with the University of Louisville (UofL), a research project is occurring with the workforce. Volunteers from the workforce participate in confidential focus groups. The research will identify common characteristics of the workforce, challenges experienced, and opportunities for engagement and career satisfaction.

Workforce feedback is also collected through an annual staff engagement survey. This anonymous survey asks both closed and open-ended questions, allowing the workforce to provide anonymous feedback as a 988 crisis counselor. The information is shared with each center to discuss successes and opportunities for improvement.

- **Marketing:** Kentucky's 988 Marketing Committee has developed a marketing plan for the Commonwealth to increase awareness and support the 988 centers. Through a Boot Camp Translation (BCT) project in 2024, two community advisory groups were convened to develop messaging for populations identified with a high prevalence of suicidal ideation, self-harm, and death by suicide. The recommendations of the BCT led to the first statewide marketing campaign that ran from December 2024 to March 2025. A second marketing campaign is ongoing for a high-risk geographic area of the state. A second community-based participatory research project will focus on marketing messages aimed at individuals with SMI and SED. Additional marketing efforts in the past year include 988 brochures, educational flyers on the use of 988 and 911, and age-appropriate coloring books. These and similar efforts will continue. All Kentucky 988 materials are shared with the 988 centers and community partners to maximize distribution across the commonwealth. The annual awareness survey is being reviewed and revised for dissemination. The information obtained from this survey identifies geographic areas for additional marketing efforts.

- **Quality Assurance:** Center-level and 988 Network Administrator-level data is reviewed monthly for changes in volume, average talk time, and flowout calls going to a national backup center. Using the monthly center reports to DBHDID, contact reasons, emergency service interventions, and referrals are reviewed to ensure 988 is providing the least restrictive, most appropriate care for the crisis. The Quality Assurance (QA) Committee has developed data collection and user feedback protocols. The data collection protocol outlines how and when demographic information is gathered from 988 contacts, emphasizing that only information voluntarily shared by the individual is collected. The user feedback protocol describes Kentucky's process for receiving and addressing user experience data provided through surveys or direct communication with DBHDID. Additionally, the protocol includes procedures for follow-up and critical incident reviews, as needed, based on available data and emerging needs. The follow-up protocol is being reviewed by the QA Committee to align with the 988 Network Administrator policies while establishing DBHDID expectations that each center offer follow-up contact within 72 hours to all 988 contacts experiencing a mental health or substance use crisis and provide documentation of the follow-up contacts. The critical incident review protocol is also under revision and is being updated to offer clear guidance to 988 centers on managing events involving 988 contacts or other situations that significantly affect a Kentucky 988 center, such as natural disasters or major infrastructure failures. These protocols help to set expectations for high-quality interactions and identify areas where additional support from DBHDID may be needed.

Additionally, center-level monthly reports are reviewed to identify errors, monitor follow-up and emergency service intervention data, and staffing changes, with Technical Assistance (TA) provided to centers on accurate reporting. As needed, changes in the monthly report are reviewed to the QA Committee and the Crisis Directors to address any data collection needs, such as reasons for contact, and demographic data. The QA Committee also reviews performance data and user feedback for continual improvements. Centers identified as needing improvement are contacted by the 988 Program Administrator to discuss the barriers and develop a plan for improvement. The 988 User Feedback Survey continues to be promoted on Kentucky's 988 marketing materials, website, and data dashboard. Feedback received from the 988 User Feedback survey is reviewed quarterly and improvement opportunities identified, which may include additional training or staffing support. Kentucky has implemented a phone number search protocol and agreement, through the grant evaluator, with the 988 Network Administrator. The phone number search, with consent from the individual, will assist in identifying which Kentucky center was reached by the contact. Identifying a specific center will allow for more tailored TA and support, as appropriate.

- **In-State Response:** The 988 call centers are enhancing their in-state answer rates, workforce capacity, and exploring chat and text expansion. All 14 CMHCs are now 988 centers, allowing for the most local care and resources. Kentucky has also ensured that all 120 counties are covered by a backup center to better assist individuals in crisis. The systems established have enabled Kentucky to consistently achieve a 90% or better answer rate since August 2024. Kentucky has one 988 center, Pennyroyal Center, that is currently accepting 988 Lifeline Crisis Chat & Text (LCCT) contacts on a limited schedule, in addition to taking 988 calls 24/7. Another Kentucky center was awarded a grant to implement 24/7 988 LCCT services by late summer 2025, which will provide access to all Kentucky individuals in crisis reaching out to 988 with support from a state-based center. Other centers are exploring the LCCT option to further increase local access to the crisis continuum.

- **Community Collaboration:** Kentucky is focused on developing partnerships with community partners to ensure access to 988 for individuals identified at high risk for self-harm. Each 988 center is contractually required to have a 988 Regional Coalition consisting of community partners. DBHDID provided guidance on regional coalition development, to include any community partner encountering or assisting individuals in crisis. The centers are encouraged to include emergency service agencies, hospitals, schools, and others to discuss local trends in behavioral health crises. In 2024, a 988-911 Liaison was hired to support Kentucky's 988 centers in developing or enhancing their relationships with emergency services to create a care pathway to 988 for behavioral health related emergency calls to 911. In collaboration with the 988 centers, the 988-911 Liaison conducted 988 overview trainings to emergency services staff in all 14 CMHC regions, with plans to continue virtual sessions annually. Additionally, presentations and trainings have been held at various conferences to further promote 988 as a behavioral health resource and encourage local partnerships with the 988 centers. The 988-911 Liaison continues to work with the center on developing Memoranda of Understandings between the 988 centers and the local PSAPs/911 centers to allow warm handoffs between 911 and 988 for individuals experiencing a mental health crisis. A survey was distributed to emergency service agencies to gauge awareness of 988 and its effectiveness in addressing behavioral health crises. The survey responses are being shared with the 988 workgroups and call centers with plans to increase messaging to emergency services. Materials have created specifically for emergency services for distribution to individuals in crisis to reduce unnecessary use of law enforcement and Emergency Medical Services (EMS). Notepads promoting 988 are being distributed across Kentucky for law enforcement and EMS agencies to provide to medically stable individuals experiencing a mental health crisis who are not committing a crime. Kentucky's 988 team is also meeting with state-level agencies to increase awareness and develop partnerships to support individuals at higher prevalence of a mental health crisis. Meetings have occurred with agencies working with juveniles in the justice system and emergency service agencies to initiate awareness and facilitate partnerships with 988 centers at the regional level.

The State Interagency Council for Services and Supports for Children and Transition-Age Youth (SIAC) created the Kentucky Rapid Response and Stabilization Services (KRRSS) Ad hoc Policy Workgroup to advance crisis services in the state. It is co-chaired by leaders representing Department for Medicaid Services and Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) and is supported by consultants at the University of Connecticut Innovations Center. In 2023-2024, Innovations Center staff conducted a Mobile Response and Stabilization

Services (MRSS) environmental scan to assess the current scope and reach of children's crisis services in the state, as well as to assess the extent to which existing approaches and services support and adhere to the best practice MRSS model, are financially sustainable, and can meet expected capacities. The report is guiding KRRSS as it develops a workplan to explore enhancement of crisis services that interrupt current pathways to residential and restrictive settings and ensure that families have access to the right services and supports at the right time and at the right intensity. The workgroup also developed a recommendation to include in the SIAC annual recommendations to legislators and the governor.

Medicaid Updates

Kentucky Department for Medicaid Services has been planning and implementing new behavioral health service and support options for Kentuckians. Services are being developed for adults with serious mental illness, youth and adults transitioning from detention centers and prisons, youth with high-acuity needs, and individuals experiencing a behavioral health crisis. Planned services include case management and medication supply for individuals re-entering the community from prisons, and provision of Home and Community Based Services (HCBS) to individuals who have significant functional needs due to their behavioral health symptoms but that do not meet the criteria for an institutional level of care.

Within the Kentucky Cabinet for Health and Family Services, the Departments for Medicaid Services; Behavioral Health, Developmental & Intellectual Disabilities, and Community Based Services are partnering with Myers & Stauffer to create a children's 1915(c) Waiver application. The waiver, named Community Health for Improved Lives and Development (CHILD) is intended to serve children with the highest acuity needs and require intensive behavioral health and residential services and supports. It will provide home and community-based waiver services to Kentucky children and youth ages birth through twenty-one who have a Serious Emotional Disturbance; Intellectual Disability; Developmental Disability, or Autism Spectrum Disorder and who meet level of care for Psychiatric Residential Treatment Facility or Intermediate Care Facility for Intellectual Disability. Priority enrollment will be granted to those children who are unhoused, are at risk of being unhoused, or transitioning out of an institution. The following services will be included in the 1915(c) application:

- o Case Management
- o Respite – Including in-home, community, and facility-based options.
- o Community Living Supports
- o Environmental and Minor Home Modifications
- o Step-Down and After Care Support (includes parental and family support)
- o Supervised Residential Care

Additionally, DBHDID is leading the 1915(i) Recovery, Independence, Support, and Engagement (RISE) Initiative in conjunction with the Department of Medicaid Services, aiming to help adults with a primary diagnosis of SMI to secure housing, access education and employment, and avoid institutionalization. The following services are available to eligible participants:

- o Assistive Technology
- o Case Management
- o Housing and Tenancy Supports
- o In-Home Independent Living Supports
- o Medication Management
- o Planned Respite for Caregivers
- o Supervised Residential Care
- o Supported Education
- o Supported Employment (Individual Placement and Support)
- o Transportation (Non-medical; covers transportation to behavioral health services, employment, education, and other community activities)

Kentucky Judicial Commission on Mental Health

Crisis services are discussed, planned, and championed in many new venues. In 2022, the Kentucky Supreme Court established the Kentucky Judicial Commission on Mental Health to explore, recommend, and implement transformational changes to improve system response to justice-involved individuals experiencing mental health needs, substance use, and/or intellectual and developmental disabilities (IDD). In 2023, the Commission engaged in Sequential Intercept Mapping and expansion of community-based crisis supports was recommended. The Commission has developed legislative recommendations to support this population, and one recommendation was adopted in the 2025 legislative session.

At the Commission's 2023 Mental Health Summit, there was a key focus on improving crisis response and support systems for individuals experiencing mental health, substance use, or developmental challenges. Plenary and concurrent sessions were dedicated to the 988 Suicide and Crisis Lifeline, Crisis Intervention Teams, overdose education and Naloxone distribution, Louisville's 911 deflection pilot program Kentucky Community Crisis Response Teams, local CMHC crisis programs, civil commitment services, competency services, and coalition building to enhance local services. A second Summit is being planned for 2026 and DBHDID will again recommend topics that support Kentucky's crisis services continuum.

DBHDID staff are members of the Commission's 10 subcommittees and department staff meet monthly to provide updates and develop strategies to support the Commission's mission, such as creating workgroups to increase service capacity, develop training curricula, and enhance data collection and analysis. CMHC and state hospital staff are partners in this work.

Services and Supports for Children and Transition-Age Youth

Over the last two years, Kentucky has been working to develop residential and hospital level services to serve children and transition-age youth with high acuity needs. These youth often have co-occurring diagnoses of mental health, substance use, intellectual disability, or autism spectrum disorder. Sometimes the youth are involved with child welfare and/or the justice system. Sometimes they are highly aggressive, large for

their age, medically complex, or have problematic sexual behavior. Kentucky Department for Community Based Services (DCBS), the state's child welfare authority, began hosting meetings every morning to coordinate care for children in non-traditional placements, such as state offices, state park lodges, emergency shelters, and hotel rooms. These meetings include partners such as regional DCBS High Acuity Specialists, DBHDID, Department for Juvenile Justice, and Aetna SKY (Kentucky's managed care organization for children in state custody).

In 2024, DCBS and DBHDID collaborated with RiverValley Behavioral Health Hospital to develop the BIRCH Unit, a 10-bed program for boys. Admissions are coordinated by Medical Directors from DCBS, DBHDID, and RiverValley Hospital.

CMHCs provide crisis residential services in crisis stabilization units (CSUs). Kentucky has 11 CSUs for adults (92 beds) and five for children (46 beds). In 2023, one child CSU closed and in 2024, one adult and one child CSU closed. Another child CSU has reported that they are considering closing their program. Programs have reported challenges recruiting and retaining staff, securing sustainable funding, and serving a growing number of clients with intense behavioral health needs. DBHDID is meeting with the CMHC to learn more about barriers and to develop a plan to address them and continuing to develop the CHILD 1915(c) waiver application to support youth with high acuity needs.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

- a. Number of locally based crisis call Centers in state
 - i. In the 988 Suicide and Crisis lifeline network: 14
 - ii. Not in the suicide lifeline network: 0
- b. Number of Crisis Call Centers with follow up protocols in place
 - i. In the 988 Suicide and Crisis lifeline network: 14
 - ii. Not in the suicide lifeline network: 0
- c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

- a. Independent of public safety first responder structures (police, paramedic, fire): 10
- b. Integrated with public safety first responder structures (police, paramedic, fire): 6
- c. Number that utilizes peer recovery services as a core component of the model: 9

Safe place to be

- a. Number of Emergency Departments: 110
- b. Number of Emergency Departments that operate a specialized behavioral health component: 2
- c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 7

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Kentucky's 5% crisis set aside is allocated to the 14 CMHCs to be used to support the crisis continuum for adults with SMI and children with SED including the support of the 988 call, chat and text services expansion. A portion of the crisis set aside, is utilized by CMHCs to support mobile crisis services and residential crisis stabilization services for children and adults. Crisis set aside funds will continue to support these core crisis services. A significant portion of set aside funds will continue to be allocated to support 988 call, chat and text services until consistent, sustained quality calls, text and chat services can be maintained.

Kentucky's crisis services programming has two dedicated staff at DBHDID to support children and adult crisis programming across the state. The three core crisis continuum services (call centers, mobile crisis services, residential crisis stabilization units) are coordinated through the work of these staff in collaboration with the 988 team.

Kentucky's 988 program has three dedicated 988 staff at DBHDID to support the 988 centers. The 988 Program Administrator, 988-911 Coordinator, and 988 Workforce Coordinator support the centers in overall 988 operations, developing and maintaining community partnerships, and building an effective and sustainable workforce.

Kentucky's crisis services program will continue working on the following projects:

- 988 Workforce: The 988 Program Administrator and 988 Workforce Coordinator support the 14 centers through workforce development and training. Utilizing TTI grant funds from 2023 and 2024, work continues to develop a dedicated 988 workforce over the next five years. A 988 Training Workgroup, consisting of DBHDID 988 staff and center representation continue to develop ongoing state-specific training plans based on 988 user feedback and frontline staff training needs. Data from both the centers and Vibrant, the 988 Network Administrator, are utilized to identify trends in 988 contact reasons and contact quality to identify both virtual and in-person training opportunities. In addition to the training work, a separate workgroup, the 988 Workforce Advisory Group, is meeting to discuss the development of a dedicated 988 workforce. This group, consisting of state and center representatives, is reviewing the proposed job architecture and workforce model to develop a statewide 988 system of recruitment, training, and retention. The work of the group will also develop a career pathway into crisis services through consistent job descriptions and training opportunities. As the 988 call, chat, and text volumes continue increasing, the efforts to develop a dedicated 988 workforce will continue indefinitely. Workforce information gathered from annual staff satisfaction surveys will be used to identify overall job

satisfaction, centers successfully engaging the workforce, and centers needing additional support. The information collected is shared with each center to identify best practices, opportunities for improvement, and support needed from the DBHDID 988 team. Through a partnership with the University of Louisville, the workforce research project will produce a report of findings from the different focus groups. Information obtained from the UofL research project will be analyzed for identifiable trends. The data will be shared with the centers identifying common characteristics of the workforce and recommended workforce best practices to assist in recruitment and retention. DBHDID will continue to support the centers in staffing levels, training opportunities, and staff wellness to sustain a well-trained, experienced workforce. The 988 Workforce Coordinator will continue to lead the workgroups to provide requested trainings and development of the dedicated 988 job architecture and workforce model.

- **Quality Assurance:** Data from the 988 Network Administrator is reviewed monthly for changes in volume, county-level usage, average talk times, and flowout calls going to a national backup center. Center-level data is also reviewed to identify trends in reasons for contacting 988, emergency services interventions, referrals, and follow-up contacts. The 988 Program Administrator continues to work with the 988 Quality Assurance Workgroup to identify opportunities for improvement based on continued performance, center-level data and 988 user feedback. The information obtained identifies trends in performance, protocols needed for statewide coordination, marketing efforts for targeted areas, and additional training needs. In addition to the 988-specific data, Kentucky continues to identify and review other data sources. Data on suicide trends is reviewed weekly and behavioral health responses by Emergency Medical Services (EMS) are being reviewed on an annual basis. Additional data sources are being reviewed to identify county-level behavioral health trends. The data is shared with the centers to highlight opportunities for additional marketing and partnership collaborations. In addition to the performance data available, Kentucky collects and reviews information from 988 users. This data is reviewed quarterly to identify trends, which is shared with the QA Workgroup and the Crisis Directors. All data received is used for system improvement at all Kentucky centers. The DBHDID crisis team will continue to collect and review available data to identify opportunities for improvement and partnership development. The data will be shared with the centers to assist in developing local and regional partnerships to address behavioral health needs. The information will also be used at the state level to increase awareness of 988 with other state agencies and identify opportunities for collaboration and partnership to improve access to the crisis continuum.

- **Marketing:** Kentucky's 988 Marketing Committee continues to identify marketing opportunities through available data, such as county-level 988 usage and self-harm trends, to increase 988 awareness and access to the crisis continuum. DBHDID will continue to use all available data to create marketing materials for populations identified at high risk for self-harm and geographic areas with low 988 usage. Quarterly newsletters will be created and distributed with a focus on the workforce, partnerships, and successes.

- **In-State Response:** Kentucky's 988 staff will continue to assist centers in achieving performance goals while providing the most local, least restrictive care to Kentuckians in crisis. The 988 Program Administrator and 988 Workforce Coordinator will provide support to the centers on staff recruitment, training, and retention to ensure capacity for the increase 988 call, chat, and text volumes. Kentucky will continue to evaluate the existing structure for effectiveness. Kentucky's centers have collectively achieved a 90% or better answer rate for calls through 14 regional centers and two backup centers. The answer rate for 988 chat/text messages will continue to improve with the addition of a 24/7 center to the Commonwealth to the current center operating on a limited schedule. The performance of all centers will be monitored to identify opportunities to increase capacity and assist more Kentuckians.

- **Community Collaboration:** Kentucky is focused on developing partnerships with community partners to ensure access to 988 for individuals identified at high risk for self-harm. The 988-911 Coordinator and the 988 Program Administrator will continue working with center on strategies to engage local community partners. The DBHDID 988 team will continue to meet with state-level agencies to increase 988 awareness and encourage local collaboration. The 988 Workforce Coordinator will continue providing training opportunities for the workforce and community partners. The training plan will increase awareness of the crisis continuum, address the needs of high-risk populations, and assist community partners in locating and accessing more advanced care. The work will continue on the mental health locator (findhelpnowky.org) to add available mental health providers and resources, informational sheets, and local community resources. Connections between the website administrator and community partners will be made to provide training on website usage for emergency services, community based partners, and any interested agency.

CCBHC Alignment and Expansion: There is coordinated work being done to increase the number of CCBHCs in Kentucky and to enhance services to align with CCBHC requirements. Four CMHCs are operating as CCBHCs as part of Kentucky's demonstration, with six CMHCs and two BHSOs planning to onboard as CCBHCs in January 2026. DBHDID staff meet with CMHCs/CCBHCs monthly to discuss CCBHC implementation. Expansion of mobile crisis services is an important aspect of those discussions. CMHCs report the following initiatives to enhance mobile crisis services for state fiscal year 2026:

- More closely align the mobile crisis team with our call center so we have stronger parameters and triggers for direct dispatch of mobile crisis response from our call center.
- Implement a new safety and tracking system for our mobile crisis team to ensure they are safe and feel secure in their safety.
- Recruit and retain qualified clinical and peer staff for mobile crisis teams.
- Deepen partnerships with law enforcement, schools, emergency departments, and other community stakeholders.
- Build visibility in the community to improve engagement and enhance crisis outcomes.
- Increase mobile crisis runs to outlying counties.
- Improve hiring practices, enhance onboarding and training processes, and promote staff wellbeing.
- Add a team to in one smaller clinic to reduce response time in that area.

CMHC Crisis Directors share implementation strategies in monthly meetings. These discussions provide support to program staff, build collaboration across regions, and enhances service provision.

7. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified 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 [Working Definition of Recovery](#).

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the [Recovery Support Services Table](#).

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

☒ Yes ☐ No

- b)** Required peer accreditation or certification? ☒ Yes ☐ No
- c)** Use Block Grant funds for recovery support services? ☒ Yes ☐ No
- d)** Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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.

Adults with SMI

Kentucky's Division of Mental Health (DMH), through contracts with 14 CMHC regions and various community partners, offers a comprehensive array of recovery support services for individuals with SMI. These include Adult, Youth, and Family Peer Support, Individual Placement and Support (IPS) Supported Employment, Supportive Housing aligned with the Permanent Supportive Housing Toolkit through SAMHSA, self-help facilitation, residential housing supports for individuals requiring enhanced supervision, Comprehensive Community Support services, warm lines, services through Consumer Operated Service Programs (COSPs) as defined in SAMHSA toolkit, Wellness Recovery Action Planning (WRAP) and other wellness activities.

DMH actively promotes the involvement of individuals with lived experience across the service spectrum. Individuals with lived experience exclusively deliver peer support and COSP services, and peer support specialists are integrated throughout the continuum whenever possible.

Peer Support Services are included as an evidence-based practice in the Direct Intervention: Vital Early Response Treatment System (DIVERTS) array of services for individuals with SMI and are provided by each CMHC. Peer Support Services are monitored in quarterly reporting. The DBHDID peer support program administrator holds quarterly meetings with peer support supervisors, providing a forum for Q&A with not only DBHDID staff but also other peer support supervisors around the state. These meetings also have educational and technical assistance presentations from guest speakers. Additionally, via a contract with a recovery-oriented provider, DBHDID maintains a Center for Peer Excellence that coordinates statewide networking, training, and newsletter opportunities for peer specialists. The Center for Peer Excellence is staffed by peer specialists who are leaders in our state.

Peers continue to serve as integral, empowered members on all Assertive Community Treatment (ACT) teams, bringing authenticity and lived expertise that enrich service delivery. Each team benefits from the unique perspective and autonomy of peer specialists, who help ground services in recovery-oriented, person-centered care. A peer with lived experience in mental health recovery contributes to the ACT Implementation Team, while the FACT (Forensic Assertive Community Treatment) Implementation Team includes a peer with lived experience in mental health, substance use, and criminal justice involvement. Their insights play a vital role in shaping practices that are both compassionate and effective for the populations served while showing that recovery is possible.

Kentucky's four state operated, or state contracted psychiatric hospitals also support recovery through "recovery malls"-therapeutic environments designed to help adults with SMI engage in meaningful recovery activities before discharge. One of these hospitals has a partnership with a local COSP to provide peer support specialists who assist with recovery mall programming, offer individual and group support to hospitalized individuals, and engage with families during visitation.

Statewide self-help offerings include Double Trouble in Recovery (DTR), National Alliance on Mental Illness (NAMI) Connection support groups led by individuals with lived experience in mental illness; NAMI family support groups led by family members with lived experience; and other recovery support groups for individuals with mental illness, facilitated by peer support specialists and others with lived experience.

To further support peer integration, CMHC contracts require the employment of at least 2.0 Full Time Equivalent (FTE) peer support specialists to serve adults with SMI who are at risk of institutionalization. Additionally, each ACT team must include at least 1.0 FTE peer support specialist.

To strengthen transitions from institutional care and reduce readmission risk, DBHDID launched a discovery phase in partnership with the Alliance for Rights and Recovery (ARR) to explore the implementation of the Peer Bridger Model. Through this initiative, an analysis of strengths, weaknesses, opportunities, and threats (SWOT) for Kentucky's four state psychiatric hospitals and their affiliated Community Mental Health Centers (CMHCs) is informing the design of a recovery-oriented framework that connects individuals with peer support before discharge, builds trust, and reinforces engagement with community-based services.

Children/youth with SED, SUD, and co-occurring SED/SUD

While many of the recovery services and supports are available to children/youth, they are not necessarily specific to this age group and may not be developmentally appropriate for children/youth with SED, SUD, or co-occurring SED/SUD. To better meet the developmental and treatment needs of children/youth, recovery services and supports for this age group are provided primarily through children's services divisions of the Community Mental Health Centers (CMHCs) rather than through substance use treatment services divisions, where services and supports are more appropriate for adults. Child, youth, and family programs within the CMHCs operate in accordance with the system of care framework that takes a collaborative, strength-based approach

to supporting the whole child/youth and family throughout a continuum of promotion, prevention, early intervention, treatment, and recovery. To that end, each of the 14 regional CMHCs has funding to support a full time Youth Treatment Coordinator (YTC). The YTCs are dedicated to raising awareness of the prevalence and possible indicators of youth substance use and co-occurring mental health concerns; educating the community and child-serving agencies about youth co-occurring mental health and substance use issues; and how to screen and make referrals for further assessment. Additionally, they are charged with educating CMHC clinicians on the unique treatment needs these youth have, connecting them to training opportunities in evidence-based/informed prevention, assessment, treatment, and recovery practices for this population, and supporting collaboration across and within CMHC divisions (i.e., substance use treatment, substance use prevention, children's behavioral health).

Based on annual reporting information, CMHCs offer the following services and supports to children/youth with SED, SUD, SED/SUD. Screening; assessment; outpatient treatment (individual, family and group sessions); intensive outpatient; school based services; group sessions for court involved individuals; aftercare support; medication management; peer support (youth and family); targeted case management (for SED and SUD); community support; transition-age youth drop-in centers; interventions for first episode of psychosis; and two counties offer flexible beds for residential services.

For youth, ages 16-25, Transition Age Youth Launching Realized Dreams (TAYLRD) provides a network of community-based drop-in centers for youth who have, or are at-risk of developing, mental health and addiction challenges. DBHDID also contracts with Young People in Recovery (YPR), a national advocacy group that supports young people in or seeking recovery by empowering them to obtain stable employment, secure suitable housing, and explore continuing education. YPR has established and maintains eight YPR chapters and five 'My Recovery Is Epic' programs. In partnership with Recovery Community Centers (RCCs), mutual aid groups have been established across the state. This includes, SMART (Self-Management and Recovery Training), SMART Family and Friends, and Double Trouble in Recovery (DTR).

Evidence-based/informed practices specific to youth with SUD are available through CMHCs and include Adolescent Community Reinforcement Approach; Functional Family Therapy; Motivational Interviewing; Nurturing Parent Programs; Seven Challenges; Seeking Safety; Matrix Model; SMART Recovery; Young People in Recovery (YPR); YPR My Recovery is EPIC.

Additionally, they can connect individuals with services and supports from other agencies within their communities if those services are not available through the CMHC (i.e., residential, intensive outpatient, partial hospitalization; mutual aid/self-help groups, medications for opioid use disorder).

DBHDID and the CMHCs partner with other community-based agencies for the provision of additional services and supports for youth with SED, SUD, SED/SUD. These include but are not limited to Kentucky's SAMHSA Statewide Family Network grantee (Kentucky Partnership for Families and Children); the National Alliance on Mental Illness; Department for Community Based Services (Kentucky's child welfare agency); Department of Juvenile Justice; Kentucky Department of Education; Administrative Office of the Courts, and Young People in Recovery.

Finally, Kentucky's State Interagency Council (SIAC) for Services and Supports to Children and Transition-Age Youth serves as the statutorily created governing body for Kentucky's system of care (SOC). The SIAC is comprised of:

- Commissioner-level representatives from 12 state agencies (across five Cabinets) that serve children, transition-age youth, and their families;
- Nonprofit Family Organization;
- Youth Representative;
- Parent Representative; and
- Subcommittee for Equity & Justice for All Youth (SEJAY).

In its role as SOC governing body, the SIAC provides opportunities for cross-agency collaboration to improve availability of and access to a continuum of evidence-based/informed practices for children/youth with SED, SUD, SED/SUD and creating policies that align with the SOC core values and guiding principles.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Kentucky's Division of Substance Use Disorder (DSUD), in collaboration with community partners, offers the following recovery support services to persons with substance use disorders: peer support services, self-help facilitation, supported employment, and recovery housing. Kentucky strives for low barrier access to quality recovery support services to support all Kentuckians seeking in or recovery.

Peers play a critical role in supporting these recovery services. Utilizing DSUD-approved curriculum, peer support specialists receive training, supervision, and continuing education. Understanding the unique challenges related to treatment and recovery for those with substance use, additional SUD peer support training has been offered through the Kentucky Overdose Response Effort (KORE). This training equipped certified peer support specialists with education and skills specific to topics such as multiple pathways to recovery, motivational interviewing (MI), and recovery planning.

Self-help facilitation and self-help groups are also offered throughout the state. These include Alcoholics Anonymous, Narcotics Anonymous, AI-Anon, Double Trouble in Recovery (DTR), SMART Recovery and Celebrate Recovery.

Recovery housing is an essential recovery support. DSUD partners with the Oxford House evidence-based model for recovery homes and contracts directly with the organization to provide outreach in Kentucky to expand recovery housing. DSUD has created a supportive infrastructure to provide technical assistance to the Kentucky Oxford House outreach staff including support with strategic planning to identify housing needs and increase access to recovery housing across the state. Kentucky Oxford House has opened houses throughout the state for men, women, men with children, and women with children. There are currently 132 houses across the state.

In 2023, legislation was enacted in Kentucky requiring recovery residences to be certified to meet the best practice standards of the National Alliance for Recovery Residences (NARR). To meet NARR certification there are four domains, ten principles, and 31 quality standards that must be met. In response, the Kentucky Recovery Housing Network (KRHN) was established to create a statewide certification process. The goal was to improve both the quality and availability of recovery housing across Kentucky. In 2024, KRHN partnered with the Virginia Alliance for Recovery Residences (VARR) to establish a new affiliate in Kentucky responsible for conducting NARR certifications for recovery residences. Through the partnership with VARR, the Kentucky Alliance for Recovery Residences (KYARR) was formed as the new affiliate. KYARR is now responsible for the NARR certification of recovery residences in Kentucky. DSUD continues to provide technical assistance to support KYARR with the certification of recovery residences. As of June 2025, Kentucky has a total of 331 certified recovery housing programs with over 4,613 beds. This includes 103 certified programs serving pregnant women and 21 serving persons with dependent children.

During SFY 2024, DBHDID continued to support the expansion of services for individuals who are pregnant and parenting with additional funding from Kentucky's Office of Drug Control Policy (ODCP). This funding supported 13 awards to providers within the Community Mental Health Centers (CMHCs) to establish and expand recovery support services. Providers focused on recovery housing that met the needs of parents with children, including easier access to telehealth services and recovery support services. To facilitate referrals for recovery housing DSUD collaborated with the Kentucky Injury Prevention Research Center (KIPRC) at the University of Kentucky to develop FindRecoveryHousingNowKY.org, a public facing recovery housing directory that helps potential residents and community partners locate Oxford Houses and NARR certified recovery housing.

Kentucky utilizes partnerships with recovery organizations such as People Advocating for Recovery (PAR) to strengthen recovery work. Through this partnership training and assistance is provided to individuals and organizations with recovery efforts. PAR provides these services to individuals in all stages of recovery, as well as their families, friends, staff, and associated programs. They also work with public, quasi-public, and private organizations, and other community partners within Kentucky.

Through the provision of the State Opioid Response (SOR) and the State Targeted Response (STR) grants, the Kentucky Overdose Response Effort (KORE) has supported the implementation of multiple recovery support programs aimed to help clients build recovery capital and maintain long-term recovery. Programs such as the Access to Recovery Program links individuals to treatment and recovery support and provides a support for services that increase recovery capital and for which there is no payor source. Recovery support services can include basic needs, transportation, childcare, employment support, and recovery housing support. In addition, 15 recovery community centers (RCCs) have been established to provide centralized resources for community-based recovery supports. Each has developed various support groups previously unavailable in their communities, including medication-friendly mutual aid, peer support, recovery capital and career coaching, and childcare for parents attending support groups. One RCC has established two mobile recovery outreach units. These mobile units provide engagement to recovery services, recovery coaching, mutual aid meetings, overdose response training and naloxone distribution, and assertive linkage to Medications for Opioid Use Disorder (MOUD).

In efforts to ensure the availability of peer support services among vulnerable populations, KORE has supported the following initiatives:

- From October 2023 through September 2024, peer support services were provided through syringe service programs (SSPs) at local health departments to 7,382 individuals to build recovery focused relationships.
- Kentucky Hospital Association (KHA) contracted with nine hospitals to incorporate peer support specialists into care plans for individuals with opioid use and stimulant use disorders at emergency department bridge clinics. Peer support specialists placed in emergency departments provide rapid access to support services and linkages to ongoing treatment post discharge.
- In collaboration with state partners overseeing deaf and hard of hearing services, 11 deaf sober gatherings, virtual, prosocial events were held between SFY 2024 and SFY 2025. The program also provided a one-day learning retreat for four deaf individuals to the Red River Gorge, located in the Daniel Boone National Forest. Additionally, a pilot project was implemented placing a deaf peer support specialist during established office hours at one of the RCCs. The RCC also created a deaf-specific recovery circle group with the deaf peer support specialist as the facilitator and are now working to expand into two other RCCs.
- KORE supported the establishment and expansion of seven quick response teams in SFY 2025. These multi-disciplinary teams respond to individuals and families following an overdose event. While their primary purpose is to conduct outreach and promote engagement in treatment services, they also provide access to harm reduction and other recovery support services, such as peer support and case management.

5. Does the state have any activities that it would like to highlight?

DBHDID has partnered with the Alliance for Rights and Recovery (ARR) to implement the Peer Bridger model in Kentucky. This specialized peer support role focuses on transitioning individuals with behavioral health issues from state psychiatric hospitals and personal care homes back into the community. Peer Bridgers will join InReach teams and support clients from admission

through discharge and post-transition, helping with initial appointments, skill development, and community reintegration.

Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has received a five-year, \$5 million Treatment for Individuals Experiencing Homelessness (TIEH) grant from SAMHSA to implement a street outreach initiative targeting unsheltered homelessness in the Louisville Metro area. The initiative, TEAM SOAR (Team-Engaged Assertive Mechanics for SSI/SSDI Outreach, Access, and Recovery), is a collaboration between DBHDID and Seven Counties Services, Louisville's Community Mental Health Center. TEAM SOAR focuses on individuals experiencing homelessness who are also living with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), or Co-occurring Disorders (COD), including veterans and transition-age youth. TEAM SOAR deploys multidisciplinary teams trained in the SOAR model—comprising a therapist, case manager, and peer support specialist—to conduct outreach, screening, and referrals directly in encampments and on the street. A second team provides dedicated support to transition-age youth. The program enhances access to eligible SSI/SSDI benefits, behavioral health services, and recovery supports, helping individuals navigate complex systems and engage in long-term care. By building on existing outreach efforts and using evidence-based practices, TEAM SOAR aims to improve service access, accelerate benefit acquisition, and expand engagement among those most vulnerable to chronic homelessness. Lessons learned from the Louisville implementation will inform the development of a replicable model, with plans to expand this approach to other regions across Kentucky in the coming years.

Kentucky has significantly expanded its individual placement and support (IPS) supported employment program, now serving 78 of the state's 120 counties. This initiative is delivered through 14 CMHCs and seven additional community providers. The program has also broadened its scope to include individuals with intellectual and developmental disabilities, as well as those experiencing substance use disorders, ensuring more comprehensive support for diverse populations.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.^[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.^[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.^[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.^[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.^[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

^[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

^[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

^[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

^[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

^[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMH10608SUM>

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

- a) The recovery of children and youth with SED? ☒ Yes ☐ No
- b) The resilience of children and youth with SED? ☒ Yes ☐ No
- c) The recovery of children and youth with SUD? ☒ Yes ☐ No
- d) The resilience of children and youth with SUD? ☒ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

- a) Child welfare? ☒ Yes ☐ No
- b) Health care? ☒ Yes ☐ No
- c) Juvenile justice? ☒ Yes ☐ No
- d) Education? ☒ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:

- a) Service utilization? ☒ Yes ☐ No
- b) Costs? ☒ Yes ☐ No
- c) Outcomes for children and youth services? ☒ Yes ☐ No

4. Does the state provide training in evidence-based:

- a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
- b) Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:

- a) to the adult M/SUD system? ☒ Yes ☐ No
- b) for youth in foster care? ☒ Yes ☐ No
- c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ☒ Yes ☐ No
- d) Is the state providing trauma informed care? ☒ Yes ☐ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Kentucky established the State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) in the

early 1990s, and it remains the governing, and guiding, body for the state's system of care efforts. Member agencies include the Kentucky Departments for Behavioral Health, Developmental & Intellectual Disabilities, Education, Community Based Services, Administrative Office of the Courts, parents and youth with lived experience plus backups, as well as others that impact the day to day lives of young people and their families. Through this intentional partnership, member agencies are able to keep each other updated on relevant activities and partnerships.

Additionally, Kentucky has established 18 Regional Interagency Councils (RIAC) to serve as the locus of accountability for the system of care, providing a structure for coordination, planning, and collaboration of services and supports to children and transition-age youth with or at risk of developing behavioral health needs and other challenges, and their families.

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

To address the unique needs of young people with co-occurring mental health and substance use disorders (M/SUD), DBHDID supports three complementary staff roles across each of the state's 14 Community Mental Health Centers (CMHCs). The Youth Treatment Coordinator (YTC) focuses on outreach, education, and community engagement related to youth substance use, targeting individuals ages 10 to 25 who are using substances or are in recovery. YTCs also work to strengthen their agency's capacity to address co-occurring disorders by offering or coordinating relevant staff training.

The Transition Age Youth (TAY) Coordinator supports youth ages 14 to 25 by collaborating with drop-in centers, participating in outreach efforts, and working alongside adult-serving clinicians to promote developmentally appropriate care for young adults with behavioral health needs.

The Youth Empowerment Liaison (YEL) is embedded within each CMHC's Regional Prevention Center (RPC) and plays a key role in youth-focused substance use prevention initiatives. YELs ensure that substance use prevention initiatives are implemented within each region and reports on youth-led and youth-serving activities.

By establishing clear expectations for these three roles to coordinate efforts, Kentucky strengthens its ability to engage transition-age youth—a group historically difficult to reach—and to support the full continuum of care from prevention to recovery. Together, these roles enhance access to developmentally appropriate, integrated services that address both mental health and substance use needs among young people.

The YTCs, TAYs, and YELs also attend their RIACs to serve in leadership roles, as well as contribute their knowledge to the membership, and help address the needs of the community.

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted?



Yes



No

2. Describe activities intended to reduce incidents of suicide in your state.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) serves as the lead agency for suicide prevention efforts across the state. DBHDID coordinates strategic planning, funds implementation activities, and ensures alignment across key partners, including the 14 Regional Prevention Centers (RPCs), Community Mental Health Centers (CMHCs), and the 988 crisis response network. Through these partnerships, DBHDID integrates statewide initiatives such as universal prevention activities, the Zero Suicide framework, postvention strategies, and crisis system enhancements to reduce suicide risk and improve outcomes for Kentuckians.

Kentucky leverages State General Funds, federal discretionary funds, and prevention funds from the Substance Use Prevention, Treatment, and Recovery Block Grant to implement universal suicide prevention strategies that enhance services for individuals with SMI and SED who are supported by the Mental Health Block Grant. In addition, MHBG funds are used to support the training of behavioral health staff, implementation of the Zero Suicide framework in CMHCs/Regional Prevention Centers, and expansion of crisis response infrastructure through the 988 system, to ensure services for Kentucky most vulnerable populations are accessible.

Individuals with SMI face significantly higher risk of suicide attempts and deaths compared to the general population. National data shows that approximately 5% of adults who experienced a major depressive episode in the past year reported attempting suicide, in contrast to just 0.3% of adults without such an episode. The risk of suicide death is also starkly elevated: individuals with mood disorders, such as depression or bipolar disorder, are estimated to die by suicide at a rate 25 times higher than the general population. Those with schizophrenia face a suicide mortality rate about 20 times greater. Although individuals with SMI represent only about 4% of the U.S. population, they accounted for 8.7% of all suicide deaths between 2003 and 2017. Kentucky supports suicide prevention, interventions, and postvention for those experiencing SMI through its CMHCs, inpatient settings, and mobile crisis teams, integrating Zero Suicide and Postvention protocols and using screening data to identify high-risk individuals for care planning and follow-up (American Psychiatric Association & SAMHSA, 2020).

Suicide prevention activities in Kentucky are aligned with the state's broader behavioral health system and the department's strategic plan. The Zero Suicide framework is embedded in CMHC service delivery and complements work occurring through mobile crisis, psychiatric hospitalization, and outpatient services. Individuals with serious mental illness (SMI) or serious emotional disturbance (SED) are prioritized for screening, safety planning, and coordinated follow-up.

Kentucky's primary, universal suicide prevention efforts are supported by 14 Regional Prevention Centers (RPCs), which assist communities in designing and executing evidence-based programs to reduce suicide risk factors and enhance protective factors. These centers also conduct county-level needs assessments to ensure that suicide prevention strategies address the specific needs of each area. Additionally, a dedicated state suicide prevention team focuses on mental health promotion, suicide prevention, intervention, and postvention throughout Kentucky. The state's capacity for training is further enhanced by specialized trainers in evidence-based programs such as Question, Persuade, Refer (QPR), Mental Health First Aid, Assessing and Managing Suicide Risk (AMSR) and Applied Suicide Intervention Skills Training (ASIST), which increases the number of community members skilled in suicide prevention.

In addition to these initiatives, Kentucky benefits from the work of epidemiologists and evaluators who track and disseminate timely data to inform suicide prevention strategies. State and local, syndromic and violence death reporting data, results of child fatality reviews, provide critical insights into gaps in services and community needs, driving ongoing improvements (Kentucky Injury Prevention and Research Center [KIPRC], 2023).

The introduction of the 988 Suicide and Crisis Lifeline in 2022 marked a significant milestone in crisis response. This national

service provides immediate, life-saving support to individuals in distress, with a focus on mental health, substance use, and suicide crises (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Kentucky's planning grant for 988 services in 2021 laid the groundwork for enhancing system capacity, ensuring resources are accessible for individuals experiencing suicide or substance use crises (DBHDID, 2023).

Despite the growing network of resources, suicide rates in Kentucky continue to rise, underscoring the persistence of several challenges. One key issue is the stigma surrounding mental health and suicide, which prevents many individuals from seeking help. Cultural factors, including societal views on mental health, treatment preferences, and historical trauma, exacerbate these barriers, especially in rural areas like Kentucky (Brown & Lanza, 2022). Furthermore, limited access to mental health care remains a significant challenge. Rural areas face shortages of mental health professionals, long waiting times for appointments, and affordability issues, particularly for uninsured individuals (KIPRC, 2023).

Another constraint is that most regional prevention funding is allocated through substance use block grants, which prioritize substance use over suicide prevention efforts based on funding parameters. While these grants can support some suicide prevention activities through shared risk factors, the lack of dedicated suicide prevention funding limits the scope and effectiveness of these programs (SAMHSA, 2023).

Kentucky has applied for and received multiple suicide prevention specific federal discretionary grants, including a Garrett Lee Smith Suicide Prevention Grant, A National Strategic Suicide Program grant, a Zero Suicide Grant, and multiple 988 capacity building grants. Funds from these discretionary grants are braided with MHBG and State General Funds to enhance access to suicide prevention, intervention, treatment, and postvention efforts in the Commonwealth. Barriers to full implementation of suicide prevention efforts, however, include the limited time frame for these grants, as well as the related obstacles of starting up a new initiative, including hiring of key personnel.

There are several current opportunities to enhance suicide prevention efforts in Kentucky. Continued expansion of evidence-based training programs for community members is critical to reducing stigma and increasing understanding of mental health issues. By building capacity among individuals who are trained to recognize warning signs and refer people to care, Kentucky fosters a more supportive environment for those at risk of suicide (SAMHSA, 2023). Moreover, engaging youth in mental health education can normalize help-seeking behaviors, makes it easier for individuals to reach out when needed.

Additionally, strengthening community engagement by collaborating with various stakeholders, including policymakers, educators, healthcare providers, and families is a key component of Kentucky's effort. This collaborative, community-based approach can amplify suicide prevention efforts and enhance the resources available to at-risk individuals (SAMHSA, 2023).

The primary threats to suicide prevention efforts in Kentucky are the ongoing stigma surrounding mental health and suicide and the availability of sustained funds. Without sustained or increased funding, Kentucky's ability to address the growing mental health and suicide crisis could be compromised. Additionally, budget reductions or lack of investment in crisis services and treatment options would threaten the progress made thus far.

The Strategic Prevention Framework (SPF) serves as a guiding framework for coalitions, prevention specialists, and community partners working to promote mental health awareness and prevent suicide. The SPF emphasizes a collaborative, evidence-based approach that prioritizes cultural responsiveness and sustainability in all its phases (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). By using this model, communities create a comprehensive, long-term approach to suicide prevention, ensuring that the efforts not only address the immediate crisis but also work upstream to foster mental well-being and resilience in the community.

To address these complex and persistent challenges, the Kentucky suicide prevention team at DBHDID is actively implementing a multi-tiered, statewide effort to reduce suicides that is grounded in the Strategic Prevention Framework. Guided by data and community input, the team works to advance suicide prevention, intervention, and postvention efforts that are both culturally responsive and sustainable. By leveraging braided funding streams Kentucky is building a stronger, more coordinated system of care for those most at risk, particularly individuals with serious mental illness (SMI) or serious emotional disturbance (SED). In the following section, we outline how the Kentucky Suicide Prevention Team is translating these priorities into action through cross-sector partnerships, capacity-building initiatives, and localized support systems that aim to reduce suicide rates and promote mental wellness across the Commonwealth.

1. Build Capacity - Given the increasing rates of suicide, Kentucky will expand the number of trained individuals in suicide prevention, intervention, and postvention. Programs such as Question, Persuade, Refer (QPR), Mental Health First Aid, Lifelines Curriculum, Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR), and Connect Postvention provide valuable tools to community members, ensuring they are equipped with the knowledge and skills to assist those in crisis. By building the capacity of individuals, families, professionals, and communities through these training programs, Kentucky can create a larger network of confident and competent responders, ready to identify warning signs and intervene appropriately. Continued federal funding will enable the expansion and sustainability of these critical training efforts, helping Kentucky meet the growing demand for prevention and early intervention resources.

In addition, enhancing crisis response systems is essential. Kentucky has already made strides by expanding 988 call centers to

provide immediate support for individuals in mental health crises. To further build capacity, youth programs such as Sources of Strength and Code RED can equip young people with the skills to assist their peers and connect them to trusted adults when they face mental health challenges (Batsche et al., 2022). Furthermore, it is vital to enhance the knowledge and preparedness of emergency department (ED) and primary care physicians, as these settings are often critical points of intervention. Ensuring that healthcare providers have the necessary training to address mental health crises will help ensure that individuals, particularly older adults who are at higher risk for suicide, receive appropriate care during their visits to the ED (Pescosolido et al., 2017).

2. Community Education - One of the most significant barriers to effective suicide prevention is the prevalence of myths and misconceptions surrounding mental health and suicide. DBHDID will continue to support prevention specialists and other community partners to educate the public on how to talk about mental health, recognize warning signs, and normalize the conversation around mental health care, just as we normalize physical health care. Educating the community on how to offer mental health support and reduce the stigma surrounding mental health challenges will encourage individuals to seek help earlier and reduce the likelihood of suicide.

3. Environmental Strategies - Environmental strategies play a pivotal role in reducing the risk of suicide. DBHDID will continue to support suicide prevention programs in schools, which are effective tools for raising awareness and changing attitudes toward mental health and suicide (Wyman et al., 2022). In addition to school-based programs, DBHDID and Regional Prevention Center staff will provide technical assistance to community partners on implementing community-wide campaigns to promote safe storage practices and limiting access to lethal means—such as firearms and medications—to reduce the risk of impulsive suicide attempts (Berman et al., 2017). Research has shown that reducing access to lethal means can significantly lower the suicide rate, especially in situations where individuals are in crisis and acting impulsively. Therefore, public education campaigns focused on safe storage of firearms and medications during times of heightened mental distress can reduce immediate risks and save lives.

4. Policy Creation and Revision - Legislative measures can provide crucial support for suicide prevention efforts. For example, Kentucky has a suicide prevention law that mandates schools to provide suicide prevention training for all students in grades 6-12 and for all school staff by September 15th of each year. This law ensures that mental health awareness and suicide prevention strategies are consistently taught and reinforced in schools, where students are particularly vulnerable to mental health challenges. DBHDID will support communities and prevention specialists in advocating for the continuous improvement of policies such as these to ensure that suicide prevention strategies are not only implemented but also adapted to address merging needs (SAMHSA, 2022). Additionally, DBHDID will support stakeholders in collaborating to draft policies that improve guidance on the safe implementation of suicide prevention programs within schools and communities.

5. Education/Advocacy - DBHDID will provide training and technical assistance to prevention specialists to advocate for and implement suicide prevention efforts at local, state, and federal levels. Sustained progress in suicide prevention requires a coordinated approach that includes not only direct intervention but also robust education and advocacy efforts. Kentucky aims to strengthen its prevention infrastructure by equipping prevention specialists and community partners with the tools and support necessary to advocate effectively at the local, state, and federal levels. Educating policymakers about the urgency and impact of suicide prevention, as well as the need for supportive legislation and long-term investment, is critical to ensuring continued momentum and sustainable funding. These advocacy efforts must be ongoing—both during and between legislative sessions—to maintain suicide prevention as a public health priority. Developing strong, proactive relationships with decision-makers allows prevention experts to contribute their knowledge and experience to policy development, increasing the likelihood of data-driven and effective legislation. With federal support, Kentucky can expand its capacity to train prevention advocates, engage policymakers through targeted outreach and education, and ensure that suicide prevention expertise is embedded in legislative decision-making processes.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ☒ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ☒ Yes ☐ No

If yes, please describe how barriers are eliminated.

As part of their Zero Suicide implementation, the University of Kentucky/Saint Claire Healthcare (UK/SCH) and Pathways Inc. have committed to delivering caring contact messages for all individuals treated following a suicide attempt. These supportive outreach messages will continue monthly for a minimum of 12 months post-discharge for each identified client.

DBHDID and St. Claire Healthcare (SCH) have taken several intentional steps to overcome common barriers in the implementation of the Zero Suicide framework. One major challenge identified early in the project was the difficulty of scheduling healthcare staff, many of whom must be booked at least 90 days in advance. To mitigate this issue, DBHDID and SCH committed to scheduling all major trainings and meetings at least three months in advance. This proactive planning ensured adequate staffing coverage and allowed key personnel to attend critical events such as the Zero Suicide Academy and evidence-based trainings like Counseling on Access to Lethal Means (CALM), Question, Persuade and Refer (QPR), and Assessing and Managing Suicide Risk (AMSR). Additionally, by hosting multiple sessions at different locations, including both the UK-SCH and University of Kentucky Healthcare (UKHC) main campuses, they were able to stagger attendance across training events to minimize service disruptions.

Another barrier involved onboarding new staff, maintaining training records, and building data systems to track implementation

progress. To address this, DBHDID and REACH Evaluation collaborated to develop user-friendly data entry forms and reporting systems, which supported grant partners in tracking their workforce development activities. DBHDID also provided individualized technical assistance and facilitated in-person planning sessions to keep all partners aligned on goals and expectations. These efforts were especially important as SCH prepared for a major electronic health record (EHR) transition to EPIC in 2026. By engaging stakeholders in early planning and leveraging technical assistance, DBHDID helped ensure continuity in suicide care tracking during the EHR changeover.

Finally, DBHDID and SCH prioritized collaboration across care systems to address fragmentation and promote person-centered suicide care. They formalized Memoranda of Understanding between UK-SCH and Pathways Inc. to coordinate warm handoffs, ensure timely follow-ups, and support joint care management planning. These partnerships were further strengthened through regular Zero Suicide Oversight Steering Council meetings, where partners reviewed policies, shared feedback, and co-developed strategies for refining care protocols. Recognizing inconsistencies in how safety plans were delivered, particularly in emergency departments and virtual settings, SCH also revised internal processes and explored secure methods, such as encrypted email and healthcare portals, to ensure that all patients, regardless of care setting, received equitable support.

Through these collaborative, data-driven, and forward-looking strategies, DBHDID and St. Claire Healthcare continue to build a strong foundation for sustainable Zero Suicide implementation.

SAMHSA Zero Suicide Cooperative Agreement

In 2023, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) was awarded a Cooperative Agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement the Zero Suicide in Health Systems initiative. This funding supports the Kentucky Initiative for Zero Suicide–Expansion (KIZS-X), which focuses on embedding the Zero Suicide framework into the St. Claire Healthcare system. The primary goal of KIZS-X is to enhance care for adults aged 18 and older who are at risk for suicide and co-occurring substance use, with an emphasis on person-centered, safe, and equitable access to behavioral health services.

The Zero Suicide framework is a nationally recognized, evidence-based model designed to improve suicide care within health and behavioral health systems. It is built around seven interrelated core elements: Lead, Train, Identify, Engage, Treat, Transition, and Improve. Each element emphasizes leadership commitment, comprehensive workforce training, systematic identification of individuals at risk, timely engagement and treatment, safe care transitions, and continuous quality improvement—all grounded in health equity principles.

As part of the KIZS-X grant activities, St. Claire Healthcare is establishing a Zero Suicide Oversight Council to guide policy development and implement evidence-based practices. Staff across the healthcare system will receive training in evidence-based approaches such as QPR (Question, Persuade, Refer), ASIST (Applied Suicide Intervention Skills Training), AMSR (Assessing and Managing Suicide Risk), CAMS (Collaborative Assessment and Management of Suicidality), and CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention).

The initiative brings together several key partners: Pathways Community Mental Health Center (CMHC), the Education Development Center (EDC), and Mental Health America-Kentucky. Together, these organizations are supporting the implementation of Zero Suicide to strengthen the regional suicide prevention infrastructure. The overarching aim is to reduce suicide deaths in Eastern Kentucky by building a responsive, coordinated system of care.

In addition to the work at St. Claire, all 14 of Kentucky's CMHCs continue to be required to conduct an annual Zero Suicide Organizational Self-Study. Based on assessment results, each CMHC develops a targeted work plan to guide capacity-building and staff training for the coming fiscal year. DBHDID provides ongoing technical assistance to support CMHCs in their implementation efforts. This process of continuous assessment, planning, and improvement is required of all clinical partners engaged in Kentucky's suicide prevention work and reinforces the sustainability of the Zero Suicide model across systems of care.

To accelerate Zero Suicide implementation, DBHDID hosted a Zero Suicide Academy in 2025, bringing together 14 teams representing CMHCs, the University of Kentucky Healthcare, and the UK/Saint Claire Healthcare (UK/SCH) system. This collaborative training supported organizations in integrating suicide risk screening protocols, community helper training, suicide-specific data collection, and safety procedures into their institutional policies and workflows. As part of their implementation, UK/SCH and Pathways Inc. have committed to delivering caring contact messages for all individuals treated following a suicide attempt. These supportive outreach messages will continue monthly for a minimum of 12 months post-discharge.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted?



Yes



No

If so, please describe the population of focus?

DBHDID works to create a multi-faceted lifespan approach to suicide prevention across the state and allocates sufficient resources to fully implement and evaluate a comprehensive approach to suicide prevention. The Suicide Prevention Team is working on using the six activities in the SPRC's Strategic Planning Approach to Suicide Prevention: 1) use data or other sources to describe your state's suicide problem and its context, 2) choose short and long-term goals based on available data to guide suicide prevention efforts, 3) identify key risk and protective factors for suicide in your state, 4) select or develop strategies and interventions that address identified risk and protective factors, 5) plan for evaluation of your strategies and interventions and 6)

evaluate and improve strategies/interventions over time. DBHDID supports all state, county, and local efforts in the planning, execution, and evaluation of their efforts, including allocation of needed resources. The data reviewed by DBHDID is received from Kentucky 988 Data Dashboard, Kentucky Behavioral Health Dashboard, Kentucky Safety and Prevention Alignment Network, Weekly Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) reports, Louisville Suicide Fatality Review and Child Fatality Reviews.

Suicide prevention efforts in Kentucky prioritize specific high-risk populations, as each group faces unique challenges and risk factors that require targeted interventions. Adolescents and young adults, for example, often grapple with academic pressure, bullying, and developmental struggles, while older adults may experience loneliness, health complications, and loss of purpose. Veterans and individuals with mental health challenges often face trauma, stigma, and difficulty accessing care. It is crucial to analyze data trends across various groups to determine the most effective prevention strategies. These strategies address specific data-driven needs, provide focused support, and foster a sense of belonging and understanding (Centers for Disease Control and Prevention [CDC], 2023), which provides a safer community for all Kentuckians.

Youth, Age 10-17: Suicide remains a leading public health concern, especially among youth, and significantly impacts potential years of life lost. In 2021, suicide was the second leading cause of death among teens, and substance use disorders, particularly alcohol, are strongly correlated with psychological distress, suicide attempts, and death (CDC, 2023). In Kentucky, the 2021 Kentucky Incentives for Prevention (KIP) Survey revealed alarming trends, showing an increase in psychological distress, substance use, and suicidal ideation among 10th graders. Specifically, 55.8% of 10th graders reported serious psychological distress, 55.2% considered suicide, and 42.5% attempted suicide within the past year.

In 2022, the suicide death rate for youth aged 10-14 was recorded at 2.36 per 100,000 individuals in the United States. However, Kentucky saw a concerning trend, with a suicide rate of 3.5 per 100,000, 48% higher than the national average. This trend emphasized the importance of tailoring suicide prevention efforts, particularly in regions where rates exceed national norms.

These troubling figures highlight the need for prevention strategies that address both mental health and substance use among young people (Kentucky Incentives for Prevention [KIP], 2021). Nationally, the Youth Risk Behavior Survey (2021) revealed that 22% of high school students seriously considered suicide in the past year, with 10% attempting suicide (Centers for Disease Control and Prevention [CDC], 2021). These data underscore the importance of comprehensive suicide prevention strategies targeting youth behavioral health.

Adolescents are at a critical stage of development, as they navigate psychosocial development, including self-esteem and relationships. These developmental milestones introduce stressors and pressures that can increase vulnerability to mental health challenges, including suicidal ideation (National Institute of Mental Health [NIMH], 2023). Kentucky's efforts focus on addressing specific stressors faced by adolescents, especially in Kentucky, a strategy that is essential for mitigating suicide rates. By focusing interventions on these unique needs, communities can better support high risk youth and reduce suicide risk.

As required by Kentucky law (KRS 158.039) every public school and public charter school shall provide two high quality, evidence-based suicide prevention awareness lessons each school year, the first by September 15 and the second by January 15, either in person, by live streaming, or via a video recording to all students in grades six through 12. Every public school shall provide an opportunity for any student absent on the day the high-quality, evidence-based suicide prevention awareness lesson was initially presented to receive the lesson at a later time. The information may be obtained from the Cabinet for Health and Family Services or from a commercially developed suicide prevention training program. Additionally, according to KRS 156.095 all certified school district employees and public charter school employees shall complete at least one hour of each of the following trainings within 12 months of initial hire and at least once every four years thereafter on high-quality, evidence-based suicide prevention training, including risk factors, warning signs, protective factors, response procedures, referral, postvention, and the recognition of signs and symptoms of possible mental illness.

In an attempt to address youth suicides and to assist school districts in meeting their DBHDID suicide prevention goals, efforts support all Kentucky youth based on their current developmental stage. Initiatives include DBHDID's Garrett Lee Smith Suicide Prevention Grant, Code RED, Sources of Strength, Lifelines Trilogy, Purple Star program, and other evidence-based and -informed efforts.

Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant: SAMHSA awarded DBHDID the 2022 Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant (GLS grant). Kentucky's Strategic Allies Fostering Empowerment of Today's Youth (KY SAFETY), the GLS grant supports the implementation of evidence-based prevention and early intervention strategies in four rural school districts. These efforts increase the number of schools and community partners capable of identifying and working with youth at risk of suicide, enhance the capacity of clinical service providers to assess, manage, and treat these at-risk youth, and improve the continuity of care and follow-up for youth identified as being at risk, including those recently discharged from emergency departments and inpatient psychiatric units. This initiative builds upon and strengthens the foundation laid by Kentucky's three previous GLS grants, various initiatives to increase the capacity of crisis line staff to respond to 988 calls, texts, and chats, and projects aimed at improving mobile crisis response services for those at greatest risk of dying by suicide, particularly youth.

Code RED is an evidence-informed safety planning tool that involves youth identifying trusted adults, delaying risky decision-

making, and identifying activities to relax and distract from thoughts of suicide. Part of the safety plan includes follow-up procedures embedded in the process to support family members receiving care during transitions from inpatient and outpatient facilities, and emergency departments. Code RED training is being delivered across Kentucky schools as part of a KY SAFETY Garrett Lee Smith Grant received by DBHDID. Code RED Training for Trainers Implementation: The Department for Public Health provided funding to include training key community stakeholders – prevention specialists, health department staff, Family Resource Youth Services Centers (FRYSCs), school nurses, faith-leaders, businesses, etc. – across Kentucky in being able to utilize Code RED with the adults and staff in their communities. By spreading Code RED across the state, more individuals can be prepared for their worst days, which can span a multitude of disasters impacting the community.

Each year, the Regional Prevention Centers (RPC) develop work plans that identify priority substances and mental health needs within their regions. For SFY 26-27, thirteen RPCs have identified suicide prevention as a priority region wide or in at least three counties based on local needs. Identified intervening variables include social and community norms, access and availability of means, low capacity for addressing needs, and perception of risk and harm. Identified contributing factors include bullying, stigma, ineffective school policies, stigma around help-seeking, high access to lethal means, need for increased capacity, low perception of risk of youth suicide, home access to lethal means, and peers who have died by suicide.

DBHDID provides support for the implementation of evidence-based curricula, including Lifelines, Sources of Strength, and Too Good for Drugs in Kentucky's schools. These curricula help meet the state mandate that requires all middle and high school students receive some type of suicide prevention information by Sept.15 and Jan.15 of each school year.

In addition to supporting implementation of the Sources of Strength, Lifelines, and Too Good for Drugs programs, DBHDID, through the RPCs, is providing one-on-one technical assistance to schools as they meet both state laws around suicide prevention education for district-wide certified school staff and suicide prevention information for middle and high school students.

The Lifelines Trilogy is a comprehensive, school-based youth suicide prevention program implemented in Kentucky since 2012, initially supported by a Garrett Lee Smith suicide prevention grant and later funded through the Kentucky Incentives for Zero Suicide and the Substance Use Prevention, Treatment, and Recovery Services Block Grant. Designed for students in grades five–12, the program aims to increase the ability of school communities to recognize and respond to suicidal behavior, and to ensure that at-risk youth are aware of and connected to immediate support resources.

The Trilogy includes three parts: Lifelines Prevention, which educates faculty, parents, and students on the facts about suicide and their roles in prevention; Lifelines Intervention, which prepares school personnel to recognize warning signs and intervene effectively; and Lifelines Postvention, which equips schools to respond to suicide or other traumatic deaths in a way that promotes healing and prevents further risk. Currently, the program is implemented in approximately 200 Kentucky schools, with many districts adopting it for all middle and high school students. The curriculum also fulfills Kentucky's legislative requirement that all secondary students receive evidence-based suicide prevention education by September 15 each school year.

Sources of Strength is a peer-led, strength-based mental health wellness program implemented in Kentucky to promote suicide prevention and substance misuse awareness among youth. Initially funded through Kentucky's third consecutive Garrett Lee Smith Youth Suicide Prevention Grant from SAMHSA in 2015, the program continued after the grant ended in 2019 through funding from the State Opioid Response (SOR) grant and the American Rescue Plan Act (ARPA), as part of the Kentucky Overdose Response Effort (KORE). The program targets middle school, high school, and college-age students, and has expanded to include the SOURCES Elementary curriculum for grades K–5. The middle and high school program uses creative messaging campaigns—through art, music, storytelling, drama, and social media—to build protective factors and promote healthy norms. The elementary curriculum emphasizes social-emotional learning and proactive mental health education through activity-based classroom lessons.

The Kentucky Purple Star Award Program was launched in Kentucky in 2021 to support military-connected youth—a population identified as being at higher risk for substance use, psychological distress, and suicidal thoughts and behaviors. These youth, who are children of active duty Service Members, National Guard, Reserves, and Veterans, report significantly higher rates of mental health challenges compared to their non-military-connected peers. In response, Kentucky's prevention network, in collaboration with state and local military partners, created the Purple Star Award to recognize schools committed to supporting these students. The program fosters a caring school environment, enhances student engagement, peer to peer support and increases adult involvement by providing military milieu training for school staff and offering tailored service to students and families. Since its inception, 138 Kentucky schools in 37 counties have received the award, and 146 school staff have completed military milieu training. The program also connects schools with evidence-informed resources and hosts recognition events, while outreach efforts—such as a Facebook page, newsletters, and State Advisory Board—extend its impact. In the 2024, the Kentucky Legislature formally recognized the value of the Kentucky Purple Star Program by passing House Bill 469, enabling legislation, which lays out the requirements to become a Purple Star School.

Kentucky's Governor's Challenge Team for Suicide Prevention among Service Members, Veterans, and their Families (SMVF) is a statewide initiative focused on reducing suicide risk within this high-risk population. Launched in 2019 as part of a national effort by the U.S. Department of Veterans Affairs and SAMHSA, the team works in partnership with local organizations and governments to build healthier, more supportive communities. Their mission emphasizes education, reducing stigma, and enhancing connection to care for SMVF. By addressing the unique needs of this group, the team seeks to inform and strengthen Kentucky's

broader suicide prevention strategies. Members of the team include representatives from the Governor's Office, state departments of Veterans Affairs and Behavioral Health, the Department of Defense, the VA VISN office, community mental health centers, local VA medical centers, readjustment counselors, first responders, and institutions of higher education.

Older Adults, Age 60+: Suicide rates among older adults, particularly those aged 65 and over, have increased significantly. In 2022, suicide deaths among individuals aged 65 and older rose by 8.1% compared to the previous year, with older adults accounting for 22% of all suicide deaths in the U.S. (National Institute of Mental Health [NIMH], 2023). Older adults often experience unique risk factors for suicide, including chronic illness, disability, loss of independence, and social isolation. Research shows that older adults tend to plan their suicides more meticulously and often use more lethal means (Gould et al., 2017). Among older adults, men aged 75 and older face the highest rates of suicide (CDC, 2023). Kentucky mirrors national trends, showing increasing suicide rates among older adults, with higher rates among men and individuals aged 85 and older. Additionally, some older adults may experience elevated suicide risk stemming from long-term stressors related to challenges accumulated over the lifespan (Budge et al., 2020).

Suicide Prevention for Older Adults in Kentucky: Kentucky is addressing rising suicide rates among older adults through two aligned, multi-year initiatives: the Crisis Diverters in Kentucky's Older Adults project (funded through the Department for Aging and Independent Living (DAIL) under the Innovations in Nutrition Grant (INNU)), and the Kentucky Strategic Suicide Prevention Project (KYSSPP), funded by the SAMHSA through the National Strategy for Suicide Prevention (NSSP) grant. These efforts aim to reduce suicide risk, strengthen crisis response, and build upstream prevention capacity across aging services systems, with a shared focus on adults aged 60 and older, particularly rural males, veterans, and farmers in Kentucky.

Project Components

Innovations in Nutrition Grant (INNU) Initiative: Aging Services Suicide Prevention Statewide

Led by DAIL in partnership with DBHDID, the INNU initiative equips aging service providers, especially home-delivered meal (HDM) drivers and senior center staff, with evidence-based suicide prevention training:

- **Question, Persuade, Refer (QPR):** A brief, 1–1.5 hour training for frontline staff and volunteers to recognize warning signs and refer individuals to help.
- **Applied Suicide Intervention Skills Training (ASIST):** A two-day intensive intervention training for Aging and Disability Resource Center (ADRC) and Area Agencies on Aging and Independent Living (AAAIL) staff to respond to individuals in acute crisis.
- **Referral Protocols:** Clear procedures guide staff on how to escalate concerns and coordinate with ASIST-trained responders.
- **Media Literacy & Education:** DAIL partnered with the National Foundation to End Senior Hunger (NFESH) to create brief videos for senior center staff, housed on the ageWELL Community Institute platform.

INNU Outcomes

- Year 1: 387 trained in QPR, 71 in ASIST; 18 crisis interventions completed; 4 educational videos launched.
- Year 2: 523 trained in QPR, 146 in ASIST; 49 interventions completed; 7 educational videos published; over 28,000 HDM and congregate meal participants now supported by trained staff.
- Year 3 Plans: Expand to Lethal Means Safety and SafeTALK training; host a post-training "What Now?" convening; develop a statewide directory of ASIST-trained responders; launch Train-the-Trainer (T4T) sessions; create three or more new training videos.

Kentucky Strategic Suicide Prevention Project (KYSSPP):

Creation of the Western Kentucky Senior Suicide Prevention Network (WKSSPN)

Focused on the identified high-risk region of the Pennyroyal Area Development District (ADD), the KYSSPP grant supports regional coordination and upstream suicide prevention strategies for older adults. The initiative is led by DBHDID in partnership with Pennyroyal Area Development District (ADD), Pennyroyal Regional Prevention Center (RPC), and REACH Evaluation.

Key Goals

- Build sustainable, cross-sector suicide prevention partnerships through regional coalition (WKSSPN)
- Understand risk factors for suicide among older adults to guide data-informed strategies using Retrospective Fatality Analysis on up to 30 suicide deaths of 60+ year old individuals who lived within the Pennyroyal region.
- Promote lethal means safety through education, campaigns, and resource mapping
- Provide evidence-based training for clinical and non-clinical providers

Community Engagement Highlight

In Spring 2025, the Western Kentucky Senior Suicide Prevention Network (WKSSPN) launched an intergenerational card campaign, engaging local youth-focused Beta Clubs to send handwritten messages and cards to older persons participating in meal programs and senior centers. This initiative helped combat social isolation within the older population and encouraged youth in positive, protective factors focused suicide prevention messaging.

To facilitate lethal means safety and education for this high-risk population group, DBHDID continues to support RPC's distribution of tangible lethal means safety resources throughout the region including at community outreach efforts, 80 magnets featuring the 988 Suicide & Crisis Lifeline were distributed to Pennyroyal Center staff and community partners. During Mental Health Awareness Month, a Facebook campaign was launched to highlight the 988 Lifeline and promote safe storage practices. To support these efforts, 25 prescription lock bags were delivered to the Muhlenberg County Health Department, with an additional 20 lock bags distributed throughout the community. Additionally, 20 drug deactivation pouches were shared at the

May 3 Muhlenberg County Health Fair to encourage safe and responsible medication disposal. DBHDID is continuing work with community organizations and businesses to work towards additional safe storage measures for firearm safety.

Strategic Alignment

KYSSPP and WKSSPN's work aligns with national suicide prevention strategies in:

- Community-based suicide prevention
- Treatment and Crisis Services
- Surveillance, Quality Improvement, and Research
- Responsive care in suicide prevention

Collaborative Partners

- State Health Insurance Assistance Program (SHIP) and Kentucky Aging Conference
- Kentucky Mental Health and Aging Coalition
- Cross-department collaborations within the Cabinet for Health and Family Services (CHFS)
- Nine western Kentucky county-located local public health departments, law enforcement, veterans' services, firearm dealers, and agricultural partners

People Who May Experience Barriers to Accessing Care: Suicide rates among high risk youth in the U.S. have increased significantly in recent years. Between 2007 and 2021, suicide rates among these youth aged 10-17 grew by 144% (from 1.54 to 3.77 per 100,000) (CDC, 2023). In Kentucky, suicide deaths among these youth aged 10-24 increased by 150% between 2018 and 2020. Possible factors contributing to this disparity include differences in symptom presentation, help-seeking behaviors, and unequal access to mental health services (Benson et al., 2021). These high risk youth often face stigma related to mental health treatment, which exacerbates the mental health crisis in this population. A survey of college students revealed a strong correlation between perceived stigma and a higher likelihood of suicide attempts (González et al., 2020). Additionally, medical mistrust and lack of access to appropriate mental health care further hinder effective prevention and treatment for these youth (Benson et al., 2023).

Kentucky High Risk Youth Suicide Prevention Initiative: DBHDID is actively implementing the Kentucky High Risk Youth Suicide Prevention Initiative—a multi-faceted effort focused on reducing suicide risk among high-risk youth ages 5–24 across the Commonwealth. The initiative prioritizes strategic collaboration, youth voice, and systemic change. DBHDID leads this initiative in partnership with a growing task force of agencies and organizations that support these youth, particularly those with serious emotional disturbance (SED) or serious mental illness (SMI).

Key Accomplishments to Date

1. Elevating Youth Voice Through Community-Engaged Research

Youth with lived experience play a central role in shaping this initiative. Youth-led focus groups gather qualitative insights that inform the design and delivery of suicide prevention activities. One standout example is the Photovoice Project, conducted in partnership with the River Valley TAYLRD center and Shawnee Transformation Youth Coalition (STYC). Fifteen youth participated in this project, capturing visual and narrative data about their environments. A third photovoice project is starting at the Kentucky River Transition Age Youth Launching Realized Dreams (TAYLRD) site.

- Risk factors identified include school-related stress, homelessness, pollution, and deteriorated neighborhoods.
- Protective factors centered around peer relationships, access to social support, and safe spaces like the TAYLRD center.

This approach not only surfaces the lived realities of specific youth but also promotes critical reflection on root causes and fosters community-driven solutions.

2. Training & Crisis System Enhancement

DBHDID is currently developing a Responsive Trainer Network. This network, working across many projects, is designed to strengthen the competencies of professionals across Kentucky's 988 and crisis response systems. The training will help behavioral health providers, and first responders engage more effectively with youth in distress, particularly those experiencing SED/SMI.

3. Data Infrastructure

Increased investment in both primary and secondary data collection allows Kentucky to better understand trends in suicide. These data are informing priority-setting, resource allocation, and the development of appropriate screening, assessment, and postvention protocols. Both a data and policy brief are in final stages of approval and will be released statewide to inform partners on scope of problem and suggested avenues for prevention.

4. Workforce Diversification Through Internship Partnerships

To create sustainable change, the initiative invests in workforce development by partnering with Kentucky State University (KSU). Together, DBHDID and KSU are co-developing a Behavioral Health Internship Program including the development of clear program guidelines outlining duration, eligibility, roles, supervision, compensation, and evaluation metrics. The university has created necessary documentation, such as intern agreements, descriptions, and evaluation forms, and implemented a recruitment plan using professional outreach materials. Once selected, interns will receive orientation and training to align with the program's expectations, and ongoing support will include supervision, check-ins, and mentorship. By the end of 2025, at least two interns will be onboarded, with at least one annually supporting DBHDID initiatives such as youth-led focus groups, policy brief

development, suicide prevention campaigns, and regular DBHDID meetings. The university will also engage in resource-sharing activities and attend regular progress meetings with DBHDID to review deliverables and address program needs.

Leveraging Youth-Voice to Drive Systems Change

This initiative takes an intentional approach to partnership and resourcing. DBHDID centers youth engagement by:

- Listening to and creating space for youth perspectives, while being mindful of positional power dynamics.
- Ensuring resources (including budget allocations) support youth participation meaningfully and equitably.
- Considering how geographic and developmental differences (e.g., rural vs. urban, middle school vs. young adult) shape youth experience and needs.

Strategic Alignment and Sustainability

DBHDID and its partners remain committed to aligning initiative goals with broader suicide prevention systems across the state. Implementation activities are designed for long-term sustainability, including outcome tracking and performance monitoring. By integrating youth-led research, training, intentional workforce development, and data-informed policy, the Kentucky High Risk Youth Suicide Prevention Initiative is building a more effective system to support the wellness of high risk youth across the lifespan, thus reducing suicide risk.

Hard to Reach Populations: Some individuals encounter barriers to accessing care that are linked to social and service system disconnects. Youth in this population are significantly more likely to experience suicidal thoughts and attempts compared to their peers (Grant et al., 2011). In Kentucky, nearly half of the youth in this population seriously considered suicide in the past year, with even higher rates among those reporting ongoing stressors related to belonging or acceptance (National Task Force – Hard to Reach Populations, 2023). These findings highlight the urgent need for tailored mental health interventions that address the unique challenges faced by these individuals. Gaps in availability of services or provider readiness may contribute to unmet needs. (Budge et al., 2020).

Support for these populations will continue by leveraging the Garrett Lee Smith grant to help address gaps and reduce community-level root cause factors that increase suicidal risk. GLS funds will be used to continue supporting Camp Beacon, a summer camp experience for youth across Kentucky, both urban and rural. Camp experiences offer engagement, social connectedness and leadership opportunities. Code RED, a Suicide Prevention training and safety planning, is conducted with all camp participants and staff.

In 2024, the 988 Marketing Committee developed a comprehensive marketing plan to raise awareness and support for 988 centers across the Commonwealth. As part of this effort, a Boot Camp Translation (BCT) project brought together two community advisory groups to create focused messaging for populations with high rates of suicidal ideation, self-harm, and suicide. The resulting recommendations informed the first statewide marketing campaign, which ran from December 2024 through March 2025. In response to a rise in suicide deaths in a specific region, a second targeted campaign was also launched. All campaign materials are distributed to 988 centers and community partners for local use. Additional outreach over the past year included brochures, educational flyers on using 988 and 911, and age-appropriate coloring books. These resources are shared statewide to ensure broad access and consistent messaging across Kentucky.

Postvention- Suicide Clusters Responses

In response to two community cluster events, DBHDID has created a cluster response plan using the CDC's Suicide Postvention Community Response Plan as a comprehensive framework. The response plan is designed to provide technical assistance to guide communities in effectively responding to the aftermath of a suicide cluster. It highlights these key steps:

- Establish a coordinated crisis response team to lead planning and intervention efforts.
- Identify and monitor individuals at elevated risk, such as close contacts of the deceased.
- Provide immediate and ongoing support to affected individuals, families, schools, and communities.
- Use safe and responsible messaging in all public communications to prevent suicide contagion.
- Engage community partners (e.g., schools, behavioral health providers, clergy) to ensure a comprehensive response.
- Monitor for additional suicide attempts or deaths to detect potential contagion early.
- Plan for long-term follow-up and support, including mental health services and postvention resources.
- Evaluate the effectiveness of the response and adjust strategies as needed to reduce future risk.

DBHDID's Cluster Response Plan ensures the immediate activation of a coordinated response team composed of mental health professionals, community leaders, educators, faith-based representatives, and crisis intervention specialists. This team works collaboratively to ensure that communication with the public and media is handled sensitively and responsibly by avoiding sensationalism and adhering to best practice reporting guidelines. It is crucial that media outlets report responsibly and follow established guidelines to reduce the risk of contagion, especially amongst individuals with SMI/SED who are already more vulnerable. Transparent communication is essential: community leaders should acknowledge the loss sensitively, promote available mental health resources, and encourage people to seek help. This messaging should reach the entire community through various channels, including media, school meetings, and social media, and involve both adult leaders and youth voices.

Preventative steps must follow swiftly, including expanding access to mental health services, training key adults and peers in suicide prevention, and identifying individuals at heightened risk, especially those connected to the deceased. The plan prioritizes

the support of individuals and groups most directly affected by the suicide—such as family members, close friends, peers, coworkers, individuals with SMI/SED and first responders—by facilitating access to mental health services, grief counseling, and psychological first aid. Additionally, it calls for the implementation of specific outreach strategies to reach identified populations within the community. In the weeks and months following a suicide cluster, the plan promotes community-wide education, the reinforcement of protective factors, and the dissemination of resources that raise awareness and build resilience. Continuous monitoring, evaluation, and feedback are integrated into the response process to measure effectiveness, inform future postvention efforts, and strengthen long-term suicide prevention strategies. In the long term, the community should work to foster mental wellness through education, resilience-building, and ongoing support networks, particularly in schools. Monitoring mental health trends and conducting post-crisis reviews can help identify gaps and guide improvements. Most importantly, the community must emphasize connection and belonging, ensuring that no one feels alone in their pain. By combining immediate support with long-term planning, the postvention model in Kentucky aims to build stabilized affected communities, reduce further risk, and foster healing and recovery.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 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 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.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☒ Yes ☐ No
2. Has your state identified the need to develop new partnerships that you did not have in place? ☒ Yes ☐ No

If yes, with whom?

Bridgehaven, Inc. – an organization located in Louisville, Kentucky founded in 1958 as a community program to assist individuals with mental illness in transitioning from psychiatric institutions back into community participation. Bridgehaven provides community-based psychiatric rehabilitation services, recovery-based services, education, and support to those living with mental illness in the Louisville area. DBHDID partners with Bridgehaven to provide training and technical assistance for support of a recovery-oriented system of care for individuals with serious mental illness (SMI), including a statewide Center for Peer Excellence, a hub for adult peer support specialists that includes relevant training, support, and networking. Most recently the Center for Peer Excellence has been working with DBHDID to build a deaf and hard of hearing peer support service network for individuals who have mental illness.

Center for Accessible Living – a non-profit 501 c (3) organization in Louisville, Kentucky whose mission is assist people with disabilities to achieve their potential for community inclusion through improving access and equal opportunity. This organization provides independent living services, information and referrals, systems and individual advocacy, peer support and mentoring, independent living skills training, supported employment, and transition and diversion services. DBHDID partners with this organization to provide Individual Placement and Support (IPS) Supported Employment for individuals with SMI and SUD.

Virginia Association of Recovery Residences (VARR) - Through a partnership with the Virginia Alliance of Recovery Residences (VARR), the Division of Substance Use Disorder (DSUD) has funded the creation of a local non-profit to become the Kentucky National Association of Recovery Residences (NARR) affiliate and operate the certification program in Kentucky. VARR has spearheaded the creation of the Kentucky Alliance of Recovery Residences (KYARR), formed a board of directors, hired an executive director and other staff, and provided training and technical assistance to the new certifying agency. They have also established a monthly open call and KYARR has begun certifying recovery houses around the state.

Council on Postsecondary Education – DBHDID partners with the Council on Postsecondary Education, Kentucky's higher education coordinating board, on workforce initiatives that assist with establishing career ladders in behavioral healthcare for individuals in recovery, as well as increasing peer support certification trainings on the campuses of the Kentucky Community and Technical College System (KCTCS). This initial initiative was called the Career Ladders in Mental and Behavioral Health (CLIMB Health). In SFY 2026, the Division of Mental Health expanded this partnership to create CLIMB Health 2.0, an innovative workforce development project directed at establishing career ladders in behavioral healthcare for secondary education students in Kentucky and thus increasing opportunities for secondary education students to participate in the behavioral healthcare workforce in Kentucky. This initiative specifically focuses on community health workers and registered behavioral health technicians and will positively impact the state service system for individuals with SED and SMI.

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.

DBHDID coordinates statewide services via the following methods:

- Instituting planning groups, planning meetings and working through implementation steps based on proven implementation methods;
- Continuing to provide statewide peer group meetings with dedicated state program administrators to offer support and foster communication with behavioral health providers.
- Creating additional and continuing established learning collaboratives, communities of practice, and other methods of providing feedback regarding implementation of identified programming for individuals with SED/SMI/SUD, including local school districts and school-based behavioral health service providers.
- Enhancing data collection and analysis, including needs assessment processes, to better identify needs through more objective and comprehensive processes.
- Continuing to leverage all-department implementation training received through SAMHSA's Training and Technical Assistance partners to continue refinement of the DBHDID overall training/technical assistance plan and to continue to support actions to put that plan into practice in order to effectively implement and support necessary programming for individuals with SED/SMI/SUD across the state.
- Continuing to participate in Cabinet-level meetings for coordination and support of the Third Amended Settlement Agreement (TASA) which focuses on supporting individuals with SMI transitioning from institutions to community living.

- Enhancing statewide availability of crisis call enters, including 988, mobile crisis units, quick response teams, use of technology and telehealth in partnership with shelters for those experiencing homelessness to provide SMI/SUD screening and referrals, co-responder efforts with law enforcement, and working early with individuals who are reentering their communities after justice involvement.
- Collaborating with the Department for Medicaid Services on available waiver programming and state plan amendments for individuals with SED/SMI/SUD.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the [State Behavioral Health Planning Councils: An Introductory Manual](#).

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

The Kentucky Behavioral Health Planning and Advisory Council (Planning Council or Council) reviews the combined state block grant plan during its August quarterly meeting and the year-end block grant reports during the November quarterly meeting. Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) staff, across divisions, draft the plans and reports and share with Council members for review. The block grant plans and reports are posted on the DBHDID Council webpage <https://dbhdid.ky.gov> and public comment is encouraged, both before and after submission. Draft copies of the combined block grant plan/year-end reports are mailed to Council members with a term (which includes Individuals with Lived Behavioral Health Experience, Family Members, Parents, and Young Adults with Lived Behavioral Health Experience), and others who request, two weeks prior to meetings, to allow time for adequate review. Additionally, the drafts are emailed to the council listserv, which includes all Council members as well as other advocacy groups and stakeholders. All are encouraged to provide comments, recommendations and questions. An archive of draft submitted and approved plans and reports is maintained on the council's website at <https://dbhdid.ky.gov/mh/bhpac-bg>. Various methods for providing comments are outlined at the document found on the council's website at <https://dbhdid.ky.gov/documents/dbh/kdhpac/comments.pdf>.

Council meetings provide an opportunity for individuals to provide verbal and/or written feedback. Meetings have been virtual since 2020 and participation continues to be high. In 2025, attendance was 140% of the 2019 level. Stipends are provided to all council members with a term to compensate them for their time as well as address any participation barriers. Council staff have participated in national technical assistance and are currently participating in Cabinet-level discussions to leverage best practices for supporting and amplifying the voices of lived experience leaders.

During the August and November council meetings, time is provided for council members and other attendees, including the general public, to ask questions, provide feedback, and present recommendations related to the use of Block Grant funding. Council members provide verbal and written feedback during the meetings. Staff encourage council members and the public to submit feedback on any plan or report—whether drafted, submitted, or approved—at any time throughout the year. Information is provided on how to submit comments to the State Block Grant Planner after the meeting via the department's website, telephone, email, or U.S. mail. In addition, the council chair signs a letter acknowledging the council's participation and the opportunity to review and provide feedback on the Block Grant plan/report. Comments and recommendations are reviewed and incorporated into the documents and system planning as applicable.

Council members have another opportunity annually to provide feedback to the department for planning purposes. The council's Finance and Data Committee meets each April to review block grant allocations (MHBG and SUPTRS-BG) for the upcoming state fiscal year and to prioritize projects/funding. The information provided by the council informs system planning and has occurred consistently for 15 years. In recent years, funding priorities have been identified during the April meeting, converted into a survey, and shared with the full council for electronic voting in May. The link to the survey is shared in the May meeting notice, in the chat box during the meeting, and in a follow-up email after the meeting. Members are also able to add additional priorities to the list.

In April 2025, 15 service priorities were compiled during the Finance and Data Committee meeting and 15 members completed the survey. The following are the top eight service needs identified:

1. Housing services;
2. Transportation services;
3. Support, mentoring, and continuing education for Peer Support Specialists, including support to become certified as a Peer Support Specialist, and information about Medicaid billing for the evidence-based practice of peer support;
4. Behavioral health services for individuals without insurance/Medicaid expansion population who may lose coverage;
5. Re-entry services and transition support specific for individuals/young people with behavioral health issues leaving prisons/jails;
6. Career sustainability/upward mobility for employed peer support specialists;
7. Crisis stabilization services for adults with serious mental illness/co-occurring substance use disorder; and
8. Services for youth with high acuity needs.

The survey results will be shared at the August 2025 Council meeting. The results also inform leadership of the priorities that members of the council identified and will be used to develop DBHDID strategic priorities and use of the Block Grant funds.

Additionally, members of the Planning Council had the opportunity to provide recommendations on the communication plan for Kentucky's new Medicaid 1915(i) initiative for eligible adults with SMI, Kentucky RISE (Recovery, Independence, Support, and Engagement).

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

- a. State Plan ☒ Yes ☐ No
- b. State Report ☒ Yes ☐ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

DBHDID utilizes multiple mechanisms to identify, plan, and implement mental health and substance use disorder treatment and recovery support services, and substance use prevention activities. This planning work is described in detail in Planning Step 2 of this application. Described below is a brief overview of these processes. Please see Planning Step 2 for more detailed information.

Multiple data sources are utilized to identify behavioral health needs and to inform planning and implementation processes for behavioral health systems of care. These data sources include national surveys/data reports, relevant research studies and national/international publications, as well as internal and external state-specific data reports.

DBHDID partners with a state university to manage client/service/human resources data as well as to provide specific data analyzing for a variety of programs, including:

- University of Kentucky Center for Drug and Alcohol Research (UK CDAR);
- University of Kentucky Human Development Institute (UK HDI) KNACK data system;
- University of Kentucky Institute for Biomedical Informatics (IBI);
- UK CDAR Kentucky Treatment Outcome Study (KTOS).

DBHDID embraces the principles of implementation science and builds partnerships with behavioral health providers, universities, other state government departments, as well as individuals who have received or are currently receiving services in their communities. Not only do these partnerships assist with planning efforts but they also assist with implementation processes, including managing fidelity assessment, training and coaching for evidence-based practices. Communication venues have been established to gather ongoing feedback, many as regular peer group meetings with statewide partners. Examples of some of these communication venues are as follows:

- Community Mental Health Center (CMHC) Chief Executive Officer (CEO) meetings with DBHDID leadership;
- State Interagency Council for Services and Supports to Children and Transition Age Youth (SIAC) meetings with state leadership and individuals with lived experience related to children and youth services;
- CMHC Substance Use Treatment Director meetings with Division of Substance Use Disorder (DSUD) program administrators;
- Community Support Program (CSP) Director meetings with Division of Mental Health (DMH) program administrators;
- Regional Prevention Center (RPC) meetings with DSUD program administrators; and
- CMHC Children's Service Director meeting with DMH program administrators.

Additionally, there is an identified DBHDID liaison for each CMHC, who is designated to attend board meetings and facilitate communication between contractual partners, as well as a DBHDID liaison for each non-CMHC contract to manage communication and needs related to those additional service and infrastructure support deliverables.

The planning council's membership also provides valuable information about behavioral health prevention, treatment, recovery, and harm reduction services, as well as the supports needed for individuals in recovery, parents, and family members. The council

and its committees meet approximately eight times per year.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ☒ Yes ☐ No
5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ☒ Yes ☐ No
6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The following council duties are included in the bylaws and guide the work of the council:

- Report directly to the Commissioner of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).
- Assist DBHDID in designing a comprehensive, recovery-oriented system of care.
- Advise DBHDID on the use of Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS -BG) funds and Mental Health Block Grant (MHBG) funds and on the quality of statewide, recovery-oriented behavioral health services.
- Review the annual combined SUPTRS-BG and MHBG Application and annual Year-End Reports pursuant to Public Law 102-321, Section 1915 (a) and to submit recommendations to DBHDID, prior to the September 1 and December 1 due dates, respectively.
- Advocate for individuals in recovery from mental health disorders and/or substance use disorders, children and youth with behavioral health challenges, and their family members.
- Monitor, review, and evaluate, at least once a year, the allocation and quality of statewide, recovery-oriented behavioral health services.

The council has 37 membership seats. Twenty of those seats are designated for individuals with lived experience of either mental health or substance use disorders, either as an individual, family member, parent, or young adult. Council members with lived experience serve as officers and chairs for the Executive, Membership, and Finance and Data committees. Those officers and chairs form the council's planning team, which meets monthly with council staff to collaboratively plan meetings, support membership, and develop policies.

Since implementing virtual meetings, council meeting participation has increased; however, the council struggles to recruit and retain young adult applicants.

Council members advocate for individuals with SED, SMI, and SUD by learning about and critically reviewing current initiatives, sharing service gaps, and making funding recommendations to the department. Most recently council members provided feedback for the communication plan of the 1915 (i) Medicaid State Plan Amendment for individuals with SMI. Council members have a broad reach of contacts for networking, and they share service experiences and capacity gaps during meetings. DBHDID values the individual and collective voices of its members and considers their recommendations. During Finance and Data committee meetings, members receive updates on block grant allocations for the upcoming year and a review of projects funded over the last few years, with alignment to council identified priorities. This feedback is a vital part of the advocacy process.

The composition of the planning council highlights the diverse experiences of its members and includes:

- Six adults with lived experience of behavioral health disorders;
- Six parents, guardians, grandparents, guardians, or foster parents who are caring for a child (birth through age 20) with behavioral health challenges;
- Six family members of an adult with lived experience of behavioral health disorders;
- Two young adults with lived experience of behavioral health disorders (age 18-25);
- One organization representing individuals with lived experience of substance use disorders;
- One organization representing individuals with lived experience of mental health disorders and/or substance use disorders;
- One organization representing family members of adults with lived experience of mental health disorders and/or substance use disorders;
- One organization representing youth and family members of youth with significant behavioral health challenges.
- One Regional Prevention Center representative;
- One Community Mental Health Center provider representative.
- Eleven representatives of state agencies that provide services to people with behavioral health disorders.

Driven by the council's planning team (council officers, committee chairs, and council staff) much work has been done over the past year to positively impact this council.

Some examples include:

- The council incorporated American Sign Language (ASL) interpreters, a captioner, and tips for making meetings deaf friendly.
- The planning team has developed a relationship with the DBHDID Communication Specialist and has begun creating infographics that members can share on their social media pages.
- The membership application is being updated to be more user-friendly, include more information about how applicants' information will be shared publicly, as well as tools to assist applicants with the application process and determining if the council is right for them.
- The council conducted its first online demographic survey in May 2023. This survey confirmed that new recruitment strategies are

needed. Staff has drafted a list of potential outreach organizations. Next steps are to share the list, expand it, and develop an outreach strategy.

- The council's planning team developed and implemented a hacking protocol for virtual meeting safety.
- The council's planning team has shared information about the Kentucky Open Meeting Law's new "cameras on" requirement and supported members as needed to meet the requirement.
- In 2024, the Membership committee initiated a new membership drive – asking each member to share information about the council with at least one person or organization. Four individuals submitted applications; three met membership criteria and were appointed.
- A member satisfaction survey/needs assessment is being developed.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Council and public comments for the current application can be found in the attached draft minutes from August 21, 2025.

Council and public comments for the year-end reports can be found in the attached meeting minutes from November 2024.

Documentation of Council review of allocations and input on financial priorities can be found in the attached Finance and Data Committee minutes from April 2025 and in the May 2025 quarterly meeting minutes also attached.

Kentucky Behavioral Health Planning and Advisory Council

Minutes

November 21, 2024 10:00 - 12:30

Council Members: Russ Williams, Kristen Shroyer, Ron O’Hair, Valerie Mudd, Steve Shannon, Phyllis Millspaugh, Elizabeth Freeland (for Deborah Sauber/KDE), Lynn Haney, Peggy Roark, Carmilla Salyers, Angeline Davis, Marcie Timmerman, Sharon Darnell, Tara Hyde, Christy Shuffett, Jackie Heitkemper, Steve Lyons, Cecilia Webber (for Jessica Wayne/DAIL),

Council Staff: Diana Hobbs, Missy Runyon, Christie Penn

Guests: Fantasia Tackett, Karen Howard, Kathy Susman, Courtney Welsh, Beth Jordan, Janice Johnston, Zara Bullock, Amber Collins, Jason Bagley, Nikki Milward, Angela Rowe, Jaydan Norris (NAMI KY), Hannah Brosnan (MHAKY), Nicole Cropper

Topic	Discussion	Notes/Next Steps
Call Meeting to Order	Sharon Darnell, Chair, called the meeting to order at 10:02 AM and welcomed members, guests, and staff. Sharon shared that Vice Chair, Robin Osborne, resigned last month and expressed appreciation for Robin’s 6.5 years of leadership and service. Staff shared that this year the Council’s Planning Team has been discussing steps staff will take to keep meetings safe from online hackers. Sharon reviewed the communication access reminders. Quorum was confirmed.	Planning Council
Introductions and Member Updates	Members, guests, and staff introduced themselves and provided updates.	Membership List
Approval of August 2024 Minutes	Members reviewed the August minutes. Peggy Roark made a motion to approve the minutes as written and Ron O’Hair seconded. Minutes approved.	Meeting Summaries
Committee Reports	<u>Executive Committee</u> Executive Committee will meet on January 16, 2025. <u>Membership Committee</u> Membership Committee Chair, Sharon Darnell, shared the following updates: • The Council has the following vacancies: Young Adult (2), Adult (3), Family Member (2). • The Membership Committee will meet again on January 16, 2025. During the meeting, membership applications will be reviewed, and	Applications to be reviewed during the January 16, 2025 Membership meeting are due January 13, 2025.

Topic	Discussion	Notes/Next Steps
	Vice Chair nominations will be solicited. Recommendations will be shared with the Council during the February quarterly meeting. - Sharon reminded the following members that their terms expire in March 2025. Members are encouraged to reapply. - Jennifer Mingo - Rebecca Seavers - Sandy Weaver - The Council reviewed a membership application (TH) that was received in September, to fill a young adult with lived experience membership vacancy. Council officers and available committee chairs met applicant on November 7 at the planning meeting and recommended bringing to the November meeting for a vote. Angeline Davis made a motion to recommend the applicant for membership. Jackie Heitkemper seconded. Motion approved.	Membership Application The Council's membership recommendation will be sent to DBHDID Commissioner, Dr. Katie Marks.
Advocacy Tips and Resources	Peggy Roark shared advocacy resources with members and led them in a discussion of advocacy tips and strategies. Members shared advocacy activities they coordinate and support.	
2025 Block Grant Year-End Reports	Missy Runyon provided an overview of Kentucky's 2025 Year-End Reports for the Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services (SUPTRS-BG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). A PowerPoint and a draft of the reports were shared with members prior to and during the meeting and the draft reports are available on the department's website. Missy educated members about the purpose of the block grant, federal allocation amounts, number of individuals served with the funds at Kentucky's community mental health centers, maintenance of effort and set-aside requirements, performance indicator status, and information on how to provide comments after the meeting. Members and guests were also encouraged to share feedback during the meeting (orally and via chat). The following comments and questions were shared and addressed during the meeting: "For the children's set aside, is it an amount or a percent?" "The Block Grant allocation has gone up over the years, but the children's set side has not gone up." "Is there a set aside for recovery support services? I'm curious how Kentucky's spending compares to the rest of the country."	Archive of Block Grant Applications and Reports To provide comments on Kentucky's Block Grant reports, please email Missy Runyon.
Department Updates	Phyllis Millspaugh, Assistant Director of the Division of Mental Health, provided DBHDID's November Opportunities, Activities, and Resources Report and shared information about the following: - U.S. Department of Justice Investigation Update - Alcohol and Other Drug Entity Licensure 988 Suicide and Crisis Lifeline	For more information about these initiatives, please contact Phyllis Millspaugh.

Topic	Discussion	Notes/Next Steps
	• CODE RED Training for Trainers • Medicaid behavioral health services initiatives • Initiatives to enhance integration of primary care and behavioral health care • University of Kentucky's EmPATH Unit • Mental health promotion resources	
Meeting Adjournment	Peggy Roark made a motion to adjourn the meeting at 11:47am. Valerie Mudd seconded. Minutes approved. The Council's meeting schedule is posted here.	<u>Next Meeting</u> Thursday, February 20, 2025

Kentucky Behavioral Health Planning and Advisory Council
Finance and Data Committee Minutes
 April 17, 2025 10:00am to 12:00pm

Members: Angeline Davis, Steve Lyons, Peggy Roark, Christy Shuffett, Jackie Heitkemper, Steve Shannon, Clark Lester, Sharon Darnell, Kelly Gunning, Olivia Maison, Savvy Shabazz, Andrea Becker, Hannah Brosnan

Council Staff: Missy Runyon, Diana Hobbs, Christie Penn

Guests: Brian Mattingly, Courtney Welsh, Margaret Corneilson, Angela Rowe, Ashley Bates, Kathy Susman, Samantha Reams, Sarah Johnson, Sherri Staley, Vanessa Pollard, Brittany Barber, Russell Williams, Lena Morehead, Tracy Desimone

Topic	Discussion	Next Steps
Call Meeting to Order and Introductions	Peggy Roark, Chair, called to order at 10:00 am and welcomed attendees. Members, staff, and guests introduced themselves. Peggy shared a special welcome to new members, Olivia Maison and Savvy Shabazz.	Archived meeting summaries
Overview of Mental Health Block Grant (MHBG) and Substance Use Prevention, Treatment and Recovery Services Block Grants (SUPTRS-BG)	Missy Runyon presented information about the MHBG and SUPTRS-BG, including current state allocation amounts, priority populations, the role of DBHDID in allocating and contracting funds, and considerations and rules in allocating funds. Missy also provided information about Coronavirus Response and Relief Supplemental Appropriations Act (CRRRA), American Rescue Plan Act (ARPA), and Bipartisan Safer Communities Act (BSCA) supplemental block grant funds. Missy explained that the remaining CRRRA and ARPA funds had recently been terminated for cause by the Substance Abuse and Mental Health Services Administration (SAMHSA) but that our state administration was working through the court system to pursue access to all block grant funds that had been awarded through duly enacted federal legislation. Current BSCA funding amounts and stipulations for those funds were reviewed. Missy discussed the many items that DBHDID considers as it prioritizes Block Grant funds, including Council funding priorities, and how the contract structure ensures clear communication of services purchased, reporting requirements, and monitoring mechanisms. Missy reported that block grant allocations for SFY 2026 had just been released to providers on Tuesday, April 15, 2025, and that specific information (beige sheets) would be provided to Council at the May quarterly meeting.	Allocation lists will be included in May Council meeting handouts.
Data Review	Missy reviewed service data from DBHDID's SFY 2024 Year in Review .	DBHDID Homepage

Member Feedback and Priority Setting	Missy shared a list of the Council’s past funding priorities and funded projects during the past four years. Committee members shared the following 2025 priorities for Block Grant funding: 1. Support, mentoring, and continuing education for Peer Support Specialists, including support to become certified as a Peer Support Specialist, and information about Medicaid billing for the evidence-based practice of peer support 2. Support for Consumer Operated Services Programs (COSPs), an evidence-based peer support program 3. Housing services 4. Transportation services 5. Curriculum/training regarding relevant life skills for individuals with behavioral health issues 6. Creating paths of career sustainability/upward mobility for employed peer support specialists 7. Crisis stabilization services for adults with serious mental illness/co-occurring substance use disorder 8. More options for mental health civil commitment evaluations for the Louisville area 9. Behavioral health services for individuals without insurance/Medicaid expansion population who may lose coverage 10. Services for youth with high acuity needs 11. Reentry services and transition support for individuals with BH issues leaving local jails 12. Reentry services and transition support specific for young people with behavioral health issues leaving prisons/jails 13. Telehealth behavioral health services 14. Trauma Informed Care training 15. Neurodivergent-Inclusive training	A funding priorities survey will be shared at the May quarterly Council meeting. Members will be able to choose their top 3 priorities. Survey results will be reviewed during the August Council meeting.
Additional Member Comments	A member shared a list of advocacy topics. 1. Reform No-Show Discharge policies. 2. Medicaid coverage for missed appointments. 3. Telehealth-First accessibility model. 4. No Forced Therapy for medication management. 5. End discrimination against clients with SUD histories. 6. Require Trauma Informed Care and Neurodivergent-Inclusive training	
Adjourn	Jackie Heitkemper made a motion to adjourn at 11:32 am. Olivia Maison seconded. Meeting adjourned.	

Kentucky Behavioral Health Planning and Advisory Council

Minutes

August 21, 2025

10:00 a.m. to 12:25 p.m.

Council Members: Val Mudd, Savvy Shabazz, Tami Blevins, Sharon Darnell, Kristen Shroyer, Jackie Heitkemper, Kelly Gunning, Clark Lester, Lynn Haney, Christy Shuffett, Phyllis Millsbaugh, Steve Lyons, Peggy Roark, Ron O’Hair, Angeline Davis, Steve Shannon, Hannah Brosnan, Andrea Becker, Christine Weeter

Council Staff: Diana Hobbs, Missy Runyon, Christie Penn

Guests: Derek Vincent, Shaquita Andrews-Higgins, Stephanie Dunaway, Kim Reeder, Tara Brewer, Jason Bagley, Janice Johnston, Margaret Corneilson, Angela Rowe, Karen Howard, Courtney Welsh, Kathy Susman, Beth Jordan, CC Webber, Breanna McGinnis, Nicole Cropper, Michelle Niehaus, Melissa Hopkins

Topic	Discussion	Notes/Next Steps
Call Meeting to Order	Sharon Darnell, Chair, called the meeting to order at 10:01 AM and welcomed members, guests, and staff. Sharon welcomed new members, Marnie Mountjoy (Department for Aging and Independent Living) and Tami Blevins (Kentucky Partnership for Families and Children). Sharon reviewed the communication reminders and thanked members for completing the 1915(i) Kentucky RISE survey that was sent out in May.	Kentucky Behavioral Health Planning and Advisory Council
Introductions and Member Updates	Members, staff, and guests introduced themselves and provided updates.	
Quorum	Missy Runyon confirmed quorum.	
Approval of May 2025 Minutes	Members reviewed the May minutes. Ron O’Hair made a motion to approve the minutes as written and Peggy Roark seconded. Minutes approved.	Approved Meeting Summaries
2026 Meeting Calendar	Sharon shared the draft 2026 meeting calendar. Jackie Heitkemper made a motion to approve the 2026 meeting calendar. Christy Shuffett seconded the motion. Calendar approved.	Meeting Calendar Staff will send Zoom calendar invitations and post the calendar on the Council’s website in December.

Topic	Discussion	Notes/Next Steps
Committee Reports	<u>Finance and Data Committee</u> Peggy Roark, Committee Chair, reviewed the results of the 2025 Funding Priorities Survey. Funding priorities were identified during the April Committee meeting and members were surveyed in May. Fifteen members completed the survey. Members ranked the following initiatives as the top five funding priorities: • Housing services (11 votes) • Transportation services (6 votes) • Support, mentoring, and continuing education for Peer Support Specialists, including support to become certified as a Peer Support Specialist, and information about Medicaid billing for the evidence-based practice of peer support (5 votes) • Behavioral health services for individuals without insurance/Medicaid expansion population who may lose coverage (5 votes) • Reentry services and transition support specific for young people with behavioral health issues leaving prisons/jails (5 votes) <u>Membership Committee</u> Sharon Darnell, Committee Chair, Sharon Darnell, reminded members that a Member Orientation will be held September 18, 2024 @ 10-12:30 ET/9-11:30 CT. All members, staff, and guests are invited to attend. The results of the 2025 Demographic Survey were reviewed. Sharon encouraged members and guests to be a part of a membership drive – please share the membership application with at least one person, group, or social media network so the council can fill the following vacant seats: • Young Adult with Lived Behavioral Health Experience of BH Disorders (1 seat) • Parent/Grandparent/Guardian/Foster Parent Caring for a Child with BH Challenges (3 seats) • Family Member of an Adult with Lived BH Experience (1 seat) • Adult with Lived Behavioral Health Experience (2 seats)	Survey results will be used to inform and guide planning for Kentucky’s continuum of behavioral health services and supports and are included in block grant application. Fillable form membership application Reach out to staff if you want paper applications.

Topic	Discussion	Notes/Next Steps
	<u>Bylaws Committee</u> Steve Shannon informed members that a Bylaws Committee meeting would be held in 2026. The meeting scheduled for September 2025 was cancelled.	The 2026 Bylaws Committee Meeting date is on the 2026 Calendar to be posted online in December.
1915(i) RISE Initiative	Derek Vincent, Program Manager for the 1915(i) Recovery, Independence, Support, and Engagement (RISE) Initiative, shared information about Kentucky's 1915(i) RISE Initiative for adults with serious mental illness (SMI) or co-occurring SMI and substance use disorder. Derek provided information about this 1915(i) state plan amendment, the assessment process, services covered, the participant's journey, and resources for learning more.	For more information, you may reach Derek at Derek.Vincent@ky.gov. KY 1915(i) RISE Initiative Website KY 1915(i) SPA KY 1915(i) Regulations
2026-2027 Combined Block Grant Application	Missy Runyon provided information about Kentucky's Application for SFY 2026-2027 Combined Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS-BG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as the Bipartisan Safer Communities Act (BSCA) application for the new award period. A draft of the application was shared with members prior to the meeting and is available on the department's home page with several methods for public comment. Missy reviewed the rules for each Block Grant and answered questions. Missy stated that comments received by August 23rd will be included in the Block Grant application; comments submitted after that date are also appreciated and utilized for system planning. The following comments and questions were provided: • "I do not see money allocated for 2026 for mass violence in schools. I see it listed in the budget, but there is not any money allocated. There is a lot of violence going on these days and I'd like to see funds allocated to address it."	Archive of Block Grant Applications and Reports Ways to Provide Public Comments on Block Grant Applications and Reports Email comments to Missy Runyon at Melissa.Runyon@ky.gov Comments and questions will be included in Kentucky's 2026-2027 Combined Application.

Topic	Discussion	Notes/Next Steps
	• “It’s good to be able to read Kentucky’s BSCA 4 budget, ask questions, and get clarity.” • “Wonderful info – thank you so much, @Missy Runyon.” • “This has been very informative, Missy! Thank you!” • “I haven’t looked at the application yet, but I will go through it and send questions to you.” • “Thank you for sharing and reviewing this with us, @Christie Penn and @Missy Runyon.”	
Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) Updates	Phyllis Millspaugh, Assistant Director at the Division of Mental Health, provided updates on the following services, collaborations, and initiatives: • 2025 Kentucky Recovery Rally at the Capitol • 2025 Recovery Summit • State Interagency Council for Services and Supports to Children and Transition-Age Youth (SIAC) and its workgroups • Office of Drug Control Policy’s funding opportunity to address Neonatal Abstinence Syndrome. • Dinner Table Project	The most recent DBHDID report that included this information with links for resources was shared in handouts and during the meeting.
Meeting Adjournment	Sharon invited members to stay on the meeting after adjournment if they need assistance with stipend requirements. Phyllis Millspaugh made a motion to adjourn the meeting at 12:09 PM. Jackie Heitkemper seconded the motion. Meeting adjourned.	<u>Next Meeting:</u> Thursday, November 20, 2025 Meeting Calendar

Kentucky Behavioral Health Planning & Advisory Council

275 East Main Street, 4W-G, Frankfort, KY 40601

August 21, 2025

Wendy Pang
Grants Management Officer
Division of Grants Management
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Wendy Pang,

I am writing on behalf of Kentucky's Behavioral Health Planning and Advisory Council to confirm that Council members met today and reviewed the combined funding application for Kentucky's mental health and substance use prevention, treatment and recovery services block grants for FFY 2026-2027. Council members received drafted copies of the application prior the meeting, and time was allotted at today's meeting for discussion. The application is also posted for public review on the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities website at [DBHDID block grants](#). Department staff welcomes comments and recommendations prior to and after submission of the 2026-2027 application on September 2, 2025.

Thank you for the continued support of community-based services for adults and youth with behavioral health challenges. Our Council is honored to serve as advisors for planning in Kentucky.

Sincerely,



Sharon Darnell
Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Melissa Runyon, Block Grant State Planner

Kentucky Behavioral Health Planning and Advisory Council

Minutes

May 15, 2025 10:00 - 12:30

Council Members: Angeline Davis; Lynn Haney; Steve Lyons; Valerie Mudd; Peggy Roark; Savvy Shabazz, Olivia Maison; Jessica Wayne; Phyllis Millspaugh; David Gutierrez; Clark Lester; Kristen Shroyer; Andrea Becker; Christina Weeter; Steve Shannon; Rachel Petit; Carmilla Salyers; Marcie Timmerman; Christy Shuffett; Ron O’Hair; Tara Hyde

Staff: Missy Runyon; Christie Penn; Diana Hobbs; Angela Rowe; Dennis Hall; Brittany Barber; Deb Davidson; Jason Bagley; Tara Brewer; Nicole Cropper; Courtney Welsh; Kathy Susman; Russ Williams

Guests: Andrea Mayberry, Deleana Weathers

Topic	Discussion	Notes/Next Steps
Call Meeting to Order	Peggy Roark, Vice Chair, called the meeting to order at 10:00 AM and welcomed members, guests, and staff. She provided a special welcome to new members, Olivia Maison, Savvy Shabazz, and Andrea Becker. Peggy reviewed the Council’s Zoom accessibility tips. Quorum was confirmed.	Planning Council
Introductions and Member Updates	Members, guests, and staff introduced themselves and provided updates.	Membership List
Approval of February 2025 Minutes	Members reviewed the minutes from the February 2025 meeting. Ron O’Hair made a motion to approve the minutes as written and Phyllis Millspaugh seconded. Minutes were approved.	Meeting Summaries
Committee Reports	<u>Finance and Data Committee</u> Peggy Roark, Committee Chair, provided a report of the Thursday, April 17, 2025 meeting. Missy Runyon reviewed State Fiscal Year 2026 Block Grant draft allocation lists for the Mental Health Block Grant, Substance Use Prevention, Treatment, and Recovery Services Block Grant, and two Bipartisan Safer Communities Act Block Grant awards. Peggy reviewed the funding priorities established by the committee and asked members to complete the 2025 Funding Priorities Survey before Friday, May 30th. The survey link was shared during the meeting. Survey results will be shared at the next quarterly meeting. Members review the committee minutes. Angeline Davis made a motion to approve the minutes as written. Valerie Mudd seconded the motion. Minutes were approved.	2025 Funding Priorities Survey Staff will send a reminder email to members.

Topic	Discussion	Notes/Next Steps
	<u>Membership Committee</u> Angeline Davis, Council Secretary, shared the following Membership updates: - Savvy Shabazz and Olivia Maison were appointed as new members and Peggy Roark has been appointed Vice Chair. Andrea Becker is the new representative for the Department of Corrections. - The Council has the following vacancies for members with a term: Young Adult (1), Adult (2), Family Member (1), and Parents (2). - The Council's Member Orientation will be held Thursday, September 18 at 10-12:30 ET/9-11:30 CT. All are invited to attend. - Members were asked to complete the 2025 Demographic Survey by Friday, May 30, 2025. The survey link was shared during the meeting. The demographic results will assist in Kentucky's 2026-2027 Combined Block Grant Application and will be shared at the August quarterly meeting. <u>Bylaws Committee</u> The Bylaws Committee will meet Thursday, September 18, 2025 at 1-2 ET/12-1 CT. Members were asked to review the Council Bylaws and submit recommendations to staff by August 15, 2025.	Please share the membership application with interested individuals. Staff will send members a reminder email. Please submit Bylaw recommendations to staff.
Reintegration Services	Seven Counties Services staff members, Andrea Mayberry and Deleana Weathers, provided an overview of reintegration/reentry services for adults with SMI, SUD, or co-occurring SMI/SUD, serving out/being paroled from three specific prisons in their service area. (Kentucky State Reformatory; Kentucky Correctional Institution for Women; and Luther Lockett Correctional Complex). These services are funded through both block grants.	Contact Andrea Mayberry for more information.
Medicaid Reentry Services	Kristen Shroyer, from the Department for Medicaid Services, provided an overview of the 1115 waiver for reentry services for individuals with SUD. This Medicaid waiver provides for reimbursable behavioral health services via Managed Care Organizations (MCOs), 60 days prior to release from incarceration until up to 12 months post release. The Center for Medicare and Medicaid Services (CMS) has requested additional information. The expected implementation date is October 1, 2025.	Contact Kristen Shroyer for more information.
Department Updates	Phyllis Millspaugh, Assistant Director of the Division of Mental Health, provided DBHDID's May Opportunities, Activities, and Resources Report and shared information about the following: - Early Childhood Mental Health - Advisory Committee on Autism's new transition resource - Psychological First Aid Training - Kentucky Community Crisis Response Team's Disaster Response - Team SOAR Monthly Learning Collaborative - Deaf and Hard of Hearing Training - KY SIX Funding Opportunities - Regional Interagency Council Learning Series	For more information about these initiatives, please contact Phyllis Millspaugh .

Topic	Discussion	Notes/Next Steps
	- Sources of Strength Training - Naloxone Distribution	
Meeting Adjournment	Olivia Maison made a motion to adjourn the meeting at 12:30 PM. Angeline Davis seconded. Meeting adjourned. The Council's meeting schedule is posted here.	<u>Next Meeting</u> Thursday, August 21, 2025

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 Mental Health Agency
 State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Andrea Becker	State Employees		Department of Corrections Lexington KY, 40511 PH: 859-246-2366	andrea.becker@ky.gov
Hannah Brosnan	Advocates/representatives who are not state employees or providers		Mental Health America Kentucky Lexington KY, 40511	hannahb@mhaky.org
Sharon Darnell	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		PH: 606-584-2716	sharon_darnell@outlook.com
Angeline Davis	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		PH: 502-500-9176	angeline.d@hotmail.com
Bridgett Fulkerson	Parents of children with SED		PH: 502-507-8839	bbarber@barbercabinetco.com
Kelly Gunning	Advocates/representatives who are not state employees or providers		NAMI Lexington Lexington KY, 40504 PH: 859-309-2856	kelly@namilex.org
David Gutierrez	State Employees		Department for Community Based Services Frankfort KY, 40601 PH: 502-564-9433	david.gutierrez@ky.gov
Lynn Haney	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		PH: 859-282-9166	haneyl@fuse.net
Jaclyn Heitkemper	Parents of children with SED		PH: 502-472-7212	jheitkemper13@gmail.com
Tyler Herrin	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		PH: 812-974-3962	tytyherrin@gmail.com
Tara Hyde	Advocates/representatives who are not state employees or providers		People Advocating Recovery Louisville KY, 40222 PH: 812-399-2659	tara@kypar.org

Fallon Kilgore	Parents of children with SED		PH: 606-356-6096	fallon.kilgore.17@gmail.com
Clark Lester	State Employees		Department for Juvenile Justice Frankfort KY, 40601 PH: 502-892-3654	clark.lester@ky.gov
Steve Lyons	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		PH: 502-321-1951	lyonssadsack@aol.com
Olivia Maison	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			olivia.maison2@gmail.com
Phyllis Millspaugh	State Employees		DBHDID Frankfort KY, 40601 PH: 502-564-4456	Phyllis.Millspaugh@ky.gov
Marnie Mountjoy	State Employees		Department for Aging and Independent Living Frankfort KY, 40601 PH: 502-564-6930	marnie.mountjoy@ky.gov
Valerie Mudd	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		PH: 859-230-3978	val@namilex.org
Ron O'Hair	State Employees		Office of Vocational Rehabilitation Morehead KY, 40351 PH: 606-780-2287	ronniel.o'hair@ky.gov
Rachel Petit	State Employees		Protection and Advocacy Frankfort KY, 40601 PH: 502-564-7029	racheln.petit@ky.gov
Peggy Roark	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		PH: 859-396-1561	peggyroark8@gmail.com
Carmilla Salyers	Advocates/representatives who are not state employees or providers		KY Partnership for Families and Children Frankfort KY, 40601 PH: 502-875-1320	carmilla@kypartnership.org
Savvy Shabazz	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		PH: 502-715-0977	savvykashabazz@gmail.com
Steve Shannon	Providers		KARP Lexington KY, 40515 PH: 859-272-6700	sshannon.karp@gmail.com
Kristen Shroyer	State Employees		Department for Medicaid Services Frankfort KY, 40601 PH: 502-564-6890	kristen.shroyer@ky.gov
Christy Shuffett	State Employees		New Beginnings Bluegrass Lexington KY, 40508	christy@nbbg.org

			PH: 859-245-2400	
Matthew Smith	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		PH: 859-492-7552	msmith2905@gmail.com
Christina Weeter	State Employees		Department of Education Frankfort KY, 40601 PH: 502-564-4772	christina.weeter@education.ky.gov
Connie White	State Employees		Department for Public Health 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.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	5	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	5	
3. Parents of children with SED	3	
4. Vacancies (individuals and family members)	7	
5. Total individuals in recovery, family members, and parents of children with SED	20	54.05%
6. State Employees	11	
7. Providers	1	
8. Vacancies (state employees and providers)	1	
9. Total State Employees & Providers	13	35.14%
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	4	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	4	10.81%
16. Total membership (all members of the council)	37	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Several of the individuals in recovery include lived experience with co-occurring M/SUD, but these categories are not organized so that is effectively represented.

Also, several of the advocacy organization representatives are also individuals in recovery but these categories are not organized so that is effectively represented.

Also, Kentucky's Department for Community Based Services includes both the State Child Welfare Agency as well as the State Social Services Agency. These categories are not organized so that is effectively represented.

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

Please respond to the following items:

1.

Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
- a)

Public meetings or hearings?

☒

Yes

☐

No
- b)

Posting of the plan on the web for public comment?

☒

Yes

☐

No

If yes, provide URL:
<https://dbhdid.ky.gov/mh/bhpac-bg>
If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:
<https://dbhdid.ky.gov/mh/bhpac-bg>
- c)

Other (e.g. public service announcements, print media)

☐

Yes

☒

No
- d)

Please indicate areas of technical assistance needs related to this section.
None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:

Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the [HIV.gov website](#).

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C. § 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		\$0.00		0	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:
Kentucky does not utilize SUPTRS BG funds for Syringe Services Programs.