Kentucky
Judicial Commission on Mental Health

2023 STATEWIDE SEQUENTIAL INTERCEPT MODEL MAPPING WORKSHOP

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The points of view expressed in this report are those of the authors and do not necessarily represent the official position or policies of the Kentucky Judicial Commission on Mental Health.

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Executive Summary

On August 11, 2022, the Kentucky Supreme Court established the Kentucky Judicial Commission on Mental Health (KJCMH) with the charge of exploring, recommending, and implementing transformational changes to improve systemwide responses to justice-involved individuals experiencing mental health, substance use, and/or intellectual and developmental disabilities. The commission membership, named by the Kentucky Supreme Court, is comprised of members from the judicial and legal communities; the juvenile criminal and child protection systems; the legislature; the business community; organizations with a substantial interest in mental health matters; and other state and local leaders who have demonstrated a commitment to mental health issues. [1]

The KJCMH identified a need to implement the Sequential Intercept Model (SIM) throughout Kentucky to identify resources and opportunities to best focus the work of the KJCMH. The KJCMH developed a three-phase implementation approach including:

1. a statewide SIM mapping workshop;
2. training facilitators to conduct local mapping workshops; and
3. conducting local mapping workshops across the state.

This report provides a summary of the Kentucky Statewide Sequential Intercept Mapping Workshop. The National Center for State Courts (NCSC) conducted the statewide SIM Mapping Workshop in Frankfort, Kentucky on February 16th and 17th, 2023. NCSC Principal Court Management Consultant Michelle O'Brien and Senior Court Management Consultant Danielle Young facilitated the event. The workshop convened 39 multi-stakeholder participants over the course of the one-and-a-half-day event.

On the first day of the Mapping Workshop, participants were presented with an overview of the Sequential Intercept Model and national and state data on topics including mental health, substance use, and justice-involved individuals to provide context for the following discussions. Participants were asked to identify current initiatives that support behavioral health improvements in the state, current or pending policies or legislation regarding behavioral health, policy or legislation needing to be revised or written, and who should be part of these efforts. Initiatives included the Kentucky Opioid Response Effort (KORE), the Kentucky State Interagency Council for Services and Supports to Children and Transition-Age Youth (SIAC), Recovery Ready Communities Certification Program, the Kentucky State Police Angel Initiative, Prison to Pipeline, increased efforts to train law enforcement in Crisis Intervention Team training,

[1] https://kycourts.gov/Court-Initiatives/Pages/Kentucky-Judicial-Commission-on-Mental-Health.aspx

and the 988 Mental Health Crisis Line. Legislation identified by participants included Senate Bill 90, the Kentucky Homelessness Prevention Project, Casey's Law, and Tim's Law.

Participants were then grouped by intercepts and their roles and asked to identify what resources and opportunities existed at each intercept. Common resources across intercepts were community mental health centers, crisis response teams, crisis lines, Narcan supply, embedded social workers, and Veterans Assistance. Common opportunities included data sharing, lack of uniformity of resources and practices (e.g., jails, prisons, community mental health centers), training to de-stigmatize mental illness, and information sharing between stakeholders and systems.

The second day began with identifying stakeholders missing from the conversation. Missing stakeholders included law enforcement, Sheriff's Association, Department of Juvenile Justice, Justice Cabinet members, legislators, Kentucky Association of Counties, Community Mental Health Centers, lived experience and families, qualified mental health professionals, private sector practitioners, Medicaid, Department for Community Based Services, Division of Behavioral Health, KORE, pharmacology, federally qualified health centers, allied service professionals, schools, fiscal court members; and the Kentucky Coalition Against Domestic Violence.

Participants were finally divided into four breakout groups based on the KJCMH committees of Prearrest/Diversion, Competency, Strengthening Communities, and Court Responses to Mental Health and asked to identify priorities and create an action plan for each of their committees based on the opportunities discussed throughout the workshop. All priorities supported person-centered justice focusing on multidisciplinary, non-adversarial team approaches; equal access to justice; trauma-informed responsive practices; and sharing resources across the community, court, and behavioral health systems.

Summary of Recommendations

Kentucky has a history of embracing change, and the Kentucky Judicial Commission on Mental Health has embraced a comprehensive approach to engagement in various activities leading up to the development of this report and recommendations. The recommendations are divided into five topics.

- **Courts as Conveners and Leaders**
- **Education and Training**
- **Data-Driven Decisions**
- **Behavioral Health Continuum of Care**
- **Peers, Individuals with Lived Experience, and Families**

Courts as Conveners and Leaders

- Encourage judges to use their leadership role as convenors to foster collaborative community and court strategies to promote community safety and improve outcomes for individuals with behavioral health needs.
- Coordinate and communicate between the behavioral health and justice systems to examine their systems and community resources to determine the best path forward to provide the best care and responses to individuals with behavioral health needs.
- Explore ways to encourage and support cross-system communication, resource sharing, and further development and implementation of sequential intercept strategies. Invite cross-system involvement in committees and meetings to further inform needs across systems.

Education and Training

A key component to enhancing the court and community response to justice-involved individuals with behavioral health needs is providing access to continued training for professionals charged with providing community supervision, care, and support. Judges and court professionals also need knowledge, data, research, and resources regarding behavioral health.

- Engage criminal justice professionals and partners to develop training programs that enhance court and community responses to justice-involved individuals with behavioral health needs.

Data-Driven Decisions

Data collection is critical for enabling outcome tracking and should be discussed across both civil and criminal matters. The Behavioral Health Data Elements Guide for the State Courts outlines ideal state court behavioral health data elements to collect across the Leading Change Model as well as elements to collect in coordination with other systems. Priority should be given to data collection that supports addressing the behavioral health needs of individuals within the community before they become justice involved.

- Create partnerships between the Supreme Court, Cabinet for Health and Family Services, Justice Cabinet, and Kentucky Department of Corrections to share information and data.
- Assess what entities are collecting data, what data is being collected, and how that data is being used. Identify entities that are doing a good job with data collection and use them as a model. Also identify entities that are successfully sharing information and data between agencies and systems. Examine their information and data sharing agreements to create a model for other agencies and systems to replicate.
- Develop Memoranda of Understanding (MOU) between agencies that provide for information and data sharing. The MOU should outline how often, in what format

(dashboards or ongoing performance reports for periodic evaluation), and when the information and data will be shared.

Behavioral Health Continuum of Care

The vision for behavioral health continuum of care is grounded in a public health model that addresses the social determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience, and recovery support to promote social integration and optimal health and productivity. The goal of a behavioral health continuum of care is to provide a full range of high-quality services that address age, gender, cultural, and other needs presented. Create a statewide vision of what a behavioral health continuum of care should look like in Kentucky. Advocate for a comprehensive behavioral health continuum of care that includes both outpatient and inpatient services as well as recovery-oriented community housing.

- Promote deflection and diversion to treatment options at the earliest point possible and institutionalize those alternative diversion pathways to treatment, including civil alternatives such as assisted outpatient treatment, involuntary commitment, and outpatient treatment.
- Ensure services being provided to users are based on evidence-based practices and follow fidelity to established models that have been researched. It is recommended an oversight committee comprised of various stakeholders from the counseling community, judiciary, and executive branch work together to develop an evaluation and coaching process to create consistency in the delivery of services and to encourage the use of known best practices in the treatment of those with behavioral health needs.

Peers, Individuals with Lived Experience, and Families

Too often, the voices of families and individuals with lived experience are not included in implementation and improvement efforts, and the court's responses suffer as a result.

- Create opportunities to listen to and gather input from individuals with lived experience and their families in all efforts to improve court and community responses. Individuals with lived experience have valuable information to inform the justice and behavioral health systems about what worked and did not work for them.
- Encourage the integration of trained peers at all appropriate points in the treatment, case management, and justice processes including hiring trained peers in programs, services, and operations to improve the responses for individuals with behavioral health needs.

National Context

Overview

The prevalence of mental illness and co-occurring disorders is greatly impacting our nation, our states, and our communities and has a disproportionate effect on our courts and justice system. The judiciary has become the default system for addressing the needs of those with behavioral health issues, and jails are the largest providers of mental health services across the country.[2] In fact, the 2017 Bureau of Justice Statistics report based on the National Inmate Survey noted that 44% of jail inmates and 37% of prisoners had previously been told by a mental health professional that they had a mental health disorder.[3] Additionally, young people with serious emotional disturbances in need of treatment are seen regularly in the nation's justice system, with an estimated 70% of justice-involved youths suffering from a mental health disorder.[4] These numbers highlight that mental illness is overrepresented among justice-involved individuals when compared to 2018 estimates of the prevalence of mental illness among the general population:[5]

After a series of resolutions adopted in 2006, 2013, and 2016, the Conference of State Court Administrators (COSCA) published a policy paper in 2017, Decriminalization of Mental Illness: Fixing a Broken System, with recommendations to court leaders. The Conference of Chief Justices (CCJ) endorsed the policy paper and its recommendations in 2018. Six recommendations were adopted.

1. Encourage policymakers to modify mental health codes to adopt a standard based on capacity and not conduct for ordering involuntary mental health treatment similar to the standard for court-ordered treatment of other illnesses.
2. Expand the use of Assisted Outpatient Treatment (AOT).
3. Encourage law enforcement agencies to train their officers in the use of Crisis Intervention Team (CIT) Training.

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[2] Jaeckel T, Economy C. Promising Solutions to Our Nation's Behavioral Health Crisis.; 2017. https://govlab.hks.harvard.edu/files/ promising_solutions_to_nations_behavioral_health_crisis.pdf.

[3] Bureau of Justice Statistics. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-2012. Washington, D.C.; 2017. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

[4] Development Services Group Inc. Intersection between Mental Health and the Juvenile Justice System. Washington, D.C.; 2017. https:// www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf.

[5] Center for Behavioral Health Statistics and Quality. Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. Rockville, MD; 2019. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/ NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

4. Support the adoption of the Sequential Intercept Model (SIM).
5. Chief justices and state court administrators should encourage and assist local judges to convene stakeholders to develop plans and protocols for their local jurisdictions.
6. Provide information to policymakers that demonstrates how increased funding for mental health treatment can reduce jail and prison costs, as has been demonstrated in Miami-Dade County, Florida.

This work led to Resolution 6, In Support of Improving the Justice System Response to Mental Illness, adopted by CCJ and COSCA at the 2018 Annual Meeting. Resolution 6 identified four areas for further action.

1. Developing resources, best practices, and recommended standards.
2. Improving caseflow management.
3. Promoting education to equip state court leaders with the knowledge, data, and resources necessary to improve responses.
4. Building the capacity of state and national leaders to implement reforms.

National Judicial Task Force

On March 30, 2020, the Boards of Directors of CCJ and COSCA took action to establish a new task force to assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with serious mental illness. The National Judicial Task Force to Examine State Courts' Response to Mental Illness (NJTF) was built upon the previous work of the NCSC National Advisory Committee supported by funding from the State Justice Institute (SJI). By the end of 2022, over 100 informational publications were produced by the NJTF, in addition to an eLearning series, webinars, and podcasts. This body of work culminated in the Task Force's Final Report and Recommendations, released on October 25, 2022 and updated in February 2023. The following are their final recommendations.

1. **State and Trial Courts Leading Change** CCJ and COSCA should lead the establishment of state-level, three-branch, multidisciplinary task forces to promote systemic changes necessary to improve the court and community responses to mental illness.
2. **Deflection and Diversion to Treatment** Courts should examine the continuum of behavioral health deflection and diversion options available in each community…to promote deflection and diversion to treatment options at the earliest point possible.
3. **Reforming the Competency to Stand Trial System** Courts and communities should reserve the competency process, including competence to stand trial, for defendants who are charged with serious crimes…individuals charged with misdemeanors and

assessed as low risk to recidivate and whose clinical conditions are not likely to substantially improve should be diverted to treatment.

4. **Court and Community Collaboration: Person-Centered** Courts should establish case management best practices regarding cases with persons with behavioral health issues, including the effective triage of cases. Person-centered justice is a collaborative approach that is necessary to ensure public safety, control costs, and create fair and effective criminal justice and case management systems.
5. **Changing the Law and Process for Civil Commitment** Courts should develop and provide multiple civil court options that are easily accessible by individuals, families, and behavioral health systems. Hospital stays for serious mental illness are too short and do not provide the time or support to promote recovery. Courts should order that involuntary treatment be provided in an outpatient setting unless outpatient treatment will not provide reasonable assurances for the safety of the individual or others or would not meet the person's treatment needs.
6. **Children, Youth, and Families** Courts should examine resources to ensure a continuum of behavioral health practices and to improve outcomes for children and families with behavioral health needs. Courts should lead efforts to divert youth with mental health needs from juvenile justice involvement by supporting opportunities for youth with mental health diagnoses to be diverted away from deeper involvement with the justice system at multiple points of contact.
7. **Domestic Relations** Courts must promote the well-being of individuals and families, including implementation of trauma-responsiveness for families throughout the life of their case and the primary desired outcome.
8. **All Judges and Court Professionals Trained, Educated, and Trauma-Informed** All judges, court personnel, and justice system partners should be provided collaborative ongoing training and education across all case types.
9. **Behavioral Health and Equity** Courts should develop and adopt a Behavioral Health and Equity statement as it relates to children, youth, and adults with behavioral health conditions and identify and implement evidence-based practices to ensure diversity, equity, and inclusion across all programs and practices.
10. **Peers, Individuals with Lived Experience, and Families** Courts should create opportunities to listen to and gather input from individuals with lived experience and their families in all efforts to improve court and community responses.
11. **Well-Being of Judges and Court Personnel** Courts should examine resources on the well-being of judges and court personnel that provide guidance, best practices, tips, and support for mental health.
12. **Key Questions All Courts Must Ask – Data and Information Sharing** Courts should lead and support the identification of data, as well as data collection and information-sharing opportunities across the community, behavioral health, and justice systems as a

critical part of developing a comprehensive and collaborative continuum of behavioral health services.

Regional Summits

In addition to the large body of publications and informational resources developed and distributed by the NJTF, they also worked with CCJ-COSCA to hold five regional summits on *Improving the Court and Community Response to Individuals with Mental Illness*. The first was held in May 2019 in Sun Valley, Idaho, the second in October 2019 in Deadwood, South Dakota, the third was in April 2022 in Austin, Texas, the fourth in May 2022 in Burlington, Vermont, and the fifth was held in June 2022 in Brooklyn, New York. State multidisciplinary teams were invited to participate and work toward identifying state priorities for change. Following the summits, many of the state teams in attendance began commissions and/or task forces to address these priorities within their state.

National Diversion Landscape

In May 2022, NJTF released the Continuum of Behavioral Health Diversions Survey Report which outlined the survey completed by State Court Administrators and State Court Behavioral Health Administrators in conjunction with input from State Behavioral Health Departments. This survey created a picture of the national landscape regarding adult behavioral health diversions and practices in each state by inquiring about behavioral health diversions across a continuum identified in Table 1 below.

Table 1: Continuum of Behavioral Health Diversions

Continuum	Most Likely to Have	Least Likely to Have	Challenges
Ideal Behavioral Health System	▪ Outpatient mental health ▪ Substance use disorder treatment ▪ Medication assisted treatment ▪ Supported housing ▪ Case management teams ▪ Recovery supports	▪ Assertive community treatment ▪ Certified peer support ▪ Psychiatric advance directives ▪ Assisted outpatient treatment ▪ Co-location of behavioral health and other services	▪ Many services not widely accessible across the state, especially in rural areas ▪ Waiting lists, ▪ Shortage in behavioral health workforce ▪ Lack of services for those in highest level of care
Ideal Behavioral Health Crisis System	▪ 24-hour crisis lines ▪ Acute psychiatric hospital units ▪ Crisis stabilization units	▪ Livingroom/peer run crisis centers ▪ Crisis residential services ▪ Partial or day hospitals	▪ Need for more crisis stabilizations, mobile crisis teams, and partnerships with

Continuum	Most Likely to Have	Least Likely to Have	Challenges
			community behavioral health providers
Pre-Arrest Deflection and Diversion	▪ Police response/CIT training ▪ Mobile crisis teams	▪ Co-responder teams ▪ Identification of high utilizers	▪ Behavioral health workforce shortage ▪ Appropriate services ▪ Access to services across the state ▪ Lack of housing/supported housing
Pre-Adjudication Diversion	▪ Prosecutor-led diversions ▪ Pretrial release resources ▪ Treatment courts ▪ Recovery peer specialists	▪ Data matching between jail and providers ▪ Court liaisons/navigators ▪ Structured warm handoffs between the jail and providers	▪ Need for data to support programs ▪ Court liaisons/navigators ▪ Not enough services ▪ Difficult to ensure equal access to diversion options
Post-Adjudication Diversion	▪ Treatment courts ▪ Alternative to incarceration sentencing	▪ Specialized behavioral health community supervision caseloads ▪ Benefits enrollment	▪ Housing ▪ Lack of services in rural communities ▪ Lack of transition planning

Person-Centered Justice for Individuals

The NJTF published A New Model for Collaborative Court and Community Caseflow Management in June 2022, which is based on research and data including the Effective Criminal Case Management project. This report established 13 Guiding Principles to strengthen community responses and minimize criminal justice involvement, promote early intervention and effective management of court cases, institutionalize alternative pathways to treatment and recovery and improve outcomes, and manage post adjudication events and transitions effectively. These Guiding Principles include:

1. Encourage all judges to use their leadership role as convenors to foster collaborative community and court strategies to promote community safety and improve outcomes for individuals with behavioral health needs.
2. Promote early intervention consistent with legal and mental health professional standards. Screening, assessment, deflection, diversion, and intervention strategies

should be employed at the initial stages of the process to minimize criminal justice system involvement.

3. Develop new caseflow management systems through a multidisciplinary, non-adversarial team approach to address the complex social and behavioral health issues presented to the courts and communities.
4. Facilitate evidence-based practices across community, court, and behavioral health systems.
5. Identify, measure, and proactively address issues of explicit and implicit bias, disproportionate access to resources, and systemic inequities.
6. Adhere to the principles due process, procedural fairness, transparency, and equal access to justice.
7. Develop trauma-informed, person-centered, responsive practices that focus on individuals with behavioral health needs for all case types and provide multiple pathways to treatment and recovery and diversion.
8. Promote individual attention to each case and each person, and treat all cases and individuals proportionally, demonstrated by judicial control of the process and procedural justice.
9. Treat all individuals with respect and neutrality and grant all individuals a voice, engendering trust in the justice system.
10. Listen to and gather input from individuals with lived experience and their families.
11. Ensure that the new model of collaborative court and community caseflow management provide for accountability, public safety, reduced costs, and improved treatment outcomes by adhering to defined performance measures.
12. Design and foster timely and efficient court and community procedures to improve the justice experience of the individuals with behavioral health needs.
13. Expand leverage, and share resources across community, court, and behavioral health systems.

Sequential Intercept Model

Overview

The Sequential Intercept Model (SIM) was developed by the Policy Research Associates as a conceptual model to inform community-based responses to the involvement of people with mental health and substance use disorders in the criminal justice system. SIM is used as an applied strategic planning tool to improve cross-system collaborations to reduce involvement in the justice system. SIM is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change.[6]

These activities are best accomplished by a team of stakeholders from multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails community corrections, housing, health, social services, people with lived experience, family members, and many others. SIM helps to develop a comprehensive picture of how people with mental and substance use disorders flow through the criminal justice system along six distinct intercept points.[7]

The model depicts the justice system as a series of points of "interception" at which an intervention can be made to divert people from the justice system and prevent them from entering or penetrating deeper into the criminal justice system. [8]

Intercept Points

- **Intercept 0: Community Services**
- **Intercept 1: Law Enforcement**
- **Intercept 2: Initial Detention and Hearings**
- **Intercept 3: Jail and Court**
- **Intercept 4: Reentry**
- **Intercept 5: Community Corrections**

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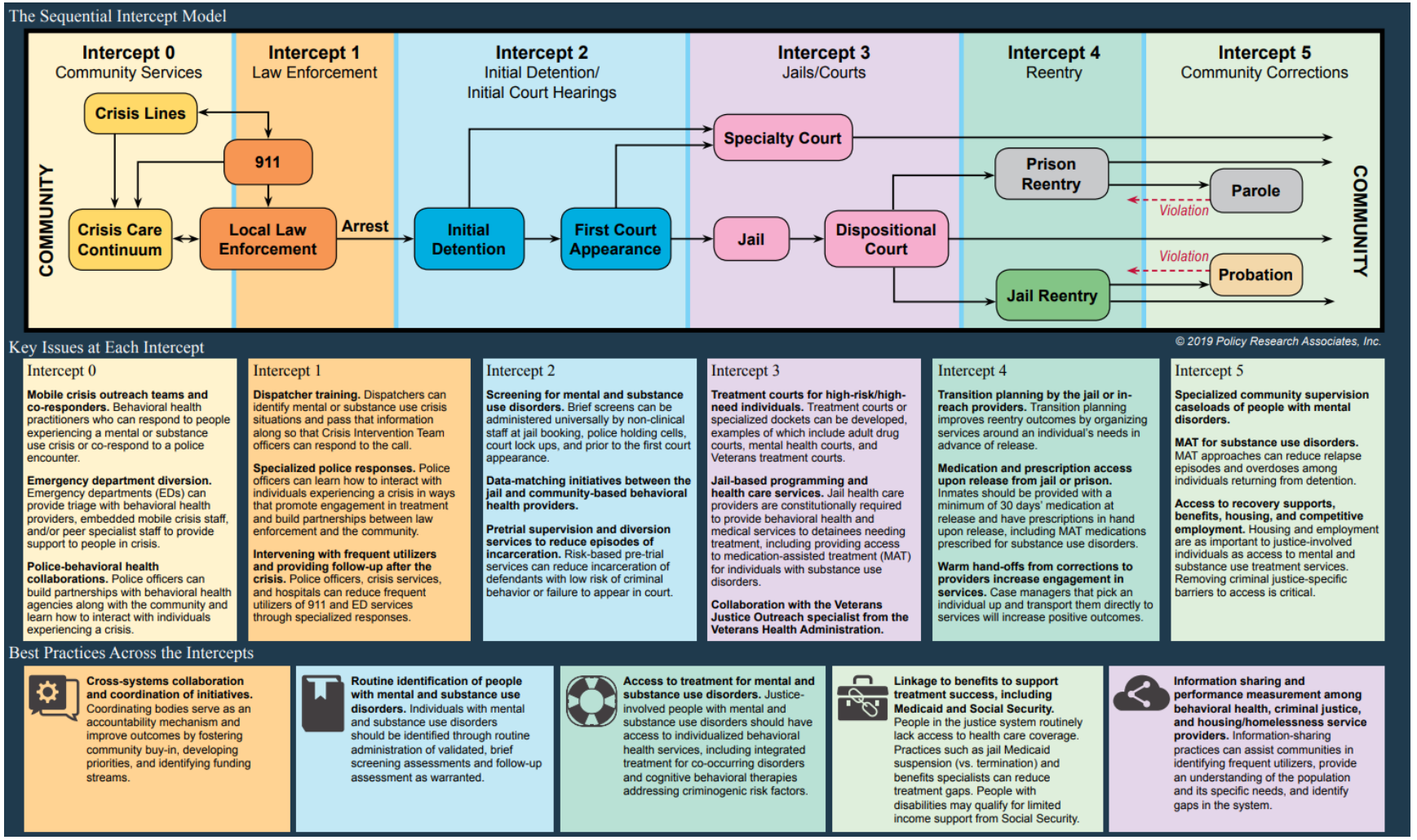
[6] SAMHSA's GAINS Center brochure for The Sequential Intercept Model: https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-brochure.pdf

[7] SAMHSA's GAINS Center brochure for The Sequential Intercept Model: https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-brochure.pdf

[8] Munetz, M.R. & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services,* 57(4), 544-549.

The following model provides an organizing tool for a discussion on how to best address the behavioral health needs of justice-involved individuals at the local level. Using the model, a community can identify local resources and gaps in services, decide priorities for change, and develop targeted strategies to increase connections to treatment and recovery support services.



Best Practices Across the Intercepts

In addition to best practices at each intercept, there are also best practices that should span all the intercepts. This section utilizes language from [The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders][9] to describe best practices across the intercepts.

Cross-systems collaboration and coordination of initiatives. Coordinating bodies serve as an accountability mechanism and improve outcomes by fostering community buy-in, developing priorities, and identifying funding streams.

Routine identification of people with mental health and substance use disorders. Individuals with mental health and substance use disorders should be identified through routine administration of validated, brief screening assessments and follow-up assessment as warranted.

Access to treatment for mental health and substance use disorders. Justice-involved people with mental health and substance use disorders should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.

Linkage to benefits to support treatment success, including Medicaid and Social Security. People in the justice system routinely lack access to health care coverage. Practices such as jail Medicaid suspension (vs. termination) and benefits specialists can reduce treatment gaps. People with disabilities may qualify for limited income support from Social Security.

Information sharing and performance measurement among behavioral health, criminal justice, and housing/ homelessness service providers. Information-sharing practices can assist communities in identifying frequent utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.

[9] PRA, Inc. (2018). *The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders* https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-brochure.pdf

Objectives of a Mapping Workshop

A SIM Mapping Workshop is an opportunity to bring together a multidisciplinary group of stakeholders from the community, behavioral health, and justice systems to share information about existing resources, discuss opportunities for improvement, network, and collaboratively plan for the future. Objectives of a mapping workshop are to:

- Use data to define the issues,
- Develop a comprehensive picture of how people with mental health and/or substance use disorders flow through the criminal justice system along the SIM intercept points,
- Identify gaps, opportunities, and barriers in the existing systems, and
- Identify priorities for improvements and initial development of an action plan to facilitate change.

Kentucky Sequential Intercept Model Mapping

The KJCMH identified a need to implement the Sequential Intercept Model (SIM) throughout Kentucky to identify resources and opportunities to best focus their work. The KJCMH developed a three-phase implementation approach with NCSC outlined below.

1. **Statewide SIM Mapping Workshop**

   State leadership planning, coordination, and capacity building sets the understanding and foundation for the rest of the work. Identifying resources and gaps, initiatives, and priorities at a state level sets the foundation for local mapping. It also provides support for counties to accomplish their goals. For example, not all changes can be accomplished at a local level. Sometimes changes need to be accomplished at a state level including changes to statutes.

2. **Training Facilitators to Conduct Local Mapping Workshops**

   Once the state mapping is complete, planning for and training facilitators will occur in coordination with NCSC.

3. **Local Mapping Workshops**

   NCSC will then work with facilitators to complete the first local mapping workshop. Facilitators will work with NCSC in the planning, execution, and follow up of the first local mapping. Then facilitators will conduct additional local mapping workshops across the state with NCSC providing TA support.

This report provides a summary of the Kentucky Statewide Sequential Intercept Mapping Workshop.

Kentucky Context

Overview

Kentucky has a history of embracing change, and the Kentucky Judicial Commission on Mental Health (KJCMH) has embraced a comprehensive approach to engagement in various activities leading up to the development of this report and recommendations. There were several driving factors for the creation of the KJCMH.

The Kentucky Court of Justice (KCOJ) launched the Responsive Education to Support Treatment in Opioid Recovery Efforts (RESTORE), made possible by a grant provided by SAMHSA to the Department of Behavioral Health supporting the Kentucky Opioid Response Efforts. The KCOJ launched the RESTORE initiative in 2019 to give judges, circuit court clerks, and court personnel best court practices to support the treatment of opioid use disorder and other substance use disorders. The initiative was led by the RESTORE Leadership Team, consisting of circuit, district, and family court judges, as well as management and staff from the Department of Family and Juvenile Services, Specialty Courts, and Pretrial Services. The RESTORE initiative focused on providing current and consistent training throughout Kentucky on opioid use disorder (OUD) to the judiciary and KCOJ personnel.

Concurrently, in 2020, the Kentucky Administrative Office of the Courts (AOC) received a grant from the State Justice Institute (SJI) to assess the court system's access to and use of mental health and substance use treatment and recovery supports within the community. The AOC used this funding to contract with the Crime and Justice Institute (CJI) to conduct a qualitative assessment of strengths, opportunities, and challenges that Kentucky judges, court personnel, and stakeholders experience when trying to connect individuals to services. The project's overarching goal was to explore the courts' readiness to shift to a recovery-oriented system of care model (ROSC). In March 2021, CJI completed its assessment and presented a final report titled "Recovery-Oriented Systems of Care: Needs and Opportunities for Kentucky's Court System." The report provides an overview of the project, explains the ROSC model, and details CJI's findings and recommendations. Acknowledging that the courts are a critical piece of Kentucky's system of care has proved to be a powerful impetus for change; the ROSC model recognizes that recovery is a unique process rather than an end goal, and that responses must adapt to an individual's evolving needs.

Following and in response to the CJI report, in June 2022, the RESTORE Leadership Team released a publication titled "Setting the Direction for Kentucky's Recovery-Oriented System of Care." This report began the transition from RESTORE to the KJCMH. Recommendations from the CJI report highlighted in the RESTORE report included convening an AOC working group to develop a vision, goals, values, and key definitions for the ROSC project, as well as identifying

key areas of the state in which to pilot local ROSC efforts. In alignment with these recommendations, the AOC appointed the RESTORE Leadership Team as the AOC Working Group, and the Working Group met over the next year to develop the framework for implementation of Kentucky's ROSC.

In April 2022, Kentucky sent a multidisciplinary team to the regional summit, *Improving the Court and Community Response to Individuals with Mental Illness* held by the Conference of Chief Justices (CCJ), Conference of State Court Administrators (COSCA), and the National Judicial Task Force to Examine State Courts' Response to Mental Illness (NJTF). Information gleaned from this event as well as guidance from the AOC Working Group and oversight from the Kentucky Supreme Court led to the establishment of the KJCMH. The Office of Statewide Programs is tasked with overseeing the movement of the courts toward the ROSC model.

To facilitate this movement, the KJCMH will follow the recommendations in "State Courts Leading Change: Report and Recommendations," published by the National Center for State Courts (NCSC) in partnership with the CCJ, COSCA, and SJI. The report is national in scope, resulting from the work of a Task Force Executive Committee comprised of Chief Justices and State Court Administrators and founded in 2020. Three task force work groups met regularly over two years to collect and analyze information, discuss and debate best responses, and develop tools and resources to be used to lead and guide system improvements. During this time, five multiday regional summits were hosted by the NJTF; teams from 45 states and territories attended the summits; and 36 states requested and are receiving technical assistance from NCSC to conduct system assessments. Kentucky is one of 36 states working with NCSC's direction, alongside the KJCMH.

The KJCMH was established on August 11, 2022, by the Kentucky Supreme Court 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 KJCMH is comprised of members from the executive, judicial, and legislative branches of government. Organizational charts for each cabinet are included in Appendix A.

The impediments, as identified by the Kentucky Supreme Court, 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 abuse disorder, and/or intellectual disability challenges; and
6. A lack of community resources to provide adequate services to minors, adults, and families.

The goals, purposes, and responsibilities of the commission are to:

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; and
9. Provide regular progress reports to the Supreme Court of Kentucky.

There are three main subcommittees that are overseen by the Executive Committee, which include the Criminal Justice Committee, the Civil and Family Justice Committee, and the Treatment and Access Committee. Each of those committees have numerous workgroups to address specific subject matter such as: Prearrest/Diversion; Competency Restoration; Juvenile Justice; Guardianship and Commitment; Domestic Violence; Dependency, Neglect and Abuse; Strengthening Communities; System Mapping; and Court Responses to Mental Health and Intellectual and Development Disabilities.

The KJCMH is comprised of 74 representatives from the judicial and legal communities; the juvenile, criminal, and child protection systems; the legislature; the business community; organizations with a substantial interest in mental health matters; and other state and local leaders who have demonstrated a commitment to behavioral health, including mental health, substance use, and intellectual disabilities issues that affect Kentuckians. A full list of the KJCMH members and its organizational structure can be found in Appendix B. The KJCMH plans to meet quarterly, and the committees will meet monthly.

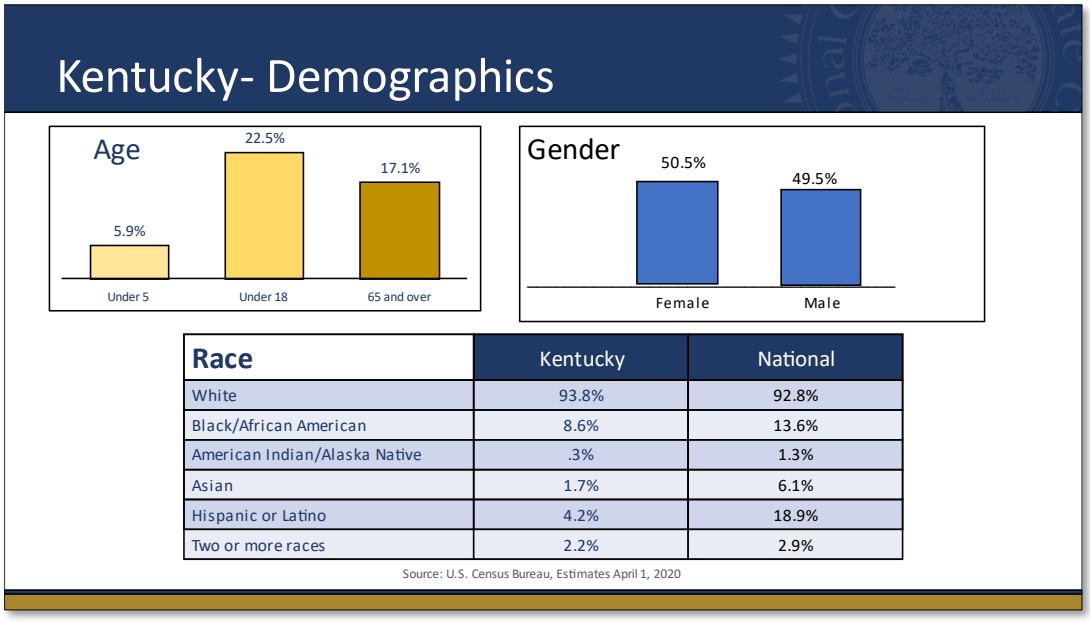
On December 13, 2022, NCSC conducted a presentation on the Sequential Intercept Model and Leading Change for the KJCMH to discuss the SIM, review the three phases of implementation, and plan for the statewide SIM Mapping Workshop scheduled for February 16-17, 2023.

During the mapping workshop, NCSC provided an overview of the SIM, national and state data, and worked with Kentucky leaders to identify state behavioral health initiatives, state behavioral health policies and legislation, resources, gaps, and opportunities for adults with mental health and substance use disorders at each intercept. NCSC also utilized the SIM to develop priorities for action plans designed to improve Kentucky's statewide system– and state-level responses to the targeted population. An agenda for the statewide SIM Mapping Workshop is included in Appendix C and a list of the workshop participants is included in Appendix D.

Statement of the Issue

An analysis of current, localized data is extremely important to gain an understanding of the statewide landscape when defining the issue and is critical in developing a continuum of services while reducing justice system involvement of people living with behavioral health disorders. Data can inform the volume of people with mental health and substance use disorders and the capacity of community, behavioral health, and criminal justice systems to route people into appropriate services at each intercept. Data can illuminate where gaps or insufficiencies in the continuum of behavioral health services may be contributing to significant impacts on the criminal justice system.[10]

As of 2020, Kentucky has 4.5 million residents of which 16.5% are living in poverty which is higher than the national poverty rate of 12.8%. Kentucky residents are nearly equal in gender, with a majority being white and less diverse when compared to national data.



Race	Kentucky	National
White	93.8%	92.8%
Black/African American	8.6%	13.6%
American Indian/Alaska Native	.3%	1.3%
Asian	1.7%	6.1%
Hispanic or Latino	4.2%	18.9%
Two or more races	2.2%	2.9%

Source: U.S. Census Bureau, Estimates April 1, 2020

[10] PRA, Inc. (2019). *Data Collection Across the Sequential Intercept Model: Essential Measures* developed for SAMHSA as a GAINS Action Brief. https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/data_across_the_sim.pdf

The poverty rate in Kentucky (16.5%) is higher than the national poverty rate of 11.6% and the state's median household income ($55,454) is 24.5% lower than the national average, $69,021.

Kentucky- Housing and Income

Housing

Number of Housing Units – 2,008,239
Owner occupied – 67.8%
Median Value - $155,100

Income/Poverty	Kentucky	National
Median household income	$55,454	$69,021
Per capita Income past12 months	$30,634	$37,638
Persons in poverty	16.5%	11.6%

Source: U.S. Census Bureau, Estimates July 1, 2021

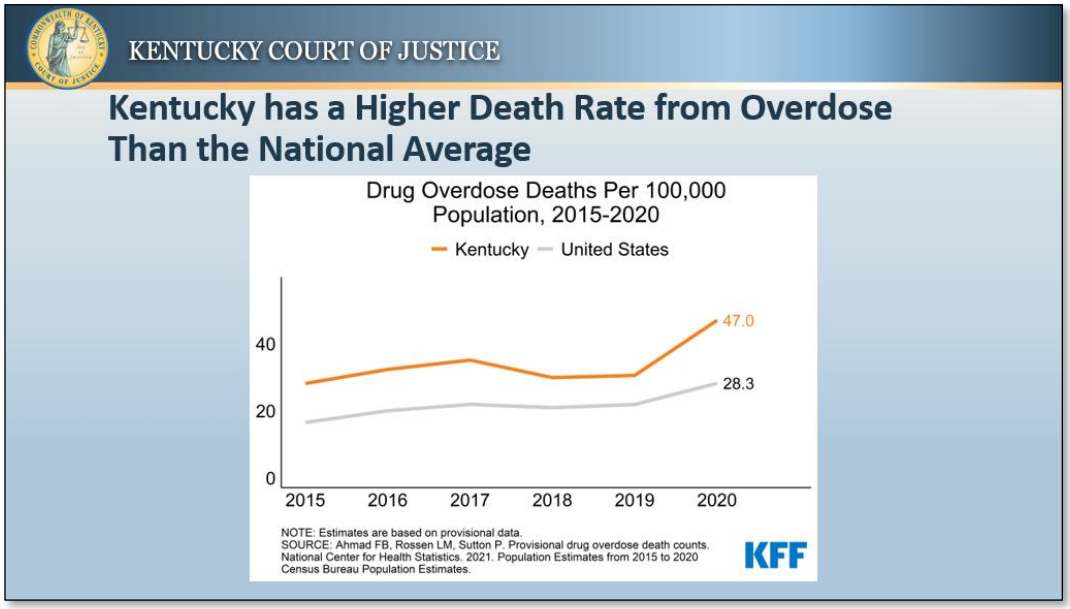
Approximately 14% of the population did not complete high school or equivalency compared to 11% nationally. Nearly 10% of Kentuckians do not have a computer and 16% do not have internet access.

Kentucky– Education

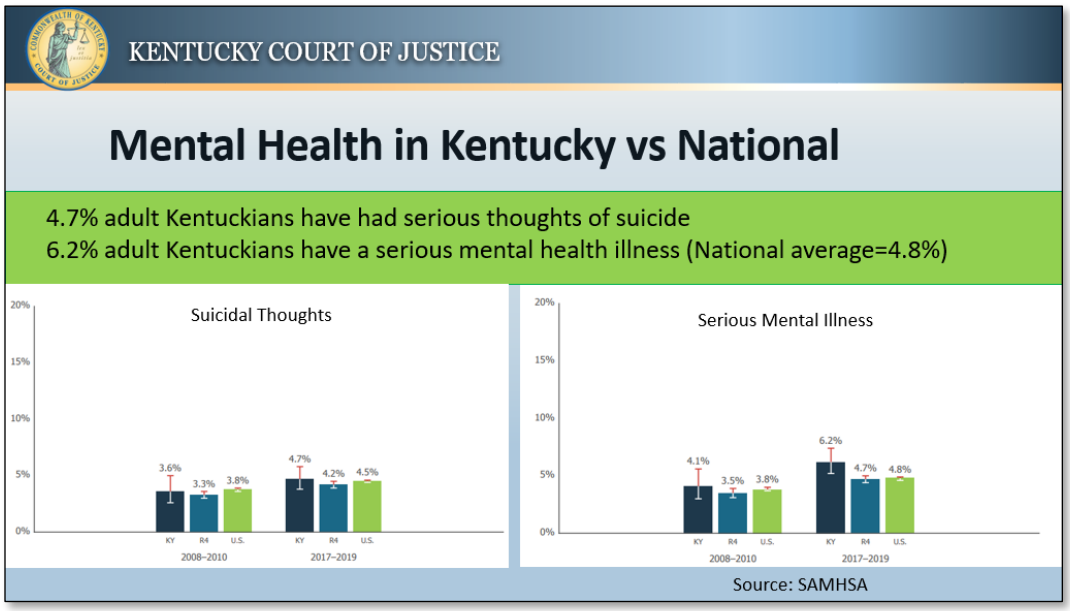
Education	Kentucky	National
High School graduate or higher	87.7%	88.9%
Bachelor's degree or higher	25.7%	33.7%
Computer/Internet		
Households with computer	90.2%	93.1%
Households with internet subscriptions	83.6%	87.0%

U.S. Census Bureau, Estimates Jul 2021

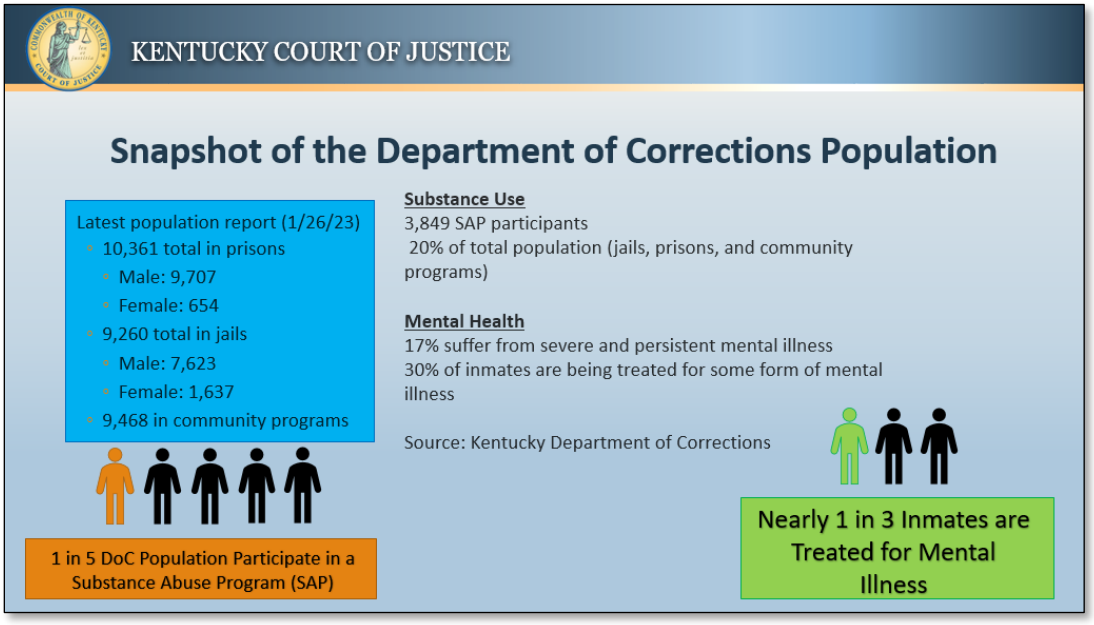
According to Kentucky data, approximately 5% of Kentuckians have been diagnosed with an alcohol use disorder, 7.5% have been diagnosed with a substance use disorder, and 28,452 individuals are currently enrolled in substance use treatment. Further, in 2021, there were 2,250 overdose deaths, which is a 14.5% increase from 2020. Fentanyl was identified in 1,639 drug overdose deaths, which accounted for 72.8% of total overdose deaths. In total, Kentucky had 49.2 overdose deaths per 100,000, which is ranked the second highest in the nation behind West Virginia.



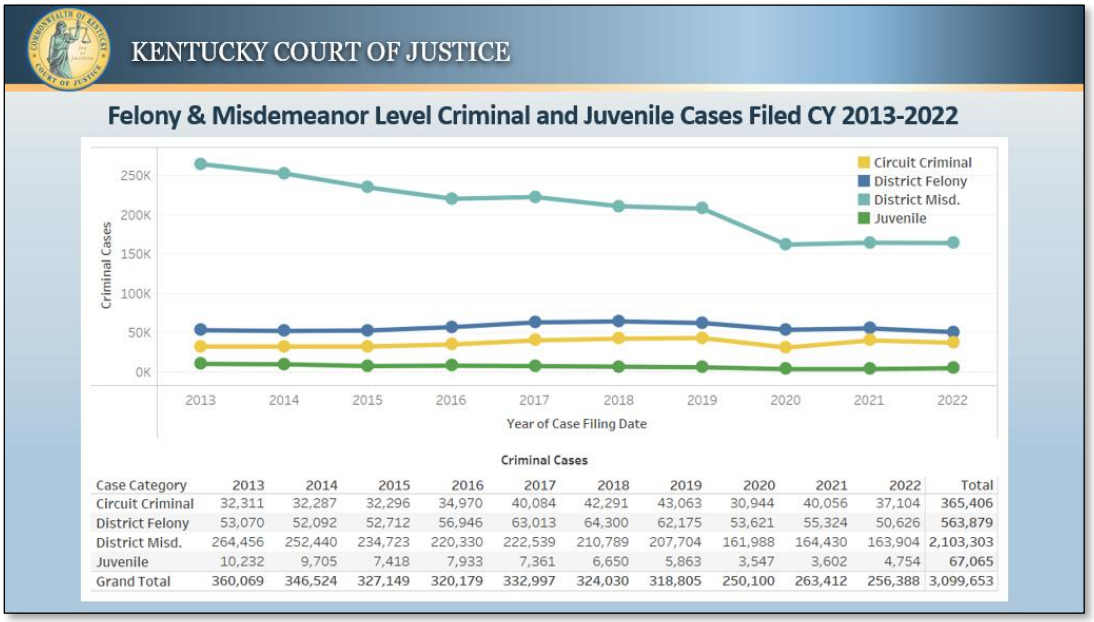
Kentucky NAMI as well as the CDC report that 746,000 adults in Kentucky have been diagnosed with a mental health condition; of those 189,000 have been diagnosed with a serious mental illness.



According to the Kentucky Department of Corrections, one third of the corrections population receives services for mental health and 20% participate in substance abuse programming.



Kentucky Criminal Felony, Misdemeanor, and Juvenile case filing have been fairly consistent since 2013; however, there was a large decrease in filings of District Misdemeanor cases from 2019 to 2020, but the number has remained consistent since 2020.



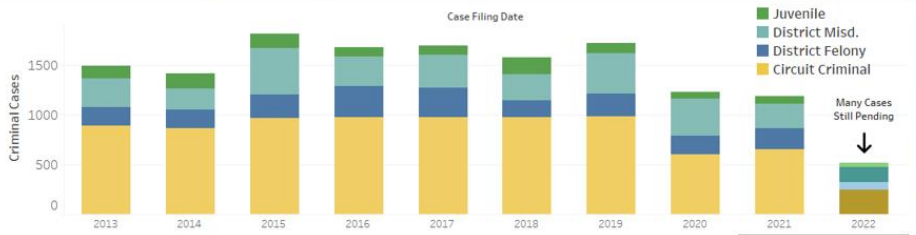
Criminal Cases

Case Category	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
Circuit Criminal	32,311	32,287	32,296	34,970	40,084	42,291	43,063	30,944	40,056	37,104	365,406
District Felony	53,070	52,092	52,712	56,946	63,013	64,300	62,175	53,621	55,324	50,626	563,879
District Misd.	264,456	252,440	234,723	220,330	222,539	210,789	207,704	161,988	164,430	163,904	2,103,303
Juvenile	10,232	9,705	7,418	7,933	7,361	6,650	5,863	3,547	3,602	4,754	67,065
Grand Total	360,069	346,524	327,149	320,179	332,997	324,030	318,805	250,100	263,412	256,388	3,099,653

Over the past nine years, competency hearings increased from 2015 through 2019 but have since decreased. The number of filings is lower than prior to 2013 with the most frequent filings being in Circuit Criminal Court and the least filings in Juvenile Court. It is noted that District Misdemeanor hearings exceed District Felony hearings.

KENTUCKY COURT OF JUSTICE

Competency Hearings in Felony/Misdemeanor Level Crim Cases Filed CY 2013-2022



Year of Case Filing Date

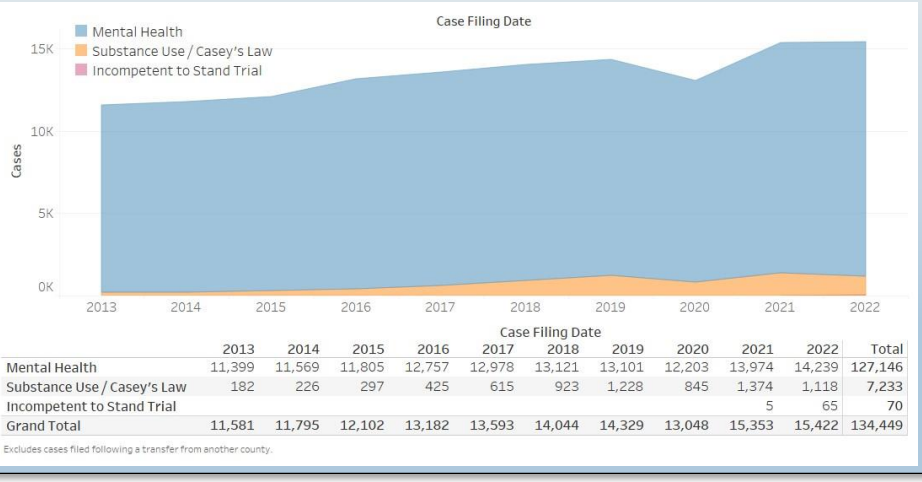
Case Category		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
Circuit Criminal	Cases	595	566	610	587	620	600	596	386	400	161	5,121
	Hearings	893	869	968	980	974	975	989	607	658	245	8,158
District Felony	Cases	106	106	135	162	148	99	117	86	102	57	1,118
	Hearings	186	182	238	314	300	174	225	184	209	81	2,093
District Misd.	Cases	191	132	218	189	178	155	208	190	138	97	1,696
	Hearings	289	212	466	295	328	257	406	373	248	146	3,020
Juvenile	Cases	81	101	83	70	72	85	60	32	36	32	652
	Hearings	123	155	148	95	93	170	107	70	70	45	1,076
Grand Total	Cases	973	905	1,046	1,008	1,018	939	981	694	676	347	8,587
	Hearings	1,491	1,418	1,820	1,684	1,695	1,576	1,727	1,234	1,185	517	14,347

One in...
71 Circuit Criminal
503 District Felony
1,239 District Misd.
102 Juvenile
Cases Includes a Competency Hearing

Involuntary Commitment cases have steadily risen since 2013 with a sharp increase between 2020 and 2021.

KENTUCKY COURT OF JUSTICE

Involuntary Commitment Cases Filed CY 2013-2022

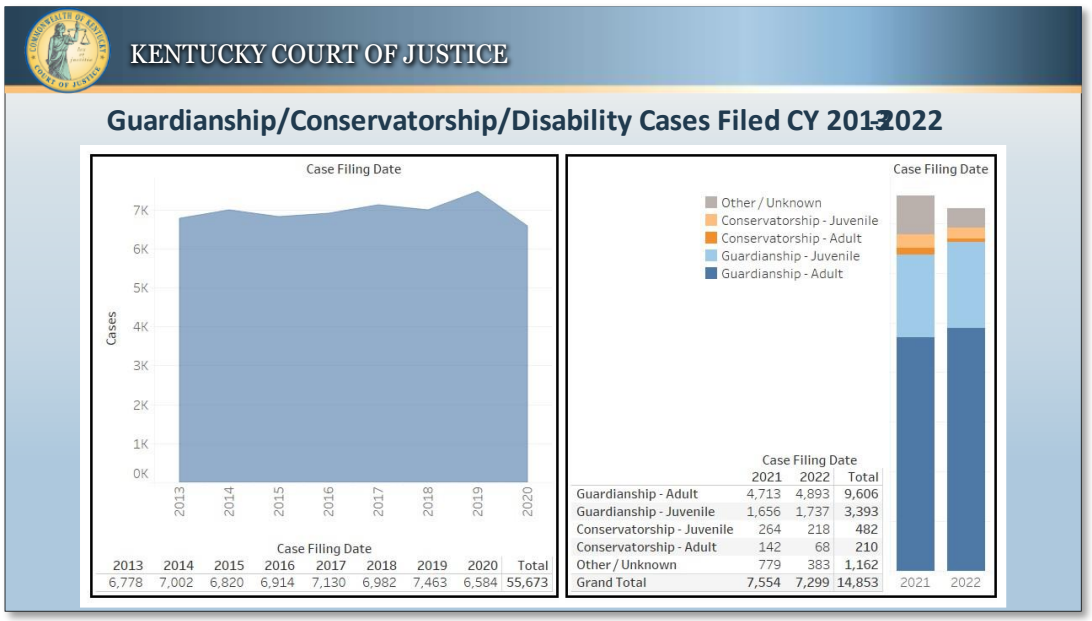


Case Filing Date

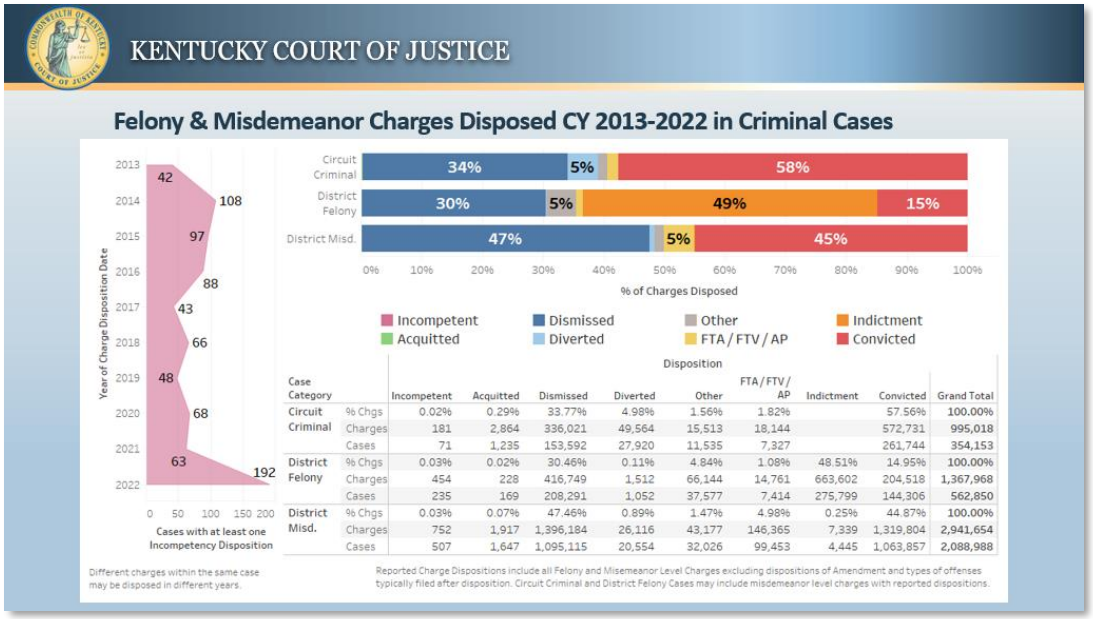
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
Mental Health	11,399	11,569	11,805	12,757	12,978	13,121	13,101	12,203	13,974	14,239	127,146
Substance Use / Casey's Law	182	226	297	425	615	923	1,228	845	1,374	1,118	7,233
Incompetent to Stand Trial									5	65	70
Grand Total	11,581	11,795	12,102	13,182	13,593	14,044	14,329	13,048	15,353	15,422	134,449

Excludes cases filed following a transfer from another county.

Guardianship, Conservatorship, and Disability cases remain steady between 2013 and 2019 with a decrease of approximately 1000 cases from 2019 to 2020.



Closure rates for Felony and Misdemeanor cases are defined below.



Goals of the Kentucky Mapping Workshop

The overall goals specific to the Kentucky Sequential Intercept Model Mapping Workshop were to detail how individuals with mental health and substance use disorders come into contact with and move through the criminal justice system; identify resources and opportunities, establish priorities for improvement, and create a strategic and sustainable action plan; improve the court and community response to persons with behavioral health disorders through multidisciplinary community collaborations implemented with appropriate resources; ensure an inclusive list of stakeholders participate in the mapping workshop; and to use data to define the issues.

Participants brainstormed additional goals including:

- Connecting individuals to services without arrest and to focus on front-end services to include self-determination of care/patient autonomy;
- Gain baseline knowledge of resources that exist, break down silos, share information, and strengthen existing resources and connections;
- Understand and identify opportunities to increase services and funding streams to fill those opportunities.

State of the State

Initiatives, Policies and Procedures, and Legislation

It is important to start with identifying the work and progress that has already been initiated or completed within the state to not only gauge the progress already achieved, but to also ensure all participants from multiple disciplines are knowledgeable of the work being done by all entities. As commonly found when bringing various stakeholders together, nearly all the participants learned about initiatives, policies and procedures, and legislation that they had not been aware of prior to attending the workshop.

Participants identified current Kentucky initiatives that support the work of the KJCMH. One such initiative is Senate Bill 90 (SB 90) which was signed by the governor on April 20, 2022. This bill establishes pilot programs in 10 counties to participate in a behavioral health conditional dismissal program. The programs started on January 1, 2023, and last for a minimum of four years. The programs include medication-assisted treatment, recovery services, and educational and vocational resources. The pilot programs are designed to provide eligible participants with a behavioral health disorder who have been charged with a qualifying offense an alternative to receive treatment and recovery support services addressing the behavioral health disorder instead of incarceration, resulting in dismissal of the charges upon successful completion. [11]

[11] https://apps.legislature.ky.gov/recorddocuments/bill/22RS/sb90/bill.pdf

Another identified initiative is the Kentucky Opioid Response Effort (KORE). Through federal funding from the Substance Abuse and Mental Health Services Administration (SAMSHA), KORE seeks to expand and sustain a comprehensive, evidence-based, recovery-oriented system of care to end the opioid epidemic in Kentucky. [12]

The Kentucky State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC)is a group consisting of state agency representatives, a youth, a parent of a child or transition-age youth with a behavioral health need, and a member of a nonprofit family organization. SIAC oversees coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families. There are currently 18 Regional Interagency Councils (RIACs) across the Commonwealth of Kentucky which operate the locus of accountability.[13]

The Kentucky Homelessness Prevention Project (194A.735) supports the work of the KJCMH in granting the Cabinet for Health and Family Services and the Justice and Public Safety Cabinet the ability to develop and implement institutional discharge planning to persons with serious mental illness, persons between the ages of 18 and 25 who may be at risk of developing serious mental illness who are being released from a mental health facility, or persons with a history of multiple utilizations of health care, mental health care, or judicial systems. This act also applies to individuals being released from any state-operated prison or who are aging out of foster care. The goal of the project is to prepare the individuals listed above for reentry into the community

[12] https://www.chfs.ky.gov/agencies/dbhdid/Pages/kore.aspx

[13] https://dbhdid.ky.gov/dbh/siac.aspx

and to offer information about any necessary linkage of the person to needed community services and supports.[14]

Kentucky also instituted the Recovery Ready Communities Certification Program, which is designed to provide a quality measure of a city or county's substance use disorder (SUD) recovery efforts. This creates the opportunity to evaluate a community's current SUD programs and interventions in a framework that is designed to maximize public health outcomes among Kentuckians suffering from SUD.[15]

The Kentucky State Police Angel Initiative is a proactive approach offering an alternative escape to those battling addiction. Anyone battling addiction can come to any Kentucky State Police post and get help finding treatment with no questions asked.

Casey's Law provides a means of intervening with someone who is unable to recognize his or her need for treatment due to their impairment. The law allows parents, relatives, and/or friends to petition the court for treatment on behalf of the substance abuse-impaired person.

Tim's Law allows for loved ones of people suffering from mental illness to go to district court to begin a legal process of filing a petition that will mandate that they get the treatment that they need to protect themselves and protect others.

Prison to Pipeline is a program that connects inmates with potential employers through virtual interviews so they can leave prison or jail with a job already waiting.[16]

Key Issues, Resources, and Opportunities at Each Intercept

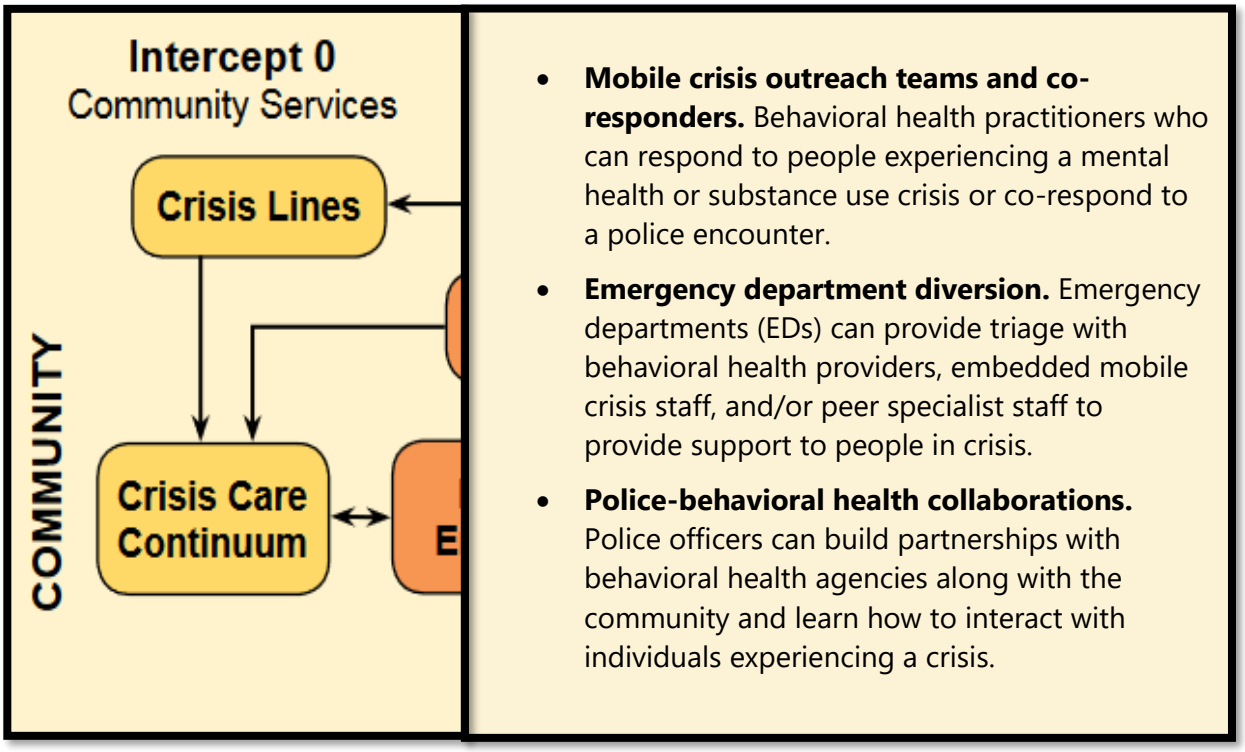
One of the main activities of SIM mapping is to identify resources and opportunities at each intercept of the Sequential Intercept Model. This section takes language from two Policy Research Associates publications on SIM, The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders and Data Collection Across the Sequential Intercept Model: Essential Measures to explain best practices at each intercept. After the explanation of each intercept, identified Kentucky resources and opportunities are summarized.

[14] https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=52405

[15] https://rrcky.org/

[16] https://www.courier-journal.com/story/news/local/2022/11/07/prison-to-work-plan-aims-to-bolster-kentucky-workforce/69627409007/

Intercept 0



Intercept 0 involves interventions for people with mental health and substance use disorders prior to formal involvement with the criminal justice system. The critical components of this intercept include the local continuum of crisis care services and resources that reduce reliance on emergency response, hospitalizations, and law enforcement to serve people in crisis or with low-acuity mental health needs. The following two tables list the identified resources and opportunities for Intercept 0.

Table 2: Kentucky Intercept 0: Community Services Resources

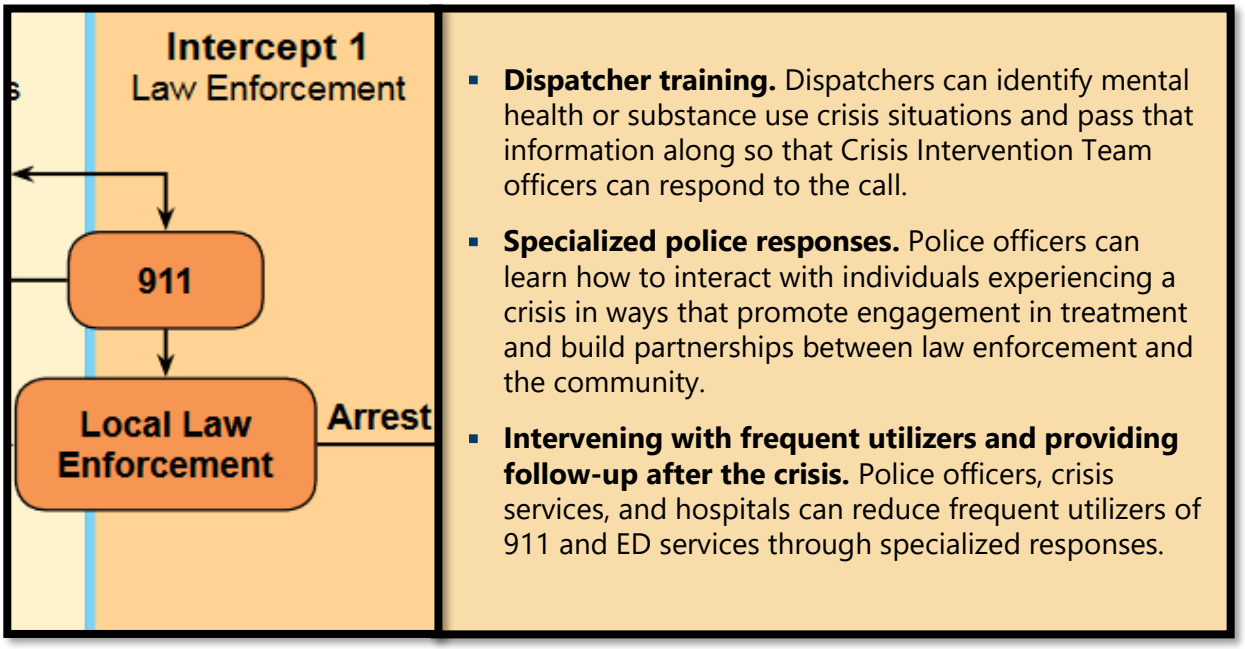
Intercept 0: Community Services Resources	
988	Hospitals
211 (United Way)	Justice and Mental Health Collaboration Program
Adult education	KYNECT
Advocacy (i.e., NAMI, protection & advocacy)	Medicaid waivers
Availability of medications for opioid use disorder (MOUD)	Payee services
Behavioral health service organizations	Peer support
Churches/religious organizations	Quick response teams

Intercept 0: Community Services Resources	
Community action programs	Recovery housing
Community mental health centers (CMHCs)	Shelters
Crisis beds	Substance use services
Family Resource Youth Services Coalition of Kentucky	Telehealth
Family support services	Victim service agencies
Find Help Now KY	Victim services hotlines
Food services	

Table 3: Kentucky Intercept 0: Community Services Opportunities

Intercept 0: Community Services Opportunities	
988 does not connect to services, triggers law enforcement pickup	Insufficient preventative services for adults (stigma)
Abstinence-Only programs	Intensive discharge planning
CMHC inconsistency in delivery of services	No parity in mental health coverage
Crisis stabilization and standards	Paternalistic approach in the system
Deflection teams/Alternative Response Model	Penalties for noncompliance
Discharges to homelessness	Sharing of information with media/news
Housing (lack of supportive and affordable housing)	Transportation
IDD crisis services	Wayfinding (navigating the system)

Intercept 1



At Intercept 1, law enforcement and other emergency service providers respond to people with mental health and substance use disorders who are in crisis in the community. When a person in crisis exhibits illegal behavior, law enforcement officers have the discretion to place the person under arrest or divert them to treatment or services. Effective diversion at Intercept 1 is supported by trainings, programming, and policies that integrate behavioral health care and law enforcement to enable and promote the deflection of people with mental illness away from arrest and a subsequent jail stay and into community-based services. Tables 4 and 5 list the resources and opportunities identified for Intercept 1.

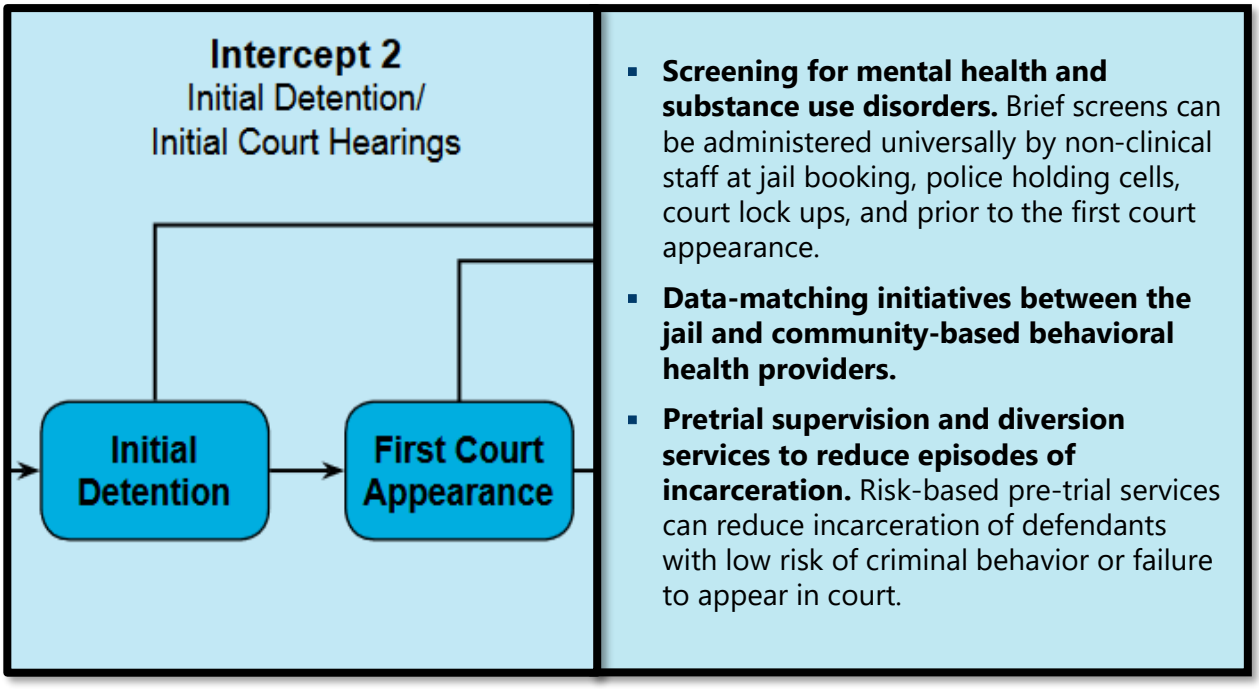
Table 4: Kentucky Intercept 1: Law Enforcement Resources

Intercept 1: Law Enforcement Resources	
Availability of court services	Grants
CIT training	KRS202A.041 Warrantless Arrest
Crisis lines	My Autism Tribe
Crisis response teams	NARCAN/harm reduction
Data	NCIC
Department for Community Based Services	Secure transportation to jail or hospital
Emergency services (fire and ambulance)	Social Workers hired in law enforcement
Funding	Take Back program

Table 5: Kentucky Intercept 1: Law Enforcement Opportunities

Intercept 1: Law Enforcement Opportunities	
Best practices responding when child is on the scene	Hospital distance
Data sharing	Knowledge of mental health training
De-Escalation training	Mental health first aid
Dispatcher training	NAMI partnership
Divert to crisis stabilization	Secondary trauma
Education of involuntary procedures	Self-care
Equity and Inclusion	Youth crisis

Intercept 2



At Intercept 2, individuals who have been arrested will go through the intake and booking process and will have an initial hearing presided over by a judicial official. Important elements of this intercept include the identification of people with mental health and substance use disorders being processed and booked in the jail, placement of people with mental health and substance use disorders into community-based treatment after intake or booking at the jail, and availability of specialized mental health caseloads through pretrial service agencies. Workshop participants identified statewide resources as well as opportunities for Intercept 2.

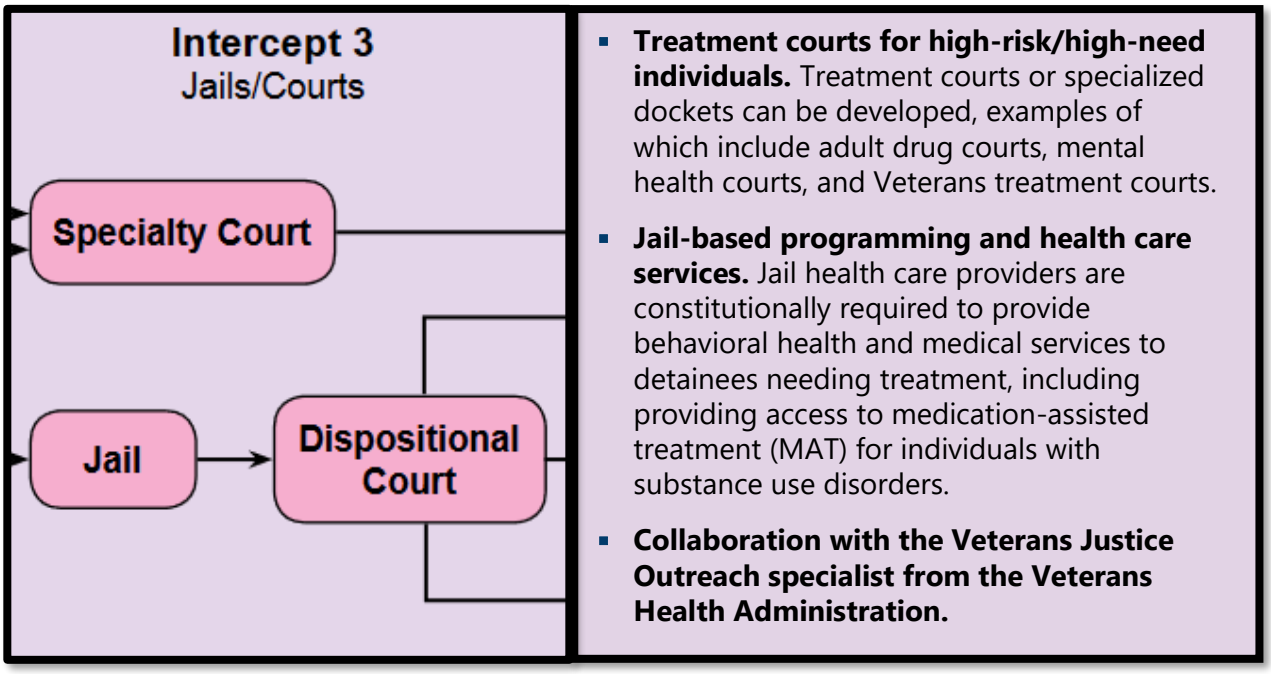
Table 6: Kentucky Intercept 2: Initial Detention/Initial Court Hearings Resources

Intercept 2: Initial Detention/Initial Court Hearings Resources	
Alternative sentencing worker program	Pretrial administrative program
Attorney	Pretrial Substance Abuse Program (PSAP)
Jail triage line	Veterans outreach specialist
Narcan supply	

Table 7: Kentucky Intercept 2: Initial Detention/Initial Court Hearings Opportunities

Intercept 2: Initial Detention/Initial Court Hearings Opportunities	
Communication between pretrial and defense	Lack of uniformity among jails
Correction officer training on interacting mental health justice-involved persons	Mental health diversion program (evidence based vs. compliance)
De-stigma training and flag system for front-line staff	Mental health network
Disclosure of privileged information	Pretrial monitoring
Expansion of SB90	PSAP limitations
Expansion of text notification	Services vary by county
Front load housing	Voices of Hope (peer support)
Jail	

Intercept 3



At Intercept 3, individuals with mental health or substance use disorders who have not yet been diverted at previous intercepts may be held in pretrial detention while awaiting disposition of their criminal cases. This intercept centers around diversion of individuals from the jail or prison into programs or services that allow criminal charges to be resolved while also addressing the defendant's mental health and substance use disorder needs. The intercept also involves jail- and prison-based programming that supports defendants in a trauma-informed, evidence-based manner during their incarceration. Tables 8 and 9 list the resources and opportunities that workshop participants identified.

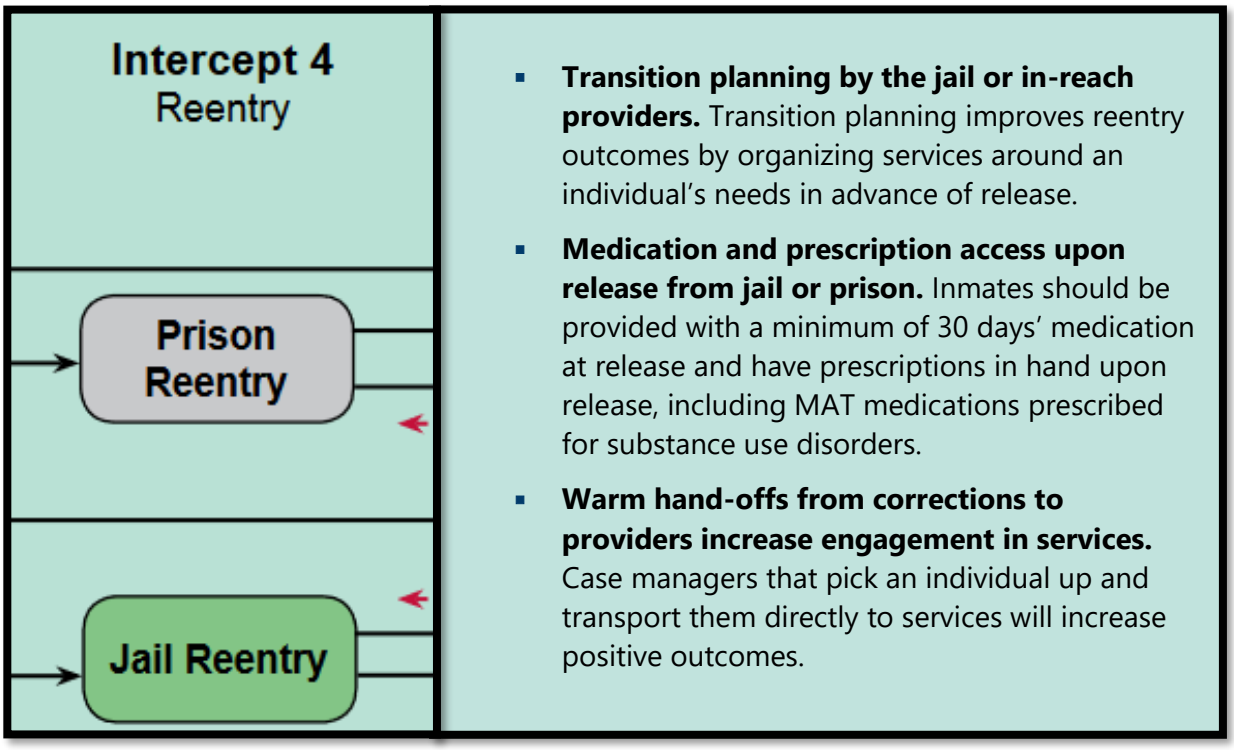
Table 8: Kentucky Intercept 3: Jails/Courts Resources

Intercept 3: Jails/Courts Resources	
504 plans	Kentucky Correctional Psychiatric Center
Alternative sentencing	Language line
Casey's Law/Tim's Law	Reentry assistance
Challenges programs	Specialty courts
Embedded social workers	Substance abuse program (jail)
Friends of the Court	Veterans justice outreach
Guardianship	Victim's advocacy services
Jail petition to move mental health to prison pretrial	

Table 9: Kentucky Intercept 3: Jails/Courts Opportunities

Intercept 3: Jails/Courts Opportunities	
Access to veteran resources	Lobby legislature to update mental health laws (community partners)
CMHC evaluate and prescribe meds to those incarcerated	Medication Assisted Treatment/MOUD in jails
Data sharing	Resources different at jail and prison
Embedded social workers	Specialty courts
Encourage jails to have mental health component	Stigma
Expanded use of Tim's Law	Telehealth/video appointments for those incarcerated
Guided interviews	Training for court staff

Intercept 4



At Intercept 4, individuals transition from detention or incarceration in a jail or prison back to the community. This intercept requires transition planning with specific considerations to ensure people with mental health and substance use disorders can access and utilize medication and psychosocial treatment, housing, healthcare coverage, and services from the moment of release

and throughout their reentry back into the community. The following tables list resources and opportunities as they pertain to Intercept 4 in Kentucky.

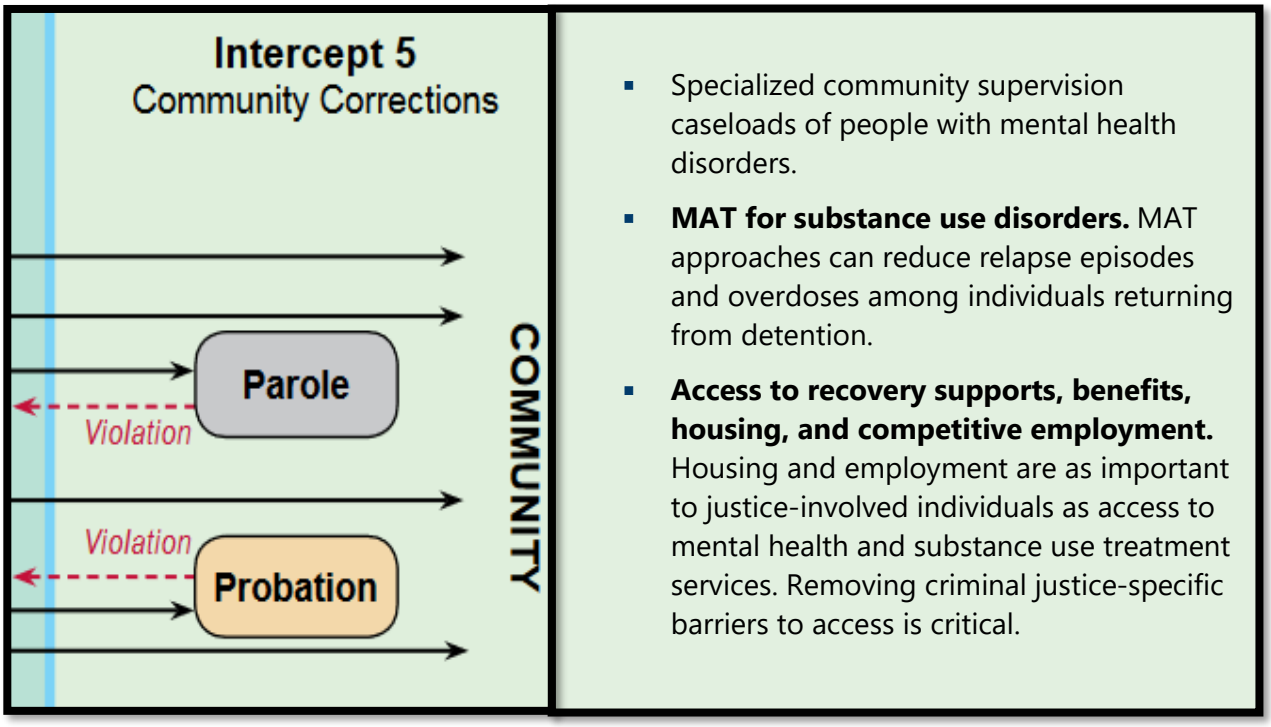
Table 10: Kentucky Intercept 4: Reentry Resources

Intercept 4: Reentry Resources	
26 Local provider networks	Reentry employment coordinators
Correctional psychiatric treatment unit	Risk assessment tools
Existing relationships with specialty courts	RKC (reentry service centers)
ID project	Sex offender treatment programs
Halfway housing	Social service clinicians (addiction)
Kentucky Adult Education (KYAE) at 13 of 14 DOC facilities	Technology (tablets)/phone app
Kentucky Correctional Institution for Women	Transportation pilot
Peer supports	Veterans assistance reentry specialist
Reentry coordinators	

Table 11: Kentucky Intercept 4: Reentry Opportunities

Intercept 4: Reentry Opportunities	
Accountability of treatment (evidence-based)	Lack of funding
Continuum of care	Medication facilitation
Cross-agency connections and ideas (child welfare)	Memorandums of Understanding
Cross-system data sharing	Non-felony assistance
Educational resource	Quality of services (data supported)
Expungement clinics/community partners	Technology
Inflexible sentencing options	Those who served out don't get case management
Jail/prison disconnection & consistency of services	Transition communication
Lack of Bureau of Prison data	

Intercept 5



At Intercept 5, community corrections agencies (also called probation and parole) provide essential community-based supervision as an arm of the court to individuals released to the community. People with mental health and substance use disorders may be at risk for probation or parole violations and benefit from added supports at this intercept. Use of validated assessment tools, staff training on mental health and substance use disorders, and responsive services such as specialized caseloads are vital to reducing unnecessary violations, decreasing criminal re-offense, and improving behavioral health outcomes through enhanced connections to services and coordination of behavioral health treatment and criminal justice supervision goals. The following two tables list the resources and opportunities identified for Intercept 5.

Table 12: Kentucky Intercept 5: Community Corrections Resources

Intercept 5: Community Corrections Resources	
Agency for Substance Abuse Policy	Job training/transformational employment
Assertive community treatment	Kentucky Judicial Commission on Mental Health
Chamber of Commerce	Medicaid 1115 waiver
Community mental health center	Peer-operated recovery supports
Community-operated recovery treatment centers	Pretrial services and specialty courts

Intercept 5: Community Corrections Resources	
Community supervision	Private providers
Department of Corrections – Felonies	Reentry and Recovery Support Services (transportation, support/benefits, system navigation, job training)
Evidence-based modalities	TA groups
Federally-qualified healthcare center	Transportation pilot
Harm reduction agencies	Veterans assistance

Table 13: Kentucky Intercept 5: Community Corrections Opportunities

Intercept 5: Community Corrections Opportunities	
Community Mental Health Centers	Collaboration and communication between providers, courts and public agencies needs to be accurate, timely, and meaningful
Terminology/lexicon	Laws pertaining to information sharing
Unexamined policies	Expand appropriate system intervention
Cross-system understanding & transparency	Efficient sharing of resources between agencies and providers
Grand funding restrictions	Coordination and strategy on openings in services
Paperwork/box checking	Gender, sexuality, race, ethnicity, disabilities, foreign languages

Action Plans

Workgroups for action planning were divided by subject matter including competency restoration, court responses to mental health, prearrest/diversion, and strengthening communities. These workgroups coincide with workgroups of the KJCMH. In accordance with their areas of expertise, participants were able to self-select the workgroup in which they participated. All completed workgroup action plans are included in Appendix E.

Competency Restoration

The competency restoration workgroup first identified the competency evaluation process as an area of focus. The priority is to make the competency evaluation process quicker, more efficient, and to reduce the waitlist. This area of concern has been under scrutiny and is one of the goals, purposes, and responsibilities of the Kentucky Supreme Court and the KJCMH. Identified objectives include drafting flexible court orders; screening tools to identify mental illness; finding providers, especially in rural areas; suggest legislative changes; improving the continuum of care; addressing the misdemeanor population; and having consistent, sustainable, and available resources. To successfully address this priority, multiple stakeholders are required including the judiciary, the Kentucky Correctional Psychiatric Center, prosecutors, legislators, the Administrative Office of the Courts, and the commissioner's office.

Court Responses to Mental Health

The court responses to mental health workgroup identified two priority areas, to train court personnel on Mental Health First aid and to increase guided interviews for mental health forms. Activities required to meet the objective of getting all court personnel trained include getting buy-in from all stakeholders, identifying trainers, and obtaining grant funding. To achieve the second priority of increasing guided interviews for mental health forms, it would require work from the Administrative Office of the Courts Pro Se Litigant group and Treatment and Access to Justice committee to create the forms. It is estimated this would take between six months and one year to complete. Responsible parties are identified as Linda Avery, Scott Emery, and the Administrative Office of Courts.

Prearrest/Diversion

The identified priority of the prearrest/diversion workgroup was to improve community crisis care and provide stabilization access to all. The objective is to create empath centers which would require collaboration by the advocacy, hospital associations, communities, legislators, statewide behavioral health, Medicaid funders, Administrative Office of the Courts, community mental health centers, first responders, and city officials. Some of the barriers include by-in/stigma, legislation, money, training, pending charges, and political climate.

Strengthening Communities

The strengthening communities workgroup determined their priority area is developing a resource guide that would be easily accessible to communities. This process would include identifying resource guides that currently exist, creating a comprehensive digital resource guide accessible by a QR code, and creating a group to review the guide annually to ensure the guide remains current.

Commitment and Next Steps

Following the Statewide SIM Mapping Workshop, the KJCMH workgroups will continue to develop their action plans based on opportunities identified at the workshop.

The KJCMH will work to develop a plan to support local communities, collect and use data to ensure proper selection of priorities, develop a communication plan while enhancing collaboration with stakeholders, and break down silos that currently exist between systems.

The Kentucky Administrative Office of the Courts will work with NCSC to identify up to 30 individuals from across the state of Kentucky to participate in a SIM Train the Trainer Workshop and develop a plan to conduct local SIM Mapping Workshops. Following the SIM Train the Trainer 2-day workshop, the trained facilitators will begin conducting local mapping workshops. These workshops will be done across the state to allow local jurisdictions gain an understanding of existing collaborations, resources, opportunities, processes, and priorities. The facilitators will provide assistance and accountability to the local communities following their mapping workshops. The information gathered will be utilized to inform decision-making for courts, behavioral health, and the community to make improvements for individuals with behavioral health needs.

The KJCMH will take action to secure statewide and local leadership support by identifying strategies to overcome barriers including the need for financial support. Goals will be documented and shared as a starting point for implementing strategies toward collaborative solutions.

The Kentucky Administrative Office of the Courts will ensure plans and efforts are shared, transparent, and accessible. The Kentucky Administrative Office of the Courts' website will be used to share information regarding the KJCMH work and progress.

Action Plan and Recommendations

Kentucky has a history of embracing change, and the Kentucky Judicial Commission on Mental Health has embraced a comprehensive approach to engagement in various activities leading up to the development of an action plan and recommendations. Activities informing this action plan and recommendations include but were not limited to the following:

- National Judicial Task Force to Examine the State Courts' Response to Mental Illness leadership and developed resources;
- Regular KJCMH meetings including the sharing of information and resources;
- Ongoing review of relevant research, reports, and literature focused on the intersection of the justice and behavioral health systems;
- KJCMH member involvement and participation in justice and behavioral health related committees, commissions, etc.; and
- Hosting a statewide SIM Mapping Workshop.

Further, responding to the need for leadership across all branches of state government, KJCMH members invested significant time and effort in promoting their work and creating awareness by presenting to numerous stakeholder groups.

While this plan serves as an initial roadmap for improving the court, behavioral health, and community response to mental health, it is not intended to be prescriptive or exhaustive. Furthermore, the action plan assumes all activities to be viewed through a lens of justice, equity, and inclusion. For ongoing information, it is suggested that court leadership review and implement strategies and resources made available through the Blueprint for Racial Justice. Launched in 2021 in response to action from the Conference of Chief Justices and the Conference of State Court Administrators, the Blueprint for Racial Justice is examining systemic change needed to make equality under the law a reality for all. Working with National Center for State Courts staff, the project is generating policies, webinars, benchcards, and other resources designed to assist court leaders with local racial justice, equity, and inclusion efforts.

Courts as Conveners and Leaders

With an estimated 70% of court-involved individuals experiencing a behavioral health disorder, courts have increasingly become the default system for addressing behavioral health needs. The rate of serious mental illness is four to six times higher in jail than in the general population, and the rate of substance use disorders is seven times higher among those in jail than in the general population. As leaders of their courts and communities, judges are in a unique position to encourage local practices aimed at improving responses to individuals with mental health and co-occurring substance use disorders.

Recommendations

- Encourage judges to use their leadership role as convenors to foster collaborative community and court strategies to promote community safety and improve outcomes for individuals with behavioral health needs.
- Coordinate and communicate between the behavioral health and justice systems to examine their systems and community resources to determine the best path forward to provide the best care and responses to individuals with behavioral health needs.
- Review and implement the Findings and Recommendations, as appropriate, of the National Judicial Task Force to Examine State Courts' Response to Mental Illness as approved by the Conference of Chief Justices and Conference of State Court Administrators in Resolution 1. The resolution urges each member of the conferences to lead, examine, educate, and advocate for system improvements in his or her state or territory.
- Explore ways to encourage and support cross-system communication, resource sharing, and further development and implementation of sequential intercept strategies. Invite cross-system involvement in committees and meetings to further inform needs across systems.
- Distribute a copy of this report and share the plans for implementation of local SIM mapping workshops along with the Leading Change Guide for Trial Court Leaders to all judges and court administrators, and encourage and empower all courts to develop judicially-led interdisciplinary teams to advise and support local SIM activities and strategies.
- Review emergency responder, behavioral health, and court data to identify "revolving door" offenders, as this population often displays multiple psychosocial risk factors such as mental illness, alcohol or substance use disorders, and homelessness. Once identified, courts may wish to convene a multidisciplinary committee to develop a more coordinated and comprehensive response to ensure treatment and provide the opportunity to break the cycle of justice involvement.

Education and Training

A key component to enhancing the court and community response to justice-involved individuals with behavioral health disorders is providing access to continued training for professionals charged with providing community supervision, care, and support. Judges and court professionals also need knowledge, data, research, and resources regarding behavioral health.

Recommendations

- Engage criminal justice professionals and partners to develop training programs that enhance court and community responses to justice-involved individuals with behavioral health disorders.
- Ample evidence points to the inequities that exist in access to treatment, misdiagnoses for marginalized populations, an over-representation of minority communities in the justice system, and a lack of behavioral health providers of color. Develop and adopt a Behavioral Health and Equity statement as it relates to children, youth, and adults with behavioral health conditions and identify and implement evidence-based practices to ensure diversity, equity, and inclusion across all programs and processes.
- Develop training in implicit bias, microaggression, and other diversity, equity, inclusion, and accessibility appropriate courses to increase judicial and justice professionals' cultural respectfulness and proficiency.
- Train on behavioral health signs and symptoms, court interventions, and trauma-informed courtrooms for court professionals (e.g., judges, attorneys, probation officers, clerks, bailiffs, etc.). Some training opportunities include:
    - How Being Trauma-Informed Improves Criminal Justice System Responses
    - Judges and Psychiatrists Leaderships Initiative Train the Trainer Program
    - NCSC Behavioral Health and the State Courts Education

Data-Driven Decisions

Data collection is critical for enabling outcome tracking and should be discussed across both civil and criminal matters. The Behavioral Health Data Elements Guide for the State Courts outlines ideal state court behavioral health data elements to collect across the Leading Change Model as well as elements to collect in coordination with other systems. Priority should be given to data collection that supports addressing the behavioral health needs of individuals within the community before they become justice involved.

Data-Driven Decision Making (DDDM) is a management approach that requires policy decisions to be substantiated with verifiable data. The DDDM process involves collecting data, analyzing it for patterns and facts, making inferences, and utilizing those inferences to guide

decision-making. DDDM success is therefore reliant upon the quality of the data gathered and the efficacy of its analysis and interpretation. DDDM can be utilized in criminal justice as a whole to examine overall effectiveness of specific interventions or activities, programs, and departments; or at the system level to examine collaborations between agencies, evaluate multi-agency initiatives, or do system mapping to address service gaps.

Performance measurement provides a pathway to continuously monitor and report on a specific activity's progress and accomplishments using pre-selected performance measures. Performance measurement is considered an essential activity in many government and nonprofit agencies because it "has a common sense logic that is irrefutable, namely that agencies have a greater probability of achieving their goals and objectives if they use performance measures to monitor their progress along these lines and then take follow-up actions as necessary to insure success."[17] Performance measurements provide timely information about key aspects of the performance of the program or activity to managers and staff, enabling them to identify effective practices and, if warranted, take corrective actions. Evaluations are systematic studies conducted to assess how well a program or activity is working and why. Partnerships should be created between the Supreme Court, the Health and Family Services Cabinet, the Justice Cabinet, and the Kentucky Department of Corrections to share information and data.

Recommendations

- Examine confidentiality laws related to sharing information and data, specifically related to behavioral health.
- Assess what entities are collecting data, what data is being collected, and how that data is being used. Identify entities that are doing a good job with data collection and use them as a model. Also identify entities that are successfully sharing information and data between agencies and systems. Examine their information and data sharing agreements to create a model for other agencies and systems to replicate.
- Develop Memoranda of Understanding (MOU) between agencies that provide for information and data sharing. The MOU should outline how often and in what format (dashboards or ongoing performance or reports for periodic evaluation) information and data will be shared and when it will be shared.
- Develop Memoranda of Agreement between agencies that address data access, data quality (type, format, frequency, etc.), data security, and confidentiality/release of information should be enacted and updated annually, or as new data points are added.

[17] Poister, Theodore (2003). Measuring Performance in Public and Nonprofit Organizations. San Francisco: Jossey-Bass, p. xvi.

- Routinely monitor key metrics as a key activity of any multidisciplinary efforts.
- Collect and review race and ethnicity data in order to identify inequitable practices and to monitor progress in achieving equity. This analysis should also extend to diversion to treatment placements.

Behavioral Health Continuum of Care

The vision for a behavioral health continuum of care is grounded in a public health model that addresses the social determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience, and recovery support to promote social integration and optimal health and productivity. The goal of a behavioral health continuum of care is to provide a full range of high-quality services to meet the range of age, gender, cultural, and other needs presented. The interventions used should reflect the knowledge and technology available as part of modern medicine and include evidence-informed practice. The continuum of care should recognize the critical connection between primary and specialty care and the key role of community supports with linkages to housing, employment, and other community resources. A good behavioral health continuum of care should also promote healthy behaviors and lifestyles, a primary driver of health outcomes.

The vision for a statewide behavioral health continuum of care should include a full array of resources in the community, diversion opportunities from the justice system, and education for stakeholders and communities about mental illness, co-occurring disorders, and opportunities within communities.

Recommendations

- Create a statewide vision of what a behavioral health continuum of care should look like in Kentucky. Advocate for a comprehensive behavioral health continuum of care that includes both outpatient and inpatient services as well as recovery-oriented community housing.
- Promote deflection and diversion to treatment options at the earliest point possible and institutionalize those alternative diversion pathways to treatment including civil alternatives such as assisted outpatient treatment, involuntary commitment, and outpatient treatment.
- Ensure that services being provided to users are based on evidence-based practices and follow fidelity to the models established and researched. It is recommended that an oversight committee comprised of various stakeholders from the counseling community, judiciary, and executive cabinetry, work together to develop an evaluation and coaching process to create consistency in delivery of services and encourage usage of known best practices in the treatment of those with behavioral health needs.

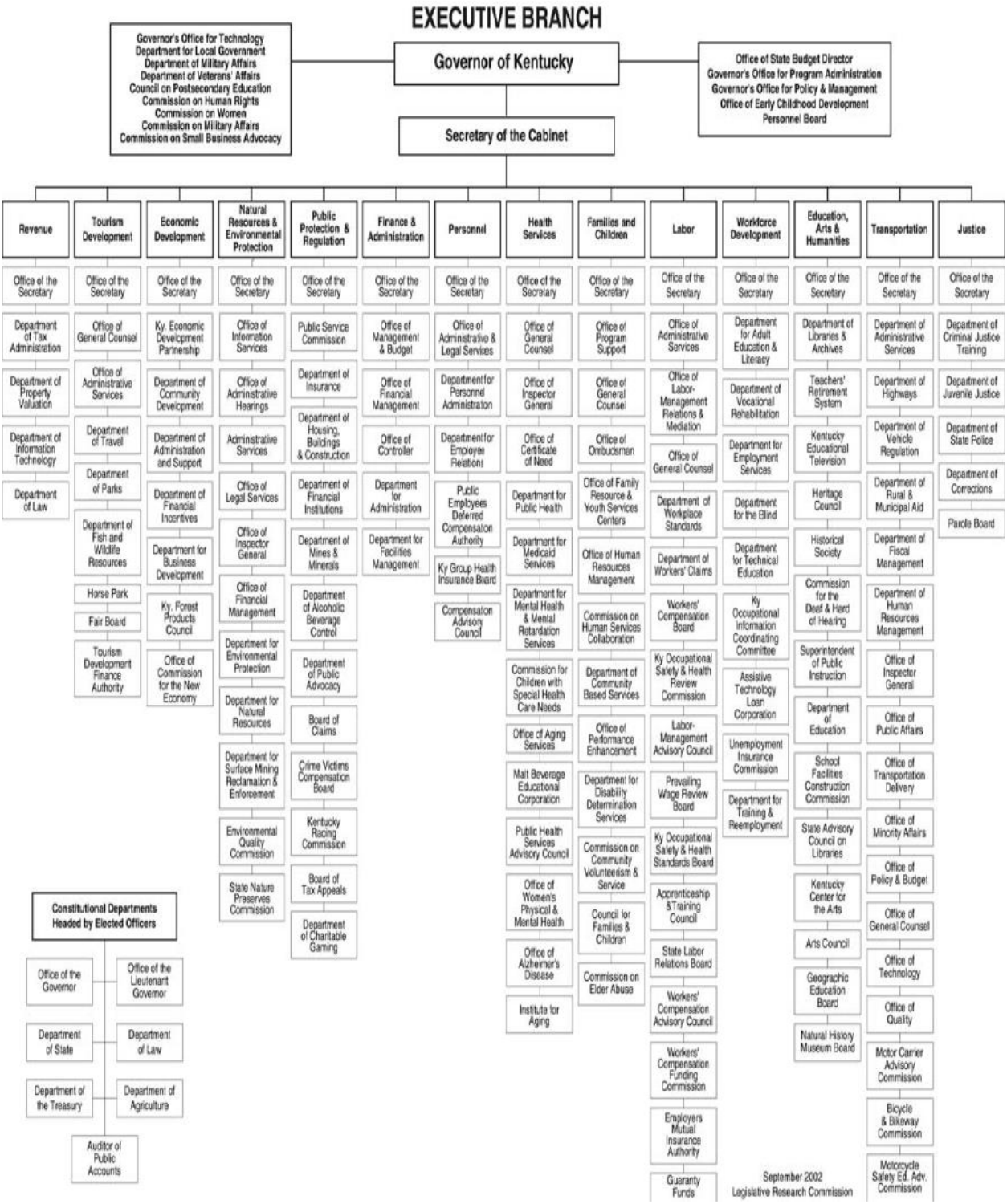
Peers, Individuals with Lived Experience, and Families

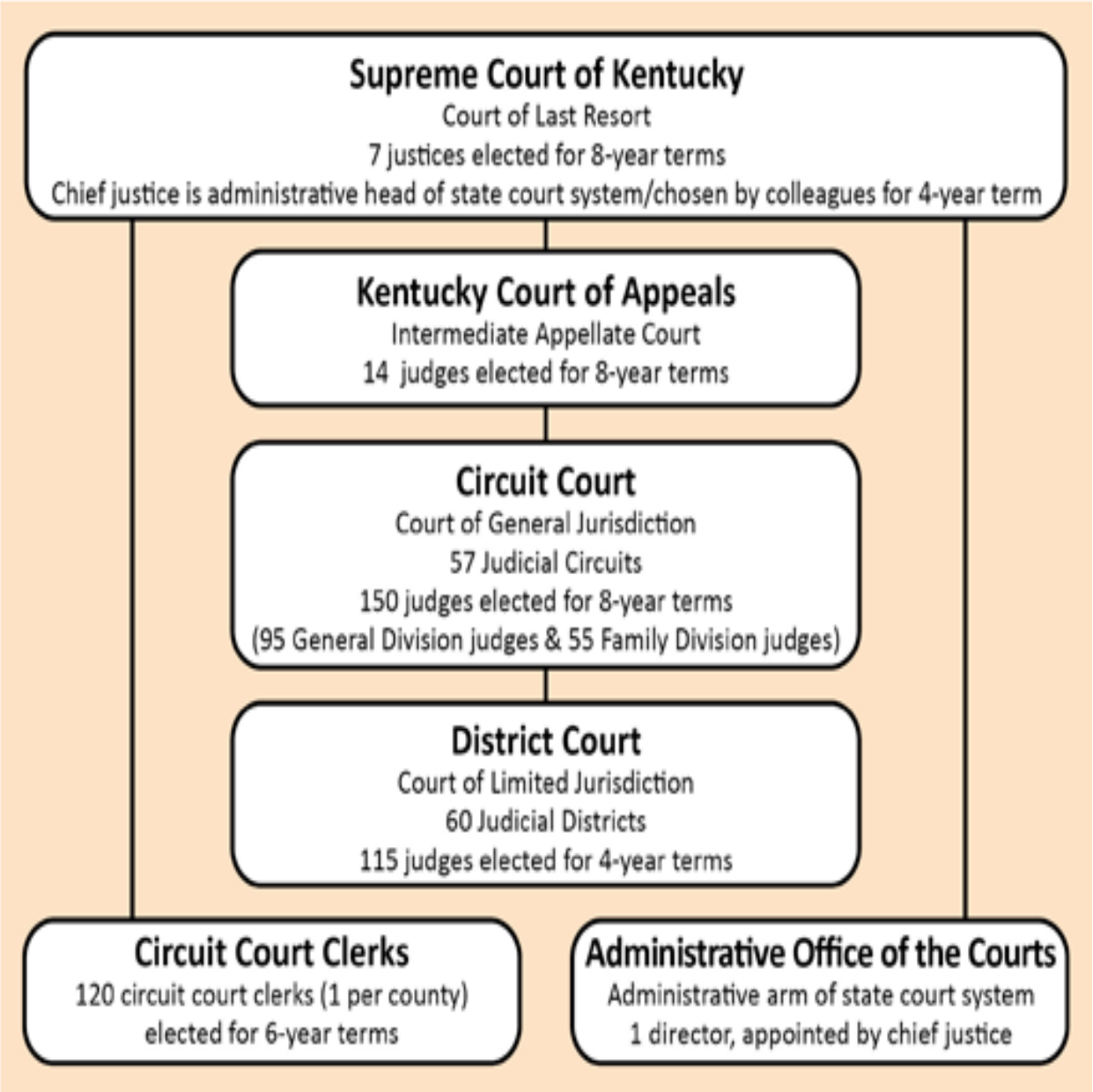
Too often, the voices of families and individuals with lived experience are left out of implementation and improvement efforts, and our responses suffer as a result.

Recommendations

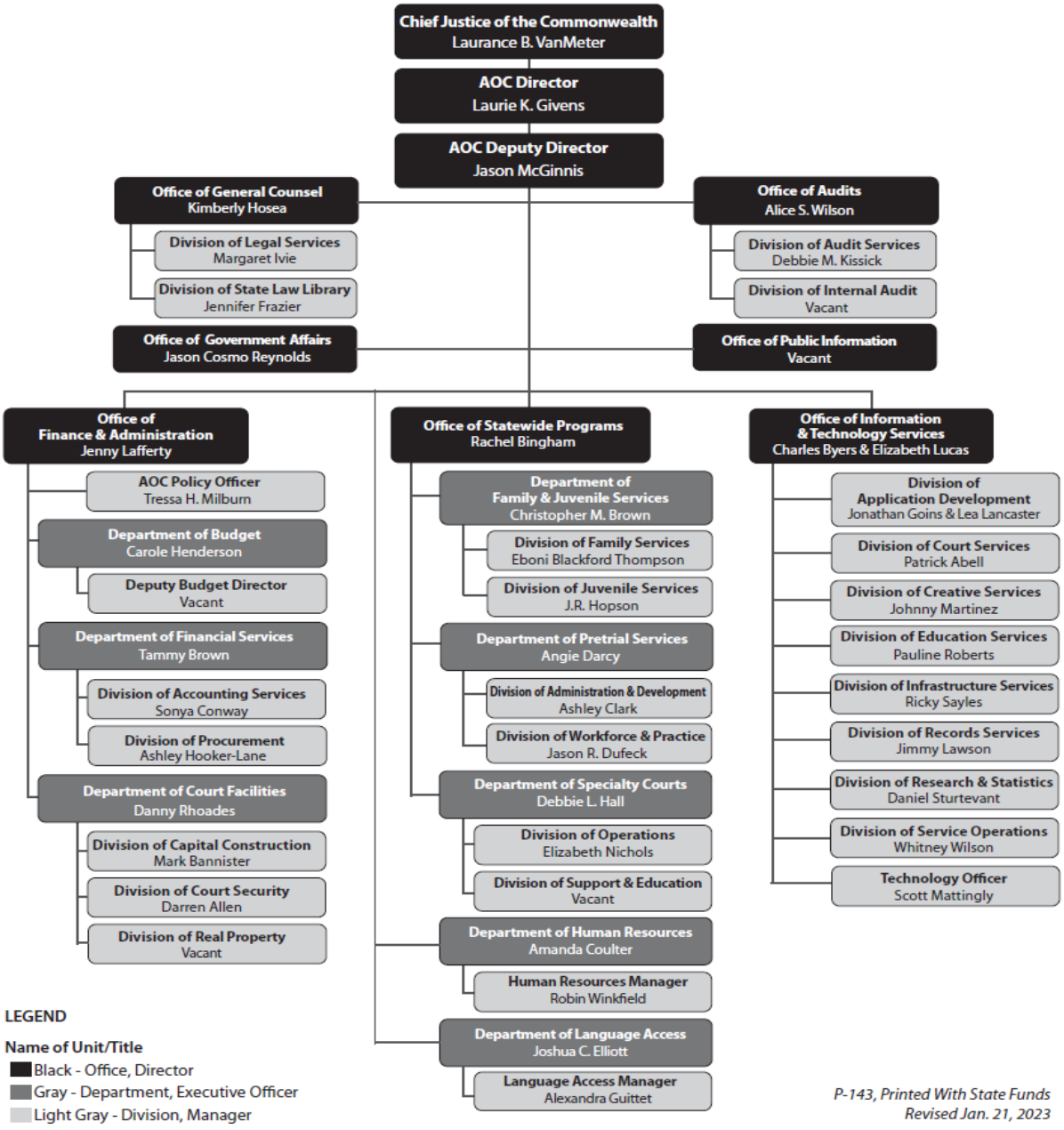
- Create opportunities to listen to and gather input from individuals and their families with lived experience in all efforts to improve court and community responses. Individuals with lived experience have valuable information to inform the justice and behavioral health systems about what worked and did not work for them.
- Encourage the integration of trained peers at all appropriate points in the treatment, case management, and justice processes including hiring trained peers in programs, services, and operations to improve the responses for individuals with behavioral health needs.
- Explore the role of peers in courts.
- Promote and support the certification and education of peers.

Appendix A: Organizational Charts




Supreme Court of Kentucky
Court of Last Resort
7 justices elected for 8-year terms
Chief justice is administrative head of state court system/chosen by colleagues for 4-year term
Kentucky Court of Appeals
Intermediate Appellate Court
14 judges elected for 8-year terms
Circuit Court
Court of General Jurisdiction
57 Judicial Circuits
150 judges elected for 8-year terms
(95 General Division judges & 55 Family Division judges)
District Court
Court of Limited Jurisdiction
60 Judicial Districts
115 judges elected for 4-year terms
Circuit Court Clerks
120 circuit court clerks (1 per county)
elected for 6-year terms
Administrative Office of the Courts
Administrative arm of state court system
1 director, appointed by chief justice

Administrative Office of the Courts
Kentucky Court of Justice



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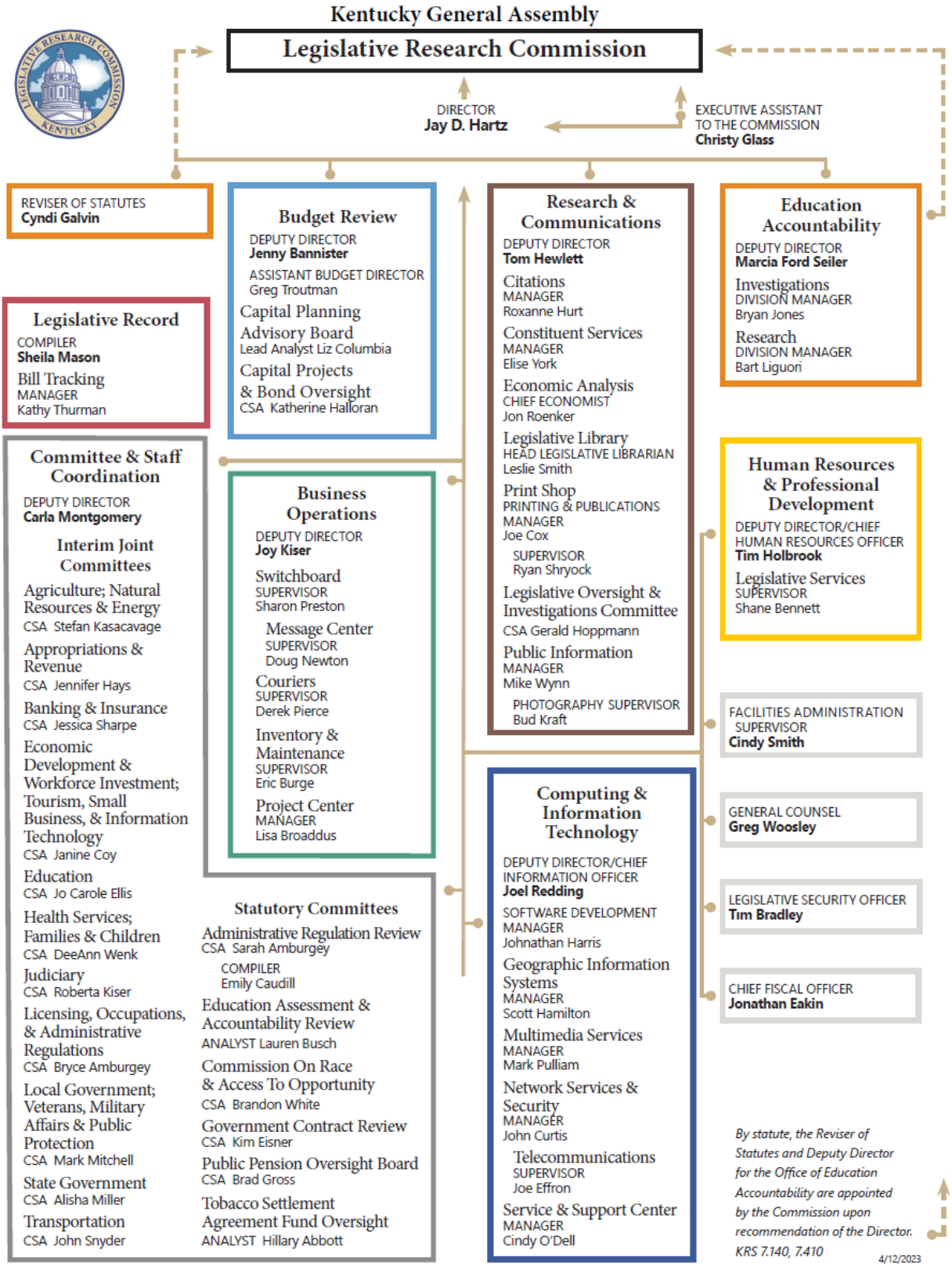
Kentucky General Assembly
Legislative Research Commission
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EXECUTIVE ASSISTANT TO THE COMMISSION
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Legislative Oversight & Investigations Committee
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Public Information
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Bryan Jones
Research
DIVISION MANAGER
Bart Liguori
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DEPUTY DIRECTOR
Carla Montgomery
Interim Joint Committees
Agriculture; Natural Resources & Energy
CSA Stefan Kasacavage
Appropriations & Revenue
CSA Jennifer Hays
Banking & Insurance
CSA Jessica Sharpe
Economic Development & Workforce Investment; Tourism, Small Business, & Information Technology
CSA Janine Coy
Education
CSA Jo Carole Ellis
Health Services; Families & Children
CSA DeeAnn Wenk
Judiciary
CSA Roberta Kiser
Licensing, Occupations, & Administrative Regulations
CSA Bryce Amburgey
Local Government; Veterans, Military Affairs & Public Protection
CSA Mark Mitchell
State Government
CSA Alisha Miller
Transportation
CSA John Snyder
Business Operations
DEPUTY DIRECTOR
Joy Kiser
Switchboard
SUPERVISOR
Sharon Preston
Message Center
SUPERVISOR
Doug Newton
Couriers
SUPERVISOR
Derek Pierce
Inventory & Maintenance
SUPERVISOR
Eric Burge
Project Center
MANAGER
Lisa Broaddus
Statutory Committees
Administrative Regulation Review
CSA Sarah Amburgey
COMPILER
Emily Caudill
Education Assessment & Accountability Review
ANALYST Lauren Busch
Commission On Race & Access To Opportunity
CSA Brandon White
Government Contract Review
CSA Kim Eisner
Public Pension Oversight Board
CSA Brad Gross
Tobacco Settlement Agreement Fund Oversight
ANALYST Hillary Abbott
Computing & Information Technology
DEPUTY DIRECTOR/CHIEF INFORMATION OFFICER
Joel Redding
SOFTWARE DEVELOPMENT MANAGER
Johnathan Harris
Geographic Information Systems
MANAGER
Scott Hamilton
Multimedia Services
MANAGER
Mark Pulliam
Network Services & Security
MANAGER
John Curtis
Telecommunications
SUPERVISOR
Joe Effron
Service & Support Center
MANAGER
Cindy O'Dell
Human Resources & Professional Development
DEPUTY DIRECTOR/CHIEF HUMAN RESOURCES OFFICER
Tim Holbrook
Legislative Services
SUPERVISOR
Shane Bennett
FACILITIES ADMINISTRATION SUPERVISOR
Cindy Smith
GENERAL COUNSEL
Greg Woosley
LEGISLATIVE SECURITY OFFICER
Tim Bradley
CHIEF FISCAL OFFICER
Jonathan Eakin
By statute, the Reviser of Statutes and Deputy Director for the Office of Education Accountability are appointed by the Commission upon recommendation of the Director.
KRS 7.140, 7.410
4/12/2023

Appendix B:
Kentucky Judicial Commission on Mental Health

Members

Kentucky Judicial Commission on Mental Health	
Hon. Debra Hembree Lambert	Deputy Chief Justice, Kentucky Supreme Court, and Chair of the Kentucky Judicial Commission on Mental Health
Hon. Denise Clayton	Chief Judge, Kentucky Court of Appeals
Hon. Larry Thompson	Chief Judge, Kentucky Court of Appeals, and Vice Chair of the Kentucky Judicial Commission on Mental Health
Hon. Denise DeBerry Brown	Family Judge, 30th Judicial Circuit
Hon. Lisa Payne Jones	Chief Circuit Judge, 6th Judicial Circuit
Hon. Cole Adams Maier	Circuit Judge, 25th Judicial Circuit
Hon. Rebecca K. Phillips	Chief Circuit Judge, 37th Judicial Circuit
Hon. Marcus Vanover	Family Judge, Chief Circuit Judge, 28th Judicial Circuit
Hon. Cameron J. Blau	District Judge, 17th Judicial District
Hon. Stephanie Burke	District Judge, 30th Judicial District
Hon. J. Foster Cotthoff	District Judge, 3rd Judicial District
Hon. Tanisha A. Hickerson	District Judge, 30th Judicial District
Hon. William "Bo" Leach	District Judge, 23rd Judicial District
Hon. Jennifer Leibson	District Judge, 30th Judicial District
Hon. Kevin R. Mullins	District Judge, 47th Judicial District
Hon. Melissa Moore Murphy	District Judge, 22nd Judicial District
Hon. John Lindsay Tackett	District Judge, 22nd Judicial District
President Linda Avery	Calloway County Circuit Court Clerk President, Kentucky Association of Circuit Court Clerks
First Vice-President Stacy Bruner	Trimble County Circuit Court Clerk First Vice-President, Kentucky Association of Circuit Court Clerks
Director Laurie K. Givens	Director, Administrative Office of the Courts
Julie Raque Adams	Majority Caucus Chair, Kentucky Senate
Whitney Westerfield	Senator, Kentucky Senate
David Meade	Speaker Pro Tempore, Kentucky House of Representatives
Kimberly Moser	Representative, Kentucky House of Representatives
Carrie Ovey Wiggins	Commonwealth's Attorney, 56th Judicial Circuit

	President, Kentucky Commonwealth's Attorneys Association
Brian Wright	Commonwealth's Attorney, 29th Judicial Circuit Immediate Past President, Kentucky Commonwealth's Attorneys Association
Chris Cohron	Commonwealth's Attorney, 8th Judicial Circuit
Stacy Tapke	Kenton County Attorney President, Kentucky County Attorneys Association
Joe Ross	Logan County Attorney Vice-President, Kentucky County Attorneys Association
Damon Preston	Public Advocate, Department of Public Advocacy
Jim Daley	Campbell County Jailer President, Kentucky Jailers Association
Berl Purdue	Clark County Sheriff President, Kentucky Sheriffs' Association
Shawn Butler	Executive Director, Kentucky Association of Chiefs of Police
Yvette Hourigan	Director, Kentucky Lawyer Assistance Program Kentucky Bar Association
Kerry Harvey	Secretary, Cabinet for Justice and Public Safety
Phillip Burnett, Jr.	Commissioner, Kentucky State Police
Sarah Johnson	Director, Kentucky Department of Corrections
Erica Hargis	Director, Division of Probation and Parole
Van Ingram	Executive Director, Kentucky Office of Drug Control Policy
Nancy Hale	CEO, Operation UNITE
Eric Friedlander	Secretary, Cabinet for Health and Family Services
Wendy Morris	Commissioner, Department of Behavioral Health, Developmental and Intellectual Disabilities
Marta Miranda-Straub	Commissioner, Department of Community Based Services
Lisa Lee	Commissioner, Department of Medicaid Services
Koleen Slusher, LCSW	Director, Kentucky Correctional Psychiatric Center
Steve Shannon	Executive Director, Kentucky Association of Regional Programs
Brenda Rosen, CSW	President, National Association of Social Workers- Kentucky Chapter
Dr. Lindsey Jasinski	Chief Administrative Officer, Eastern State Hospital- University of Kentucky
Dr. Andrew Cooley	Chief Medical Officer, Eastern State Hospital- University of Kentucky
Dr. Marc Woods	Chief Nursing Officer, Eastern State Hospital- University of Kentucky

Dr. Rebecca Frost	Facility Director, Western State Hospital
Wes Butler	Attorney, Kentucky Hospital Association
Patrick Padgett	President, Kentucky Medical Association
Dr. John J. Wernert	Norton Healthcare
Dr. Rebecca Pender Baum	President, Kentucky Counseling Association
Whitney P. Allen, Jr.	Commissioner, Kentucky Department of Veteran's Affairs
Jim Henderson	Executive Director/CEO, Kentucky Association of Counties
Amy Hale Milliken	President, Kentucky Association of Counties
Phil Sammons	Immediate Past President, Kentucky Association of Counties
J.D. Chaney	Executive Director, Kentucky League of Cities
Ashli Watts	President and CEO, Kentucky Chamber of Commerce
Jim Flynn	Director, Kentucky Superintendent Association
Glenda Harrison	Executive Director, Kentucky Access to Justice Commission
Nan Hanley	Associate Director, Kentucky Access to Justice Commission
Melony Cunningham	Executive Director, NAMI Kentucky
Terry Brooks	Executive Director, Kentucky Youth Advocates
Lisa DeJaco Crutcher	Executive Director/CEO, Catholic Charities of Louisville
Chris Griffith	Christian Appalachian Project
Rabbi Shlomo Litvin	Director, Chabad of the Bluegrass
Dr. Todd Gray	Executive Director-Treasurer, Kentucky Baptist Convention
Raoul Cunningham	President, NAACP Louisville
Amy Luttrell	CEO, Goodwill
Bryan Hubbard	Executive Director, Kentucky Opioid Abatement Advisory Commission
Hon. John D. Minton Jr.	Chief Justice (Ret.), Kentucky Supreme Court

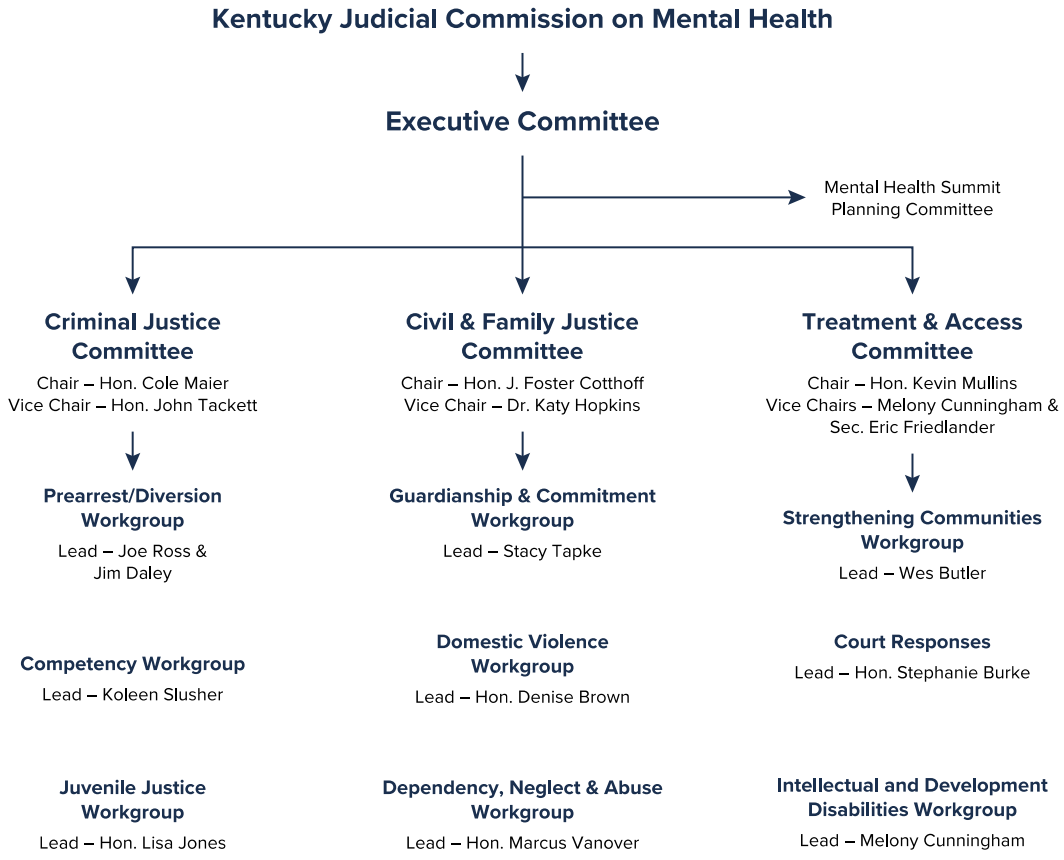
Structure

KENTUCKY JUDICIAL COMMISSION ON
MENTAL HEALTH

COMMISSION STRUCTURE

Chair – Deputy Chief Justice Debra Hembree Lambert, Kentucky Supreme Court
Vice Chair – Honorable Larry Thompson, Chief Judge, Kentucky Court of Appeals

Established August 11, 2022, the Judicial Commission on Mental Health is comprised of 74 representatives from the judicial and legal communities; the juvenile, criminal and child protection systems; the legislature; the business community; organizations with a substantial interest in these matters; and other state and local leaders who have demonstrated a commitment to mental health, substance use, and/or intellectual and developmental disabilities affecting Kentuckians.



March 21, 2023

Appendix C: SIM Mapping Workshop Agenda

Kentucky Judicial Commission on Mental Health

Sequential Intercept/Leading Change Statewide Mapping

AGENDA Day 1

THURSDAY, FEBRUARY 16, 2023

9:00am-4:00pm

9:00AM – 9:15AM	**Welcome and Opening Remarks** **Laurie K. Givens, Director** **Kentucky Administrative Office of the Courts**
9:15AM – 10:00AM	**Introductions**
10:00AM – 10:30AM	**Overview of Sequential Intercept Model and Goals of Mapping** Mapping based on the Sequential Intercept Model (SIM) and Leading Change brings together stakeholders from various disciplines and systems to identify strategies to divert people with mental health and substance use disorders away from the justice system and into treatment. SIM is a strategic planning tool used to identify available resources and opportunities and plan for community change. The prevalence of mental illness and substance use disorders has greatly impacted our nation, each of our states, and our communities, and has had a disproportionate impact on our nation's courts and justice system. New strategies must be developed to ensure that people receive appropriate, evidence-based services in our communities and are appropriately diverted from the justice system.
10:30 AM – 10:45 AM	**Break**

10:45 AM – 12:00 PM **Kentucky's Plan for Sequential Intercept Model, Commission Goals, and State of the State Discussions**

Determining goals for a statewide initiative requires collaboration and identifying resources and opportunities to systematically solve existing and emerging problems. The phases of Sequential Intercept Model implementation and goals of the Commission will be discussed. The state of the state discussions will also include examining current state initiatives, policies, and legislation that support behavioral health improvements. It is important to identify who is involved in these efforts and who may need to be involved moving forward, as well as analyze data availability and needs.

12:00 PM – 12:30 PM **Lunch**

12:30 PM – 3:45 PM **Identify Resources and Opportunities Across the Intercepts**

The mapping process serves as a dynamic, interactive tool for developing partnerships within the community by identifying resources and opportunities at each of the points that individuals seek or obtain services and move through the criminal justice system.

3:45 PM – 4:00 PM **Review of Day, Questions, and Homework**

Determining gaps and opportunities is just the beginning. Identifying potential solutions and prioritizing those efforts is the next step to ensure improved responses for persons with behavioral health disorders. Mapping next steps will be discussed.

AGENDA Day 2

FRIDAY, FEBRUARY 17, 2023

9:00-12:00

9:00 AM – 9:15 AM — **Welcome and Review of Day One and Homework**

9:15 AM – 10:45 AM — **Identifying Priorities and Developing Solutions**

Determining priorities for a community requires collaboration to systematically solve existing and emerging problems. Considerations for establishing priorities will be discussed and workgroups will discuss priorities and action plan solutions.

10:45 AM – 11:00 AM — **Break**

11:00 AM – 11:30 AM — **Supporting Local Communities**

The work does not stop with statewide mapping. True change occurs at the local level. Discussions will occur about how the Commission and statewide efforts can support the work of local communities.

11:30 AM – 11:45 AM — **Commitment and Next Steps**

A cross-systems Commission is necessary to ensure that the identified priorities are addressed through community collaboration. Commitment from the Commission and its members, next steps, and ways to sustain the work will be discussed.

11:45 AM – 12:00 PM — **Closing Remarks**

Rachel Bingham, Director, Office of Statewide Programs

Kentucky Administrative Office of the Courts

Appendix D: Workshop List of Participants

Name	Title	Agency	Days in Attendance
Linda Avery	Calloway Circuit Clerk	Kentucky Administrative Office of the Courts	☐ 2/16/23 ☒ 2/17/23
Deb Bennett	Operations Supervisor	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Rachel Bingham	Director of Statewide Programs	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Chris Brown	Executive Officer- Family & Juvenile Services	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Cheyla Bush	DEI Director	Kentucky Department of Public Advocacy	☒ 2/16/23 ☒ 2/17/23
Patrick Carrington	Diversity & Inclusion Coordinator	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Vanessa Chauhan	VAWA Program Coordinator	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Ashley Clark	Manager- Pretrial Services	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Shaleesa Clayton	Alternative Sentencing	Department of Public Advocacy	☒ 2/16/23 ☒ 2/17/23
Melanie Cunningham	Executive Director	NAMI	☐ 2/16/23 ☒ 2/17/23
Jim Daley	Campbell Jailer	Campbell County Detention Center	☒ 2/16/23 ☐ 2/17/23
Angie Darcy	Executive Officer- Pretrial	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Jason Dufeck	Manager- Pretrial	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Dr. Tonika East	Director of Lifelong Learning	Kentucky Adult Education	☒ 2/16/23 ☒ 2/17/23
Jeff Edwards	Director	Department of Public Advocacy	☒ 2/16/23 ☒ 2/17/23
Nathan Goins	Family Court Liaison	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23

Name	Title	Agency	Days in Attendance
Debbie Hall	Executive Officer-Specialty Courts	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Erica Hargis	Director of Probation and Parole	Department of Corrections	☒ 2/16/23 ☒ 2/17/23
J.R. Hopson	Manager- Division of Juvenile Services	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Dr. Lindsay Jasinski	Chief Administrative Officer	Eastern State Hospital-University of Kentucky	☒ 2/16/23 ☒ 2/17/23
Sarah Johnson	Addiction Services Director	Department of Corrections-Addiction Services	☒ 2/16/23 ☒ 2/17/23
Hon. Lisa Jones	Daviess Chief Circuit Court Judge	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
McKenzie Marshall	Legal Liaison	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Dr. Michael Meier	Director of Behavioral Health	Campbell County Detention Center	☒ 2/16/23 ☐ 2/17/23
Shawna Mitchell	Project Director	Kentucky Judicial Commission on Mental Health	☒ 2/16/23 ☒ 2/17/23
Ashley Morden	Forms	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Elizabeth Nichols	Manager- Specialty Courts	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☐ 2/17/23
Damon Preston	Public Advocate	Department of Public Advocacy	☒ 2/16/23 ☐ 2/17/23
Jason Reynolds	Government Affairs Liaison	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Michelle Sawyers	Operation Supervisor- Family & Juvenile Services	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Ian Shepard	Program & Data Analyst	Kentucky Administrative Office of the Courts	☒ 2/16/23 ☒ 2/17/23
Koleen Slusher	Facility Director, KCPC	Department for Behavioral Health, Developmental and Intellectual Disabilities	☒ 2/16/23 ☒ 2/17/23
Major Zachary Smith	Major	Campbell County Detention Center	☒ 2/16/23

Name	Title	Agency	Days in Attendance
			☐ 2/17/23
Curtis Stauffer	Managing Director	Kentucky Housing Corporation	☒ 2/16/23 ☒ 2/17/23
Seth Stevens	Attorney	Kentucky Judicial Commission on Mental Health	☒ 2/16/23 ☒ 2/17/23
David Trimble	Major	Kentucky State Police	☐ 2/16/23 ☒ 2/17/23
Jennifer Van Ort-Hazzard	Mental Health Court Coordinator	NAMI- Lexington	☒ 2/16/23 ☒ 2/17/23
Kathy Vasquez	Veterans Justice Outreach Specialist	Veterans Association	☒ 2/16/23 ☐ 2/17/23
Marc Woods	Chief Nursing Officer	Eastern State Hospital-University of Kentucky	☒ 2/16/23 ☒ 2/17/23
Brian Wright	Commonwealth Attorney, 29th Judicial Circuit	Commonwealth of Kentucky	☒ 2/16/23 ☒ 2/17/23

Appendix E: Workgroup Action Planning Forms

Prearrest/Diversion Workgroup

PRIORITY: Community crisis care/stabilization accessible to all

Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Empath Centers	1. Strategize approach 2. Identify hospital/medical center & share info and blue-print 3. Gain legislation clarity 4. System development 5. First responders & partners training 6. Training/hiring/ building 7. Execution, data, & publicity	▪ Current examples ▪ Info, hospitals and associations ▪ Legislators advocacy ▪ Insurance ▪ CMHC; private, other level of care ▪ Police, EMS, ER, community action, transportation alternatives	1. 3-6 months 2. 6-9 months 3. 3-6 months 4. ongoing 5. ongoing 6. 6-9 months 7. ongoing	▪ Politics ▪ Current services or lack thereof ▪ Buy-in/stigma ▪ Training/ownership ▪ Legislation money ▪ Change in buy-in over time ▪ Pending charges	1. Data, Advocacy, Hospital Assoc & Community Research; multi-location hospital systems 2. Legislators/currents/statewide behavioral health/Medicaid funders, AOC 3-7. CMHCs, private; first responders; city officials; hospital locations

Competency Restoration Workgroup

PRIORITY: Make competency evaluation process quicker, more efficient, and reduce waitlist.					
Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Flexible Orders	Educate Judicial leaders and legislators	▪ Over half the country is using video conferencing; use to educate. ▪ Flexible form orders already in place, ready for shipment, just need to meet with judges and send a message	Messaging to courts in 2-3 months	Convincing Judges and Legislators	KCPC, Judges, Prosecutors
Order threshold for referral to competency & screening tool	Investigate the legal lens regarding screener vs. full-blown evaluation	Other states' model for order thresholds- Texas and Washington			
Reduce the waitlist	Educate Judicial Leadership and Legislature	Flexible form orders already in place, ready for shipment, just need to meet with judges and send a message			

PRIORITY: Make competency evaluation process quicker, more efficient, and reduce waitlist.					
Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Finding providers for restoration especially in rural areas		Commissioner's office CMHC support			
Legislative changes based on a behavioral health process	Allow data sharing between KCPC and AOC; broaden eligibility requirements for SB90; Allow defendants to provide confidential information to provider during competency evaluation; require a screening tool	National Mental Health Taskforce Questions Court Leadership Asks; Justin Long Cross-agency collaboration			

PRIORITY: Make competency evaluation process quicker, more efficient, and reduce waitlist.					
Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Broaden restoration services and make the network between legal system and treatment more seamless (continuum of care)	More recommendations to programs; training evaluators to be more expansive; add mental health treatment services into the picture while stuck in competency process			If found incompetent, then there aren't restoration services; if found incompetent for misdemeanor, supposed to file 202A- if standard not met, there is nothing else to do. No restoration for these folks at the end of the road.	
Target misdemeanor population and get them out of the system log		Data from AOC to pull cases and see where interventions could take place DBH has first-episode psychosis episode funds		Officers arresting individuals first instead of taking for 202A evaluation; confidentiality for data	

To have consistent, sustainable, and available resources	▪ Find out what does exist and what is working ▪ Find out inconsistencies across systems ▪ Need to know what the CMHC's are required to provide ▪ Identify what the contracts are supposed to provide ▪ Identify payer sources and what they are paying for ▪ Resource mapping and assessments ▪ Available telehealth services ▪ Consumer feedback ▪ Increase care coordination	▪ Outside entity to assist with evaluation and assessment ▪ Analyze the data ▪ Funding- higher reimbursable rate ▪ Looking at job classifications requirements and salary will help with recruitment and retention	Begin working immediately- monthly meetings, revisions, updates Long term goal: 1-3 years for completion	▪ Workforce development ▪ Changes in administration ▪ Appropriations for funding ▪ Legislative cycles ▪ Time to secure contracts	Lead: DBHDID, Secretary's office Collab: legislative sponsors (ex: NAMI) MCOs; CMHCs; local representation across the state (self-advocates, clerks, etc.)

Court Responses to Mental Health Workgroup

PRIORITY: Train court personnel on mental health first aid

Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Train all court personnel with Mental Health First Aid	▪ Identify court personnel and get buy-in from justice partners; CDW, Pretrial, clerks, JSS, Court Security, local bar, corrections, open invite to anyone who works with the court. ▪ Persons responsible for arranging training would be Chief Judge and Circuit Court Clerk ▪ Identify a trainer for each area. ▪ Determine if grant funding is available.	▪ Who provides the training and identify trainer(s) for each area and identify costs (location, AV, materials, lunch, fee for training) ▪ Justice Lambert ▪ County Attorney ▪ Community Mental Agencies	6-hour training	▪ Lack of buy-in from participants/ supervisors/ employers ▪ Scheduling	▪ Mental Health Commission (Justice Lambert), Judge Lisa Jones and Clerk Linda Avery to encourage training to be introduced at Judicial/Clerk colleges- Presidents of Associations ▪ Community Mental Health Agencies ▪ Avery to reach out to Justice Lambert to ask her to encourage Associations to provide this training at the colleges.

PRIORITY: Increase guided interviews for mental health forms					
Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Create guided interviews for 202A Guardianship	Work with AOC's Pro Se Litigant group and A2J to create these forms.	▪ Scott Emery ▪ A2J ▪ AOC Legal ▪ Pro Se Litigant ▪ Public Stations	Begin immediately with 6 months to a year to complete	▪ Access to computers ▪ Transportation ▪ Public can't eFile	▪ Linda Avery will reach out to Scott Emery ▪ AOC

Strengthening Communities Workgroup

PRIORITY: Resource Guide					
Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Identify resource guides that already exist	▪ Identify resources guides that are already available ▪ How up to date are the guides which are located?	▪ SAMHSA ▪ 211 ▪ KSP ▪ Schools ▪ Health Department ▪ ASAP ▪ Probation & Parole ▪ State Psychiatric Hospital ▪ United Way ▪ IT Services ▪ Mental Health of Kentucky	3-6 months	▪ Stale information ▪ Reviewing and compiling such a large volume of information	▪ Mental Health Commission Resource Page ▪ AOC IT

PRIORITY: Resource Guide					
Objective *What do we want to achieve?*	**Activities/Tasks** *What do we have to do to meet the objective?* *What are the specific tasks to meet the objective?*	**Resources** *What resources are necessary to complete the activity? (people, time, space, equipment, money, access to services)* *What data exists in this space?*	**Timeframe** *How much time is required for the activity/task?* *When action can begin on this activity/task?*	**Barriers** *Are there any potential barriers to consider?*	**Responsibility** *Who will take the lead?* *Who should be at the table for collaboration?* *Who is already engaged in this activity?*
Create comprehensive digital Resource Guide accessible by QR code		▪ Information obtained from objective 1	TBD	Volume of data	▪ Mental Health Commission
Create a group to review resource guide annually	Get buy-in from Mental Health Commission		Annually after resource guide is published	Lack of commitment for annual reviewers	▪ Mental Health Commission ▪ AOC workgroup which includes a variety of AOC employees