Kansas

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/06/2020 9.47.14 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2020
End Year	2021

State SAPT DUNS Number

Number	878195098
Expiration Date	

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

Agency Name	Kansas Department for Aging and Disability Services
Organizational Unit	Behavioral Health Services
Mailing Address	503 S. Kansas Ave.
City	Topeka
Zip Code	66603

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

First Name	Andrew
Last Name	Brown
Agency Name	Kansas Department for Aging and Disability Services
Mailing Address	503 S. Kansas Ave.
City	Topeka
Zip Code	66603
Telephone	785-291-3359
Fax	785-296-0256
Email Address	Andrew.Brown@ks.gov

State CMHS DUNS Number

Number	878195098
Expiration Date	

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

Agency Name	Kansas Department for Aging and Disability Services
Organizational Unit	Behavioral Health Services
Mailing Address	503 S. Kansas Ave.
City	Topeka
Zip Code	66603

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

First Name	Andrew
Last Name	Brown
Agency Name	Kansas Department for Aging and Disability Services

Mailing Address	503 S. Kansas Ave.
City	Topeka
Zip Code	66603
Telephone	785-291-3359
Fax	785-296-0256
Email Address	Andrew.Brown@ks.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

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

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

From	
To	

V. Date Submitted

Submission Date	8/30/2019 4:56:47 PM
Revision Date	8/6/2020 9:45:44 AM

VI. Contact Person Responsible for Application Submission

First Name	Cissy
Last Name	McKinzie
Telephone	785-296-4079
Fax	785-296-0256
Email Address	Tamberly.McKinzie@ks.gov

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

Footnotes:

State Information

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

Fiscal Year 2020

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

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

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

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

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

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: Kansas

Name of Chief Executive Officer (CEO) or Designee: Laura Howard

Signature of CEO or Designee[1]: Laura Howard

Title: KDADS Secretary

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

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

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

Footnotes:

Capitol Building
Room 241 South
Topeka, KS 66612

Kansas
Office of the Governor

Phone: (785) 296-3232
governor.kansas.gov

Laura Kelly, Governor

August 30, 2019

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

RE: Delegation of Signatory Authority, Kansas Combined Block Grant Application

To Whom It May Concern,

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

Respectfully,

Laura Kelly

Governor Laura Kelly

New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404

Laura Howard, Secretary

Kansas
Department for Aging
and Disability Services

Phone: (785) 296-4986
Fax: (785) 296-0256
kdads.wwwmail@ks.gov
www.kdads.ks.gov

Laura Kelly, Governor

November 6, 2019

Substance Abuse and Mental Health Services Administration (SAMHSA)
U.S. Department of Health & Human Services

To Whom It May Concern:

Re: Substance Abuse Prevention and Treatment Block Grant
Community Mental Health Services Block Grant

I certify that the Kansas Department for Aging and Disability Services (KDADS) and all sub-recipients (contractor & sub-awardees) for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant will comply with the following special condition of award:

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

Sincerely,

Andrew Brown
Commissioner
Behavioral Health Services

State Information

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

Fiscal Year 2020

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
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Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

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

Footnotes:

State Information

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

Fiscal Year 2020

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Laura Howard

Signature of CEO or Designee[1]: Laura Howard

Title: KDADS Secretary

Date Signed: 8/19/19

mm/dd/yyyy

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

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

Footnotes:

Capitol Building
Room 241 South
Topeka, KS 66612

Kansas
Office of the Governor

Phone: (785) 296-3232
governor.kansas.gov

Laura Kelly, Governor

August 30, 2019

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

RE: Delegation of Signatory Authority, Kansas Combined Block Grant Application

To Whom It May Concern,

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

Respectfully,

Laura Kelly

Governor Laura Kelly

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Laura Howard

Title

Secretary

Organization

Kansas Department of Aging and Disability Services

Signature:

Date:

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

Footnotes:

The Secretary for the Kansas Department for Aging and Disability Services (KDADS) is also the Secretary for the Kansas Department for Children and Families (DCF). In her role as Secretary, she represents the agencies in front of the Legislature but does not lobby.

Planning Steps

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

Narrative Question:

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

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

Footnotes:

FFY2020 - 2021 Combined Block Grant Application

Section II: Planning Steps

Step One Narrative

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

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

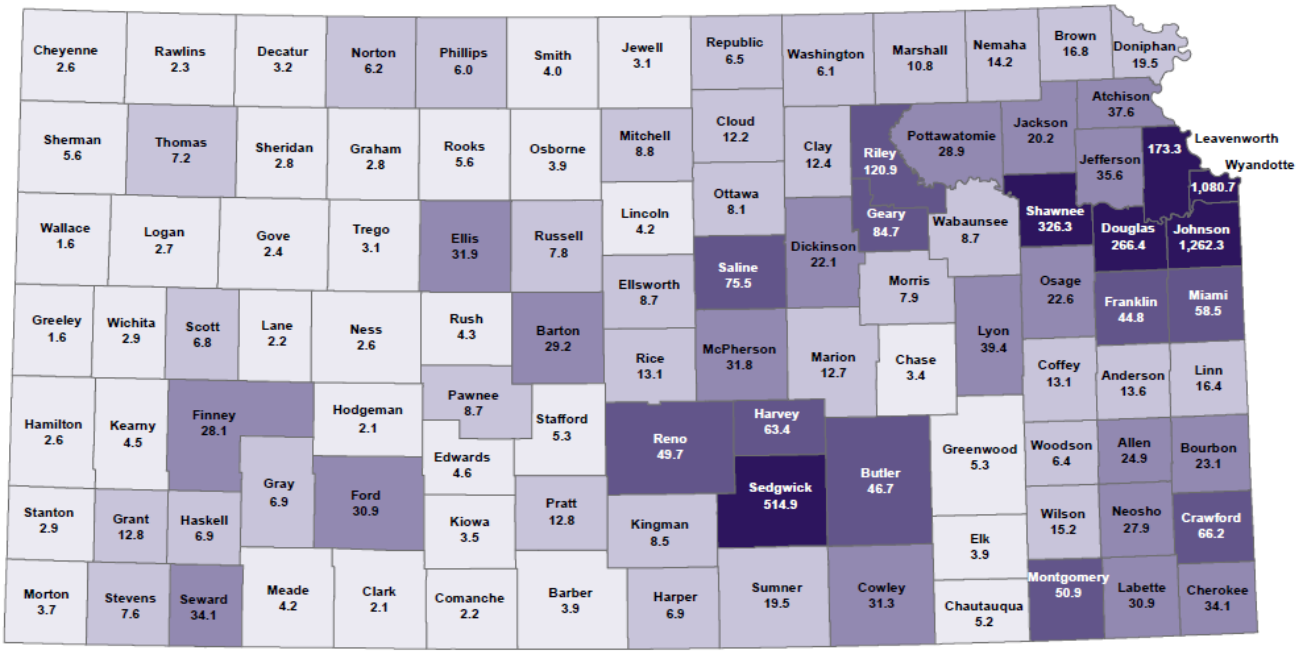
  This narrative must include a discussion of the current service system's attention to the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for FY 2020 HIV-designated states or a state designated in any of the prior three FY and opted to use SABG funds for early intervention services for HIV (EIS/HIV), Persons at Risk for HIV. See Appendix A for a list of the FY 2020 HIV-designated states.

Kansas

Located in the center of the continental United States, Kansas is a state with a population estimate by the U.S. Census Bureau in 2018 of almost 3 million people with population density ranging from urban areas to rural and frontier (https://www.census.gov/quickfacts/fact/dashboard/KS/PST045218).

Kansas consists of 105 counties with population density classifications in Kansas, by County, for 2018 as illustrated in the map from the Kansas University Institute for Policy & Social Research embedded below:

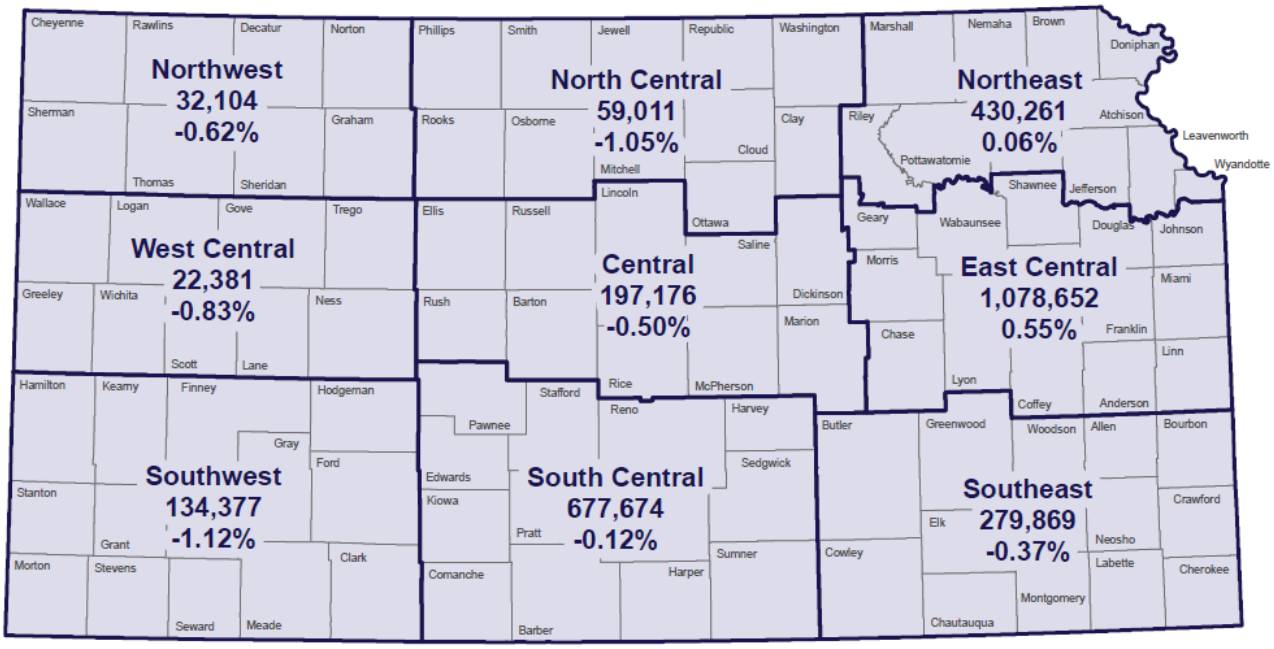
Population Density Classifications in Kansas, by County, 2018



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2018.

As also illustrated in the map below titled, “Population of Kansas by Region, July 1, 2018 and Percent Change, 2017-2018 from the Kansas University Institute for Policy & Social Research, it is estimated that Kansas has slightly increased in population in the northeast and east central regions of Kansas from 2017 – 2018. The other regions of Kansas decreased in population slightly from 2017 - 2018.

Population of Kansas by Region, July 1, 2018 and Percent Change, 2017-2018



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau.

State: 2,911,505
0.03%

The U.S. Census Bureau estimates age distribution of a little over twenty-four percent (24.2%) of the population are under 18-years-old and just under sixteen percent (15.9%) are 65-years-old and over. It is estimated that a little over half of the population is female (50.2%). Race distribution is estimated at: White alone (86.4%), Hispanic or Latino (12.1%), Black or African American alone (6.1%), Asian alone (3.1%), Two or more races (3.0%), American Indian and Alaska Native alone (1.2%), and Native Hawaiian and other Pacific Islander alone (0.1%). Over ninety percent (90.5%) of the population are high school graduates or higher. Over eight percent (8.8%) are persons with a disability (under age 65) and over ten percent (10.2%) of Kansans are persons without health insurance (under age 65).

State of Kansas

Kansas recently elected a new governor. Governor Laura Kelly became the 48th governor of the State of Kansas in January of 2019. Under Governor Kelly, Dr. Lee Norman was appointed the new Secretary of the Kansas Department of Health and Environment (KDHE).

KDHE, a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waiver programs: Autism, Frail Elderly, Intellectual/Developmentally Disabled (I/DD), Physical Disability, Serious Emotional Disturbance,

Technology Assisted, and Brain Injury. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance use disorder, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. The current Governor has made efforts to expand Medicaid in Kansas. As of July 2019, the Kansas legislature has not expanded Medicaid.

Under Governor Kelly, Jeff Zmuda was appointed the Acting Secretary of Corrections. Laura Howard was appointed the new Secretary for the Kansas Department for Children and Families (DCF) and the Kansas Department for Aging and Disability Services (KDADS). Janis DeBoer was appointed the Deputy Secretary of the Kansas Department for Aging and Disability Services.

Kansas Department for Aging and Disability Services (KDADS)

Under Secretary Howard, KDADS was reorganized into five commissions: Financial and Information Services Commission, Aging and Disability Community Services and Programs Commission, State Hospital Commission, the Survey, Certification and Credentialing (SCC) Commission, and the Behavioral Health Services (BHS) Commission with a new Strategic Vision.

The Strategic Vision under Secretary Howard and Deputy Secretary DeBoer includes the following objectives: transparency, value our staff, a culture of continuous improvement, collaboration, ethics, celebrate success, break through roadblocks and to focus on data, outcomes and accountability.

State Hospital Commission

Kim Lynch was appointed State Hospital Commissioner of the newly established State Hospital Commission within KDADS. Secretary Howard announced the creation of a new State Hospital Commission in February this year as part of a strategic plan to develop a cohesive approach to supporting and empowering the Kansans it serves. The new Commission also affords the agency the opportunity to improve communication and collaboration between State Hospitals, Commissions and stakeholders.

Oversight of the Kansas Neurological Institute and Parsons State Hospital and Training Center for individuals with intellectual and developmental disabilities fall under the purview of this Commission.

Survey, Certification and Credentialing Commission (SCC)

Patty Brown was appointed the new Survey, Certification & Credentialing Commissioner. Behavioral Health provider licensing and certification fall under her direction. KDADS field staff working out of regional offices across the state work directly with behavioral health providers to complete and ensure compliance with licensing standards and requirements. This is done by licensing site visits with each of the licensed programs throughout Kansas. During these visits, clinical files are reviewed for compliance, a review of policies and procedures is completed, as well as, an inspection of the physical location.

Aging & Disability Community Services and Programs Commission (A&D CSP)

Amy Penrod was appointed the Commissioner of the Aging & Disability Community Services and Programs Commission. The Aging & Disability Community Services and Programs (A&D CSP) Commission manages a system of community-based supports and services for persons with disabilities, which are delivered through the Medicaid Managed Care system (KanCare) in partnership with organized networks. These services include programs for those with physical disabilities, intellectual/developmental disabilities, frail elderly and children with autism. It is responsible for coordinating intra-agency KDADS activity around KanCare. The Commission works with each KDADS Commission to ensure that client services are monitored appropriately. The Commission coordinates with all three KanCare Managed Care Organizations (MCOs) regarding KDADS-specific program areas (home and community-based service waivers and behavioral health).

A&D CSP also administers a variety of community-based programs for the aging population through contracts and grants of state and federal funds. The programs administered include Older Americans Act, congregate and home-delivered meals, caregiver programs, in-home services, Senior Care Act services, and Client Assessment, Referral and Evaluation (CARE) program, as well as quality assurance programs for the Older Americans Act and Senior Care Act. In addition, it is responsible for the Aging and Disability Resource Center, or ADRC, the single-entry point for older adults and persons with disabilities to connect with local experts who can help them choose a long-term care option. The Commission oversees and implements grants that assist individuals who are aging or have a disability under Senior Health Insurance Counseling for Kansas (SHICK), Senior Medicare Patrol (SMP), Lifespan Respite and Community Transition Opportunities. The SHICK program assists individuals with questions related to Medicare. The SMP program educates the community about reporting Medicare/Medicaid and health-care fraud and abuse and how to identify and report scams. The Commission's Community Transitions Opportunities program works with nursing facilities to identify residents who wish return to living in a community setting.

Financial and Information Services Commission (FISC)

Brad Ridley is the Commissioner of the Financial and Information Services Commission. The Financial Information Services Commission is responsible for various administrative functions that support other KDADS Commissions. The Accounting Division is responsible for processing all agency payments and monitoring expenditures. It also monitors KDADS' grants to other organizations. The Budget Division prepares the KDADS budget, monitors legislative activity related to the budget and handles requests for budget information. The Information Services Division maintains the KDADS computer network and various web application systems. In addition, the Commission provides technical support to agency staff and business partners. The Fiscal and Program Evaluation Division is KDADS' auditing, reporting and data analysis group. It is responsible for managing nursing facility reimbursement programs.

Behavioral Health Services Commission (BHS) Staffing and Structure

Andy Brown was appointed the new Behavioral Health Services Commissioner. Mental Health (MH), Problem Gambling (PG), and Substance Use Disorder (SUD) Prevention, Treatment, and Recovery services fall under Commissioner Andy Brown's direction. The Commissioner of BHS is the Single State Authority (SSA) for SAPT (Substance Abuse Prevention and Treatment) and the State Mental Health Authority (SMHA). The Behavioral Health Service Commission partners with care providers,

communities and community mental health centers to help Kansans with behavioral health, substance use disorder and other addictions services. KDADS is responsible by statute and holds the authority and responsibility for coordinating mental health care and substance abuse/addiction services across the state. The Commission works in close coordination with the Governor's Behavioral Health Services Planning Council.

The Behavioral Health Services Commission staff recently reorganized under Commissioner Brown. The following describes our staff structure and responsibilities:

Directly under the supervision of Commissioner Brown, there is one Behavioral Health (BH) Senior Administrative Assistant, a Special Projects Coordinator position, the Director of Adult Services, a Crisis Intervention Team (CIT)/VA Program Coordinator and a Director of Youth Services.

Directly under the supervision of the Director of Youth Services is the Prevention Program Manager and the Child & Community Inpatient Program Manager. The Prevention Program Manager is the National Prevention Network (NPN) representative for Kansas and supervises two Prevention Consultants. The Prevention team manages all the substance use disorder (SUD) prevention services, as well as, mental health promotion initiatives including suicide prevention. This includes the management of SAMHSA prevention grants and management and oversight to all aspects of the SAPTBG prevention set-aside. This team also partners with other state agencies to ensure our state is compliant with all aspects of the federal Synar regulations and partners with other staff to integrate prevention to all behavioral health services.

The Child and Community Inpatient Manager supervises a Youth Engagement Specialist and a System of Care Project Coordinator. The Child and Community Inpatient Manager oversees the eight Psychiatric Residential Treatment Facilities (PRTFs) within the State of Kansas.

The Director of Adult Services is the National Treatment Network (NTN) representative for Kansas. Under the Director of Adult Services is a Housing & Employment Benefit Manager, a Mental Health Program Manager, a Problem Gambling Program Manager, and the Block Grant/SUD Program Manager. The Block Grant/SUD Program Manager is also the State Opioid Treatment Authority (SOTA) representative for Kansas.

The Mental Health Program Manager supervises the Housing and Homelessness Project Coordinator, the Adult Consumer Affairs Coordinator, and the vacant Adult Inpatient Coordinator.

The Problem Gambling Program Manager supervises two Problem Gambling specialists.

The Block Grant/SUD Program Manager supervises an Opioid Response Program Coordinator and the Problem Gambling/SUD Project Coordinator. The PG/SUD Project Coordinator is the Women's Treatment Coordinator for the State.

BHS Programs and Services

Prevention Services

Kansas is entering its fifth year of a state prevention system re-design. This new prevention system is comprised of both mental health and behavioral health partners that support community coalitions who are funded through the SABG. Significant changes have been made within those communities that are

supported through the system. This structure provides more robust resources, development of coalition infrastructure, capacity building and the strengthening of community level priorities through the utilization of data. Communities are supported through two phases. The first phase is planning, where coalitions will assess their community, build capacity and plan for approved evidence-based strategies that will best support their priority areas. The second phase, implementation, is the act of implementing chosen evidence- based strategies takes place. This allows the grantees time to develop a comprehensive plan during the first phase, so they become successful in the implementation phase. In FY20-21, Kansas continues to work toward integrating mental health and behavioral health concerns with the focus on increasing more sustainable strategies such as environmental and programmatic.

Substance Use Disorder Services

The Kansas Department for Aging and Disability Services (KDADS) license behavioral health providers in Kansas. Licensing standards identify expectations and guidelines for the development and operation of substance use disorder (SUD) treatment programs licensed/certified by the State of Kansas. When new providers apply for a license and during regular site visits, KDADS staff verify compliance with these standards. The standards are rigorous and cover a range of areas, including but not limited to, client rights, confidentiality, client record review, incident reports, member accessibility, program environment and safety, assessment, treatment planning, updates and discharge planning/follow-up.

Kansas contracts with three Managed Care Organizations for Medicaid and an Administrative Services Organization (ASO) for Block Grant substance use disorder treatment services. KDADS monitors the Medicaid plans and the ASO that oversee, authorize and reimburse for SUD treatment services.

Beacon Health Options, formerly Value Options, oversees Substance Use Treatment Block Grant services. As the current Administrative Services Organization (ASO) for Kansas, Beacon Health Options manages: 1) Statewide substance abuse services for individuals identified with a Substance Use Disorder who meet SABG treatment fund eligibility, 2) Problem Gambling treatment (funded through the Problem Gambling and other Addictions Grant Fund), 3) Treatment for Third and Subsequent DUI Clients (Funding by KDOC), and 4) the Help Line for SUD and Problem Gambling (PG) Treatment services.

Utilizing a combination of funding sources (SAT Block Grant, State general funds, and State fee funds), 13,380 people (unduplicated) were served under the substance use disorder block grant in state fiscal year (SFY) 2018. The highest proportion of people served under the Block Grant were ages 25-years-old to 34-years-old (4,989 people). The next highest number of people served fell into the age group 35-years-old to 44-years-old (3,738 people) followed by those aged 18 -24 (2,117 people). The primary reason people access Block Grant treatment services in Kansas (both higher and lower levels of care) is for methamphetamine dependency followed closely by alcohol dependency.

Beacon contracts with licensed substance use disorder providers to provide treatment services. There are 44 Block Grant providers in 106 locations throughout Kansas. One of these providers is a Federally Recognized tribe. Services paid under the Block Grant include both inpatient and outpatient services: ASAM Level 0.5 Early Intervention, ASAM Level 1: Outpatient, ASAM Level 2 Intensive Outpatient Services or Partial Hospitalization and ASAM Level 3: Residential or Inpatient services.

There are five Designated Women's Facilities (DWFs) in Kansas in nine locations across the state. DWFs undergo the same rigorous licensing requirements as described above. Designated Women’s Facilities

receiving Block Grant funds give priority admission to pregnant women, women with dependent children and women using IV drugs. DWFs provide a full continuum of services as follows:

1) Treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate,
2) Provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care,
3) Provide or arrange for child care while the women are receiving services,
4) Provide or arrange for primary pediatric care for the women's children, including immunizations,
5) Provide or arrange for gender-specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting,
6) Provide or arrange for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect,
7) Provide or arrange for sufficient case management and transportation services to assure that the women and their children have access to the services provided by (2-6) above.

DWFs also provide pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of services to include: case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments, employment and training programs, education and special education programs, drug-free housing for women and their children, prenatal care and other health care services, therapeutic day care for children, Head Start and other early childhood programs.

The Kansas Department for Aging and Disability Services (KDADS) also licenses methadone clinics in Kansas. There are a set of standards specific to methadone clinics which includes onsite reviews of policies, procedures, and client records.

The ASO and the Medicaid plans contract with Substance Use Disorder providers to provide a full continuum of services for those who inject drugs. The ASO maintains and manages the State's substance use disorder hotline and waitlist for residential treatment. The ASO ensures those who inject drugs and other priority populations are given priority in accessing care.

The majority of the methadone clinics in Kansas are located primarily in urban areas and are self-pay. Medicaid plans are highly encouraged to contract with Methadone clinics. Currently, three of the nine methadone clinics are Medicaid providers. There is one methadone clinic in the ASO network under the Block Grant program.

Kansas was awarded the State Opioid Response (SOR) grant to help address the opioid crisis. Increases in opioid-related drug misuse and deaths parallel the increase in prescription opioid availability. According to data from Kansas Tracking and Reporting of Controlled Substances (K-TRACS), the Kansas prescription drug monitoring program, there were more than 5.4 million Schedule II-IV prescriptions and more than 332 million pills dispensed in Kansas in 2018. Kansas is using this funding to invest in expanding access to treatment, particularly evidence-based treatment, and to reduce the number of opioid-related deaths across our state. KDADS' Behavioral Health Commission oversees and monitors grant activities. KDADS is currently using SOR award funding to provide medication- assisted treatment

(MAT) services to uninsured patients in Kansas. Four grantees cover treatment services for all 105 counties in Kansas in different geographical locations and include a medical center/methadone clinic, a substance use disorder provider, a regional alcohol and drug assessment center, and a mental health center.

Kansas is fortunate to have a strong network of Oxford Houses throughout the state. KDADS provides a combination of Block Grant and State General funds to enable the nonprofit Friends of Recovery Association (FORA) to establish Oxford Houses throughout the state. The term "Oxford House" refers to any house operating under the Oxford House Model, a community-based approach to addiction treatment which provides an independent, supportive, and sober living environment. Oxford Houses in Kansas include men only, women only, men with children, and women with children. According to the Friends of Recovery site (http://www.friendsofrecovery.com/about-oxford-house/), "Unlike traditional halfway houses, there are no staff. An Oxford House is a self-run and self-supported recovery house. The concept is the same that underlies 12-step programs. Addicted individuals help themselves by helping each other abstain from alcohol and drug use one day at a time.

Residents assume and learn responsibility for their recovery. Additionally, there are no time limits. This allows an individual to focus on establishing a new set of personal values that center around sobriety. It allows the individual to practice the skills of responsible family and community living with their new Oxford House family."

Further, "having houses in good neighborhoods with a safe environment for recovery to flourish may be the single most important reason for the Oxford House success. Using this cost-effective way to improve the chances of recovery from addiction may be the best way to show the community that recovery works and that recovering addicts can become model citizens. Oxford Houses have an 80% success rate, nationally." The State of Kansas has supported the efforts of FORA for many years. In 2001, there were 19 Oxford Houses in Kansas. The number has grown over the years to 126 Houses. For a comprehensive list of Kansas Oxford Houses, please see: http://www.friendsofrecovery.com/wp-content/uploads/2019/07/2019-Phone-List-1.pdf

In Kansas, there is a Kansas Tuberculosis Control Program within the Kansas Department of Health and Environment. State laws and regulations require that cases of tuberculosis be reported to the local or state health department. The Kansas Tuberculosis Control Program provides, free-of-charge, anti-tuberculosis medications to local health departments for the treatment of TB disease. Additionally, preventative medications for individuals with TB infection are provided at no cost to local health departments or other medical providers. In order to receive medications for a person afflicted with TB infection, the health care provider or local health department must provide the state program information about the diagnostic screening of the patient (skin test and chest x-ray results). For individuals with active TB disease, the local health department must provide information about the diagnostic screening of the patient along with information about the patient's treatment, potential contacts to the patient, and other detailed information as requested on an ongoing basis.

For substance use disorder Block Grant treatment services, KDADS maintains a policy on our website specifically related to Tuberculosis to ensure compliance with the federal regulation to facilitate the provision of TB services and to create the necessary linkages between substance use disorder providers and local health care providers. Contractual agreements with the ASO and in the ASO's provider

agreement with providers also include language about TB referrals. Contract language with the plans and in provider agreements include compliance related activities.

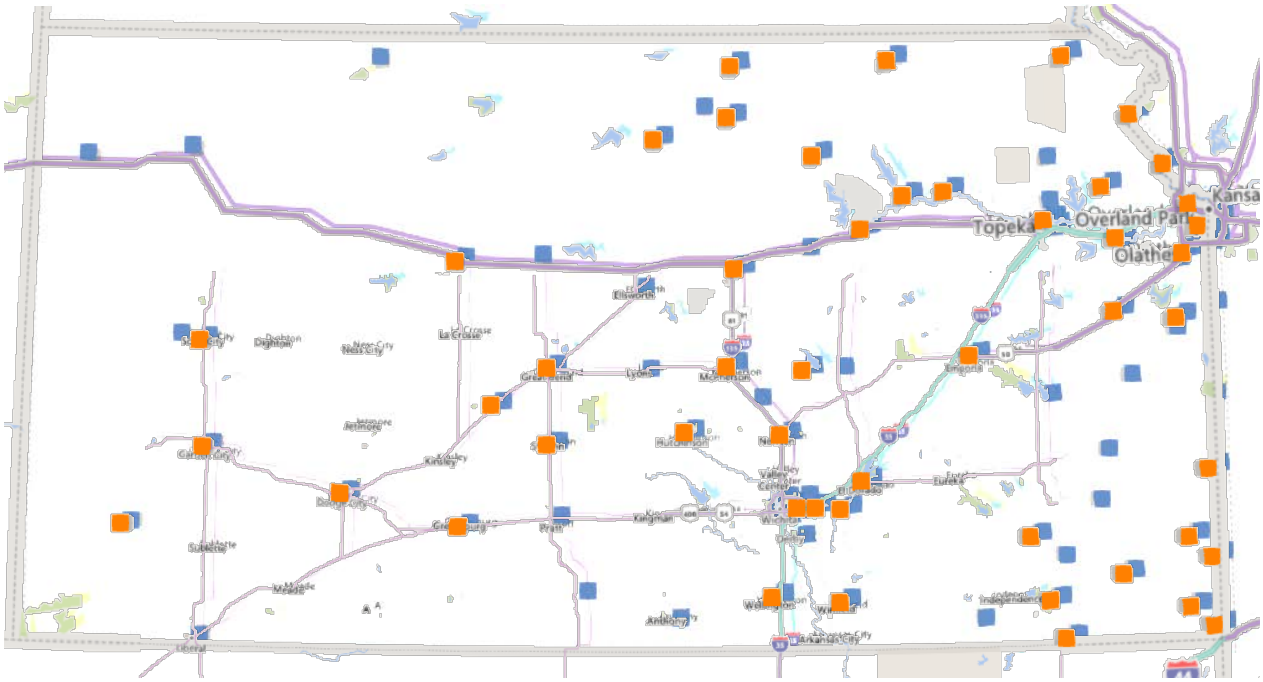
Many substance use disorder providers are dually licensed as Community Mental Health Centers (CMHCs) enabling them to coordinate both mental health and substance use disorder care for those with co-occurring diagnoses. Many providers are partnering with Federally Qualified Health Centers (FQHCs) and other primary medical providers to offer SBIRT (Screening, Brief Intervention and Referral to Treatment) services, integrated treatment, and facilitated access to ongoing medical care. Substance abuse treatment (SAT) providers offer a comprehensive continuum of care of BG funded services including: assessment, peer mentoring, outpatient, intensive outpatient, reintegration, social detox, and intermediate. All SAT services are based upon clinical need/medical necessity through the contracted plans.

The Kansas SAT provider network possesses many strengths. Nine Substance Abuse Block Grant providers (or 20.5%) of 44 Block Grant network providers are accredited through some type of accreditation body (COA, CARF, Joint Commission). The SAT Block Grant providers serving Kansans are very experienced in their field with long histories of serving those with behavioral health issues. Increasingly, providers offer services utilizing evidence-based models of care. A number of Kansas SAT Block Grant providers also offer counseling that specifically address trauma experienced by consumers. Strong ASO oversight of Block Grant funded SAT providers and extensive data collection processes help to ensure that providers offer effective services that meet the needs of the person seeking services.

Kansas Providers Map

Community Mental Health Centers and Substance Use Disorder Service Providers July 2019

CMHC locations – orange and SUD locations - blue

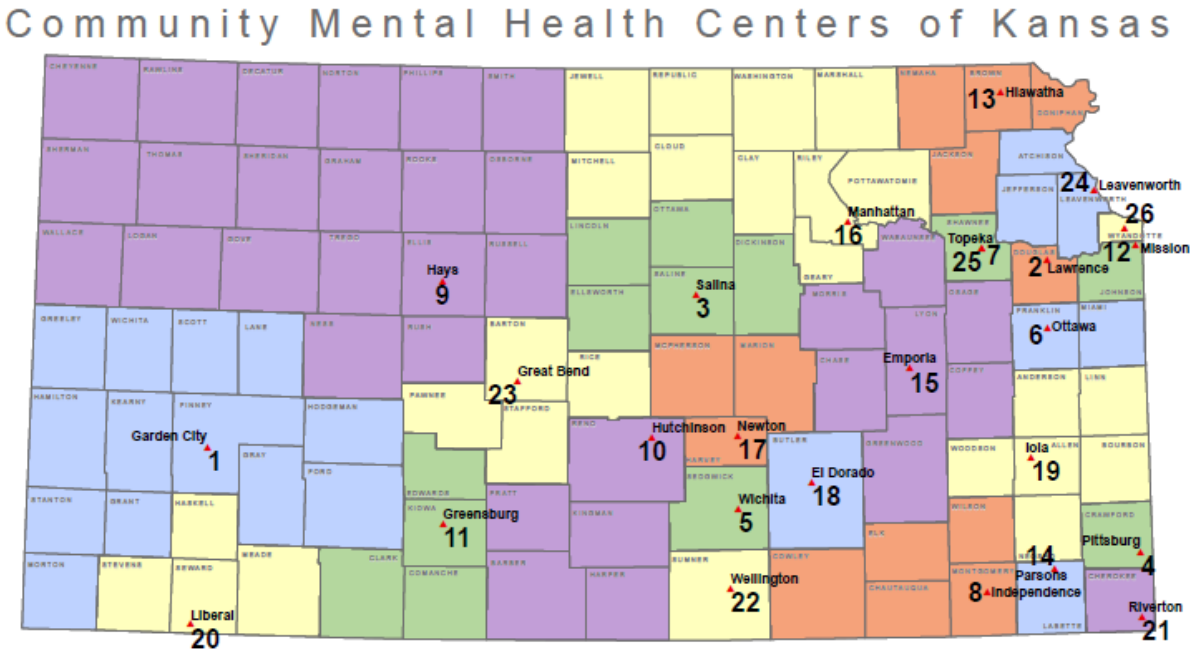


Mental Health Services

42 U.S.C. § 300x-1 - U.S. Code - Unannotated Title 42. The Public Health and Welfare § 300x-1. State plan for comprehensive community mental health services for certain individuals

Criterion 1: Comprehensive community-based mental health systems - The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities

Community Mental Health Centers (CMHCs) are charged by statute with providing the community-based public mental health services safety net in Kansas. Under Kansas Statutes Annotated (KSA) 19-4001 et. Seq., and KSA 65-211 et. Seq., twenty-six licensed Community Mental Health Centers (CMHCs) currently operate in the state including a children's-specific CMHC by one of the providers.



Source: Association of Community Mental Health Centers of Kansas, Inc. (www.acmhck.org)

These Centers have a combined staff of over 4,000 providing mental health services in every county of the state in over 120 locations. Together they form an integral part of the total mental health system in Kansas. The CMHCs operate under extensive state licensing regulations; are subject to licensure site reviews; and provide extensive required data routinely to the Kansas Department for Aging and Disability Services (KDADS). The CMHCs also conform to Medicaid and Medicare standards and audits.

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals with mental health problems in the least restrictive environment. The Centers provide services to all those needing it, regardless of economic level, age or type of illness. The Centers strongly endorse treatment at the community level to allow individuals to continue functioning in their own homes and communities, at a considerably reduced cost to them, third-party payers, and/or the taxpayer.

CMHCs provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. Per the State Automated Information Management System (AIMS), CMHCs served 102,22 adults (>18) in state fiscal year 2019 throughout Kansas. In the same fiscal year, CMHCs served 43,644 youth (<19). For Medicaid, the CMHCs contract with the three KanCare managed care health plans. For the Mental Health Block Grant services, the CMHCs contract with the State.

Services provided by CMHCs include: evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education, consultation, treatment and rehabilitation services, and 24-hour emergency services. Community-based mental health services also include assistance in securing employment services, housing services, medical and dental care, peer support and other supports. Almost all CMHCs in Kansas also offer substance use disorder treatment in their areas of the state.

CMHCs provide services and treatment to these persons in the priority target populations as defined by K.S.A. 39-1602, which are adults with severe and persistent mental illness (SPMI), children and adolescents experiencing a serious emotional disturbance (SED), and other individuals at risk of requiring institutional care.

Kansas law designates CMHCs as the gatekeepers for admission to state mental health hospitals. Under contract, CMHCs also carry out similar functions for nursing facilities for mental health, psychiatric residential treatment facilities and Medicaid-funded community hospital psychiatric services.

Crisis Centers

KDADS funds several Crisis Centers across the state with impressive early outcomes. These centers with detox beds and beds for stabilizing people in mental health crises give police officers and medical teams a place to take people where they can stay up to 23 hours instead of housing them in jails or emergency rooms. For example, the Sedgwick County Community Crisis Center (a joint endeavor between a Community Mental Health Center and a Regional Alcohol Drug Assessment Center) is estimated by the Wichita State University Public Policy and Management Center to have resulted in community cost avoidance to hospitals, EMS, and law enforcement of between $13.2 and $21.6 million in its first three years of operation. The full report can be found here:
https://www.wichita.edu/administration/diversity/ppmc/documents/SACK.pdf

Consumer Run Organizations (CROs)

Kansas has built an infrastructure of Consumer Run Organizations (CROs) to promote recovery through peer support recovery supports to those who currently or in the past have accessed mental health services, especially those with severe and persistent mental illness. Ten CRO's were awarded funding from KDADS for FY2020. CROs are legally incorporated, nonprofit, consumer-governed and operated organizations using a peer recovery model built on self-direction, empowerment, peer support and hope

for restoring individuals to a life that is integrated and meaningful according to each person's own terms. Typically, a CRO provides an array of services to its members that include leadership, education, training and research opportunities, one-on-one peer support, peer support groups, drop-in centers, self-help groups, employment support, life skills training, health and wellness activities, bridge supports from state institutions to life in the community, and education about Medicaid and other community resources to connect members to services. CROs seek to provide a safe, healing and trauma-free environment which enhances wellness and promotes resiliency. Peer support is distinct from other social supports in that the persons providing support can draw from their own recovery journey to inspire hope in others who are facing similar situations. There are ten CROs that receive funding by KDADS across the state of Kansas.

The Community Support Medication Program (CSMP) is a payment source of last resort for uninsured/underinsured Kansans in need of antipsychotic and/or antidepressant medication. Medication is distributed on a first-come, first-served basis. Without the support of these medications, program recipients would be at risk for hospitalization. Consideration of generic forms of medication and alternative funding sources are expected. An individual must meet the three following criteria: 1) clinical need 2) At-risk need and 3) financial need as evidenced by lower income and/or lack of insurance that would cover needed medications.

Criterion 2: Mental health system data and epidemiology - The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

According to the Behavioral Health Barometer for Kansas, Volume 4 (https://www.samhsa.gov/data/sites/default/files/Kansas_BHBarometer_Volume_4.pdf), for the years of 2014-2015, Kansas's annual average percentage of past year SMI among adults aged 18 or older was similar to the corresponding national annual average percentage. In Kansas, an annual average of about 87,000 adults aged 18 or older (4.1% of all adults) in 2014-2015 had SMI in the past year. The annual average percentage in 2014-2015 was not significantly different from the annual percentage in 2011-2012.

According to the Barometer, in 2015, 37,451 children and adolescents (aged 17 or younger) were served in Kansas's public mental health system. The annual average percentage of children and adolescents (aged 17 or younger) reported improved functioning from treatment received in the public mental health system was higher in Kansas than in the nation as a whole. The annual average percentage for adults (aged 18 or older) was higher in Kansas than in the nation as a whole.

Criterion 3: Children's services - In the case of children with serious emotional disturbance, the plan--

(A) *subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act [20 U.S.C.A. § 1400 et seq.]);*

(B) *provides that the grant under section 300x of this title for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and*

(C) *provides for the establishment of a defined geographic area for the provision of the services of such system.*

System of Care

SAMHSA awarded a four-year System of Care (SOC) Expansion and Sustainability Cooperative Agreement to KDADS in 2016. The purpose of this program is to improve behavioral health outcomes for children and youth (ages birth through 21 years) with serious emotional disturbances (SED) and their families. Kansas SOC is the partnership of the Kansas Department for Aging and Disability Services (KDADS), Wichita State Community Engagement Institute (CEI), and four Community Mental Health Centers (CMHCs): Compass Behavioral Health, South Central Mental Health Counseling Center, Sumner Mental Health Center and Wyandot Center for Community Behavioral Health.

Kansas SOC supports the wide scale operation, expansion and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (CMHI). This will build upon progress made in developing comprehensive SOC across the county by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure and the development and implementation of evidence-based and evidence-informed services and supports. Other activities supported will include the implementation of systemic changes, training and workforce development.

The following mental health services to youth to obtain the outcomes of improved behavioral health status of functionality of participants include: 1) diagnostic and evaluation services 2) outpatient services 3) 24-hour emergency services 4) intensive home-based services for children and their families when the child is at risk of out-of-home placement 5) intensive day treatment services 6) respite care 7) therapeutic foster care services, services in therapeutic foster family homes or individual therapeutic residential homes, and group homes caring for not more than ten children 8) assisting the child in making the transition from services received as a child to the services to be received as an adult and 9) other recovery support services (e.g. supported employment) and focus efforts to provide early treatment for those youth with early onset of SED/SMI to children and youth.

Within each CMHC catchment area, the SOC is establishing collaborations across child-serving agencies (e.g. substance use, child welfare, juvenile justice, primary care, education, early childhood) and among critical care providers and programs to build bridges among partners, including relationships between community and residential treatment settings. Families and youth are integrally involved in the planning, governance, implementation, evaluation, and oversight of grant activities and in the system planning efforts to expand and sustain the SOC. Mechanisms such as peer support, youth leadership development, youth-guided activities, parent support services and family advisory bodies, and self-help programs will be used to promote and sustain youth and family participation. SOC also implements an integrated crisis response strategy that creates a continuum of community-based crisis services and supports to reduce the unnecessary use of inpatient services by children and youth with SED.

Another mechanism for ensuring that Kansas children receive integrated services for their multiple needs is with the KDADS Home and Community Based (HCBS) 1915 (c) waiver program. Kansas administers Medicaid waivers for both children and youth who have a severe emotional disturbance (SED) and for those with autism (which is also covered under the Medicaid state plan). To be eligible for a waiver, one must be determined: 1) Eligible for the specific waiver program 2) Functionally eligible via a functional assessment and 3) Financially eligible. The single "point of entry" that completes each functional assessment varies depends on which waiver is being applied for.

Serious Emotional Disturbance (SED) Waiver

The local community mental health center (CMHC) is the single point of entry for the SED Waiver. Services provided under the SED Waiver are for children 4 to 18 years of age who experience serious emotional disturbance and who are at risk of inpatient psychiatric treatment. SED Waiver services provide children with special intensive support, so they may remain in their homes and communities.

Parents and children are actively involved in planning for all services. Local Community Mental Health Centers provide services covered by the program. Children who meet eligibility requirements will receive a medical card and are eligible for Medicaid physical and behavioral health services.

SED Waiver Services include:

- Wraparound Facilitator: A person who works with the family and their identified supports to set treatment goals and decide on services for the child and family.
- Parent Support and Training: Services designed to provide education, assistance, and other support to parents and families.
- Independent Living Skills Building: Staff supported development of the skills needed in order to live independently.
- Attendant Care: A staff person who helps the child with daily tasks.
- Professional Resource Family Care (Crisis Stabilization): Intensive support services provided to the child outside the home in a safe environment.
- Short Term Respite Care: provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. Short Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings including Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds.

The Autism Waiver provides support and training to parents of children with an Autism Spectrum Disorder (ASD) diagnosis to help ensure children with ASD can remain in their family home. Autism Waiver Services include:

- Family Adjustment Counseling: Family Adjustment Counseling offers guidance and assistance for family members of a child with Autism Spectrum Disorder (ASD). These services are provided by a Licensed Mental Health Provider (LMHP) and help the family in coping with the

child's diagnosis and daily needs, by offering a safe and supportive environment to express emotions and ask questions.

- Parent Support and Training (Peer to Peer): Parent Support and Training assists family members to acquire the knowledge and skills needed to understand and address the specific needs of and treatment for the child in relation to ASD and develop the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom and behavior management.
- Respite Care: Respite Care offers temporary direct care and supervision of the child to provide relief to families and caregivers of a child with ASD. A respite care provider assists with normal activities of daily life in order to meet the needs of the primary caregiver as well as the child.

The following three services were previously part of the Autism Waiver and are now part of state plan services that a child can access with a medical card. The child does not need to be on a waiver to begin or to continue to receive these services:

- Consultative Clinical and Therapeutic Services (provided by an autism specialist): Consultative Clinical and Therapeutic Services focus on improving of behavioral challenges related to the diagnosis of autism spectrum disorder (ASD). They teach skills to help the family and paid support staff or other professionals with meeting the needs of the child with ASD. The autism specialist assesses the child and family's strengths and needs, develops the Individual Behavior Plan/Plan of Care (IBP/POC), coordinates services, provides training and technical assistance, and monitors the child's progress within the program.
- Intensive Individual Supports: Intensive Individual Supports services are provided to a child with autism spectrum disorder (ADS) to assist in acquiring, retaining, improving, and generalizing skills needed to successfully function in their home and community. This may include development of skills such as social skills, language and communication, motor skills, engagement, cognitive skills, and behavior skills.
- Interpersonal Communication Therapy (ICT): Interpersonal Communication Therapy (ICT) works to improve social communication symptoms related to the diagnosis of an autism spectrum disorder (ASD). ICT includes the development of skills such as conversation, unplanned communication, understanding of verbal and nonverbal communication.

To be eligible for the Autism Waiver, an individual must meet the following criteria: 1) Be 0-5 years old (at time of application; they can apply until their sixth birthday) 2) Be diagnosed with an Autism Spectrum Disorder, Asperger's Syndrome or a Pervasive Developmental Disorder – Not Otherwise Specified and 3) Be financially eligible for Medicaid. Autism Waiver services are typically limited to three years. An additional year of service is available in some cases based upon a review process. Requirements for this one-year extension of services beyond the three-year initial limit include the following: 1) The child must meet eligibility based on a Level of Care assessment at the annual review of the third year of services, and 2) Data collected by the KanCare managed care organization must demonstrate a need for continued Autism Waiver services.

Criterion 4: Targeted services to rural and homeless populations - The plan describes the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

KDADS currently offers several programs to assist individuals who are homeless or at risk of homelessness and experiencing an SMI: Supported Housing funds, Interim Housing, and Projects for Assistance in Transitioning from Homelessness (PATH).

Projects for Assistance in Transitioning from Homelessness (PATH)

PATH is a SAMHSA funded program designated to support the delivery of eligible services to persons who have a SMI and may also have a co-occurring disorder, are homeless or at risk of becoming homeless. Through outreach services provided by CMHCs, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive services. Collectively, these efforts help homeless individuals with SMI secure safe and stable housing, improve their health, and live a self-directed, purposeful life.

Supported Housing Fund Program

The Kansas Department for Aging and Disability Services, Behavioral Health Services Commission fund the Supported Housing Fund Program (SHF) with state general funds in the amount of $535,714. The SHF is able to provide “tenant-based housing first” assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is accomplished by providing temporary flexible funds for their housing needs. In FY2019, funds from the Supported Housing Fund program assisted approximately 95 individuals per month in obtaining or maintaining housing.

Interim Housing Program

The Behavioral Health Services Commission funds an Interim Housing Program. As a response to policy to prevent discharging individuals into homelessness, Kansas’ mental health system saw a need to create more “interim” housing options for individuals leaving Nursing Facilities for Mental Health or State Psychiatric Hospitals who are without permanent housing arrangements. In FY 2019, BHS funded six Interim Housing (IH) projects across the state. Interim Housing is defined as short-term housing that is used until a more permanent housing arrangement can be made.

Unlike the Supported Housing Fund Grant, which provides tenant-based assistance, these funds provide “project-based rental assistance.” Project-based housing provides immediate assistance, without the need for the individual to undergo a housing search, traditional tenant screening process, and acquisition of the furniture and items necessary to establish a household while still in-patient in a hospital setting. Upon entering the IH project, the CMHCs Housing and Homeless Specialists and other case managers immediately begin providing the assistance necessary for the resident to obtain more permanent housing.

Collectively, the FY2019 IH grantees prevented homelessness for 85 individuals. Of those individuals who exited the program, 80% moved into a community-based living situation by the end of the grant term. Approximately 50% of the individuals assisted in the Interim Housing Units were chronically homeless.

Criterion 5: Management Systems - The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 300x of this title for the fiscal year involved.

Except as provided for in paragraph (3), the State plan shall contain the information required under this subsection with respect to both adults with serious mental illness and children with serious emotional disturbance.

Mental Health First Aid

To ensure that emergency health staff and first responders are able to train others in their arenas of work, KDADS staff attended Youth Mental Health First Aid training of facilitators. KDADS staff then facilitated several trainings. CMHCs also offer Mental Health First Aid training within their communities for educators, families, clergy, health care professionals and other stakeholders. Each CMHC also participates in disaster planning and training at both the local and state levels.

Crisis Intervention Training (CIT)/Veterans Services

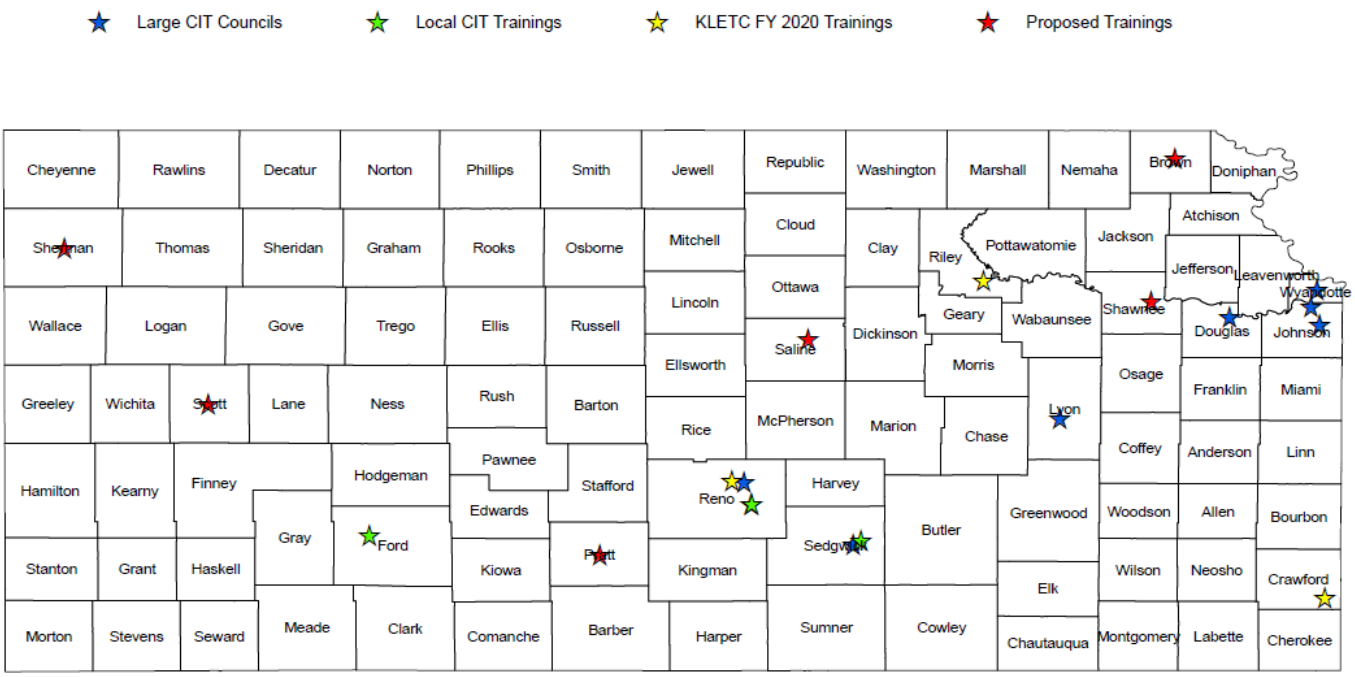
The current KDADS state coordinator for the Crisis Intervention Training (CIT)/Veterans services position has nine years of senior ranking active duty military service and civilian law enforcement experience. KDADS has taken a comprehensive and proactive approach to train law enforcement, first responders and other professionals around the state in the areas of mental health and crisis intervention. The Behavioral Health Services Commission and the Governor's Behavioral Health Services Planning Council have provided grant funding to CIT and veteran's programs. This funding created a new employment position and the ability to train hundreds of law enforcement professionals in the state of Kansas on Crisis Intervention and Veteran Programs Training. Through this grant, KDADS has partnered with the Kansas Law Enforcement Training Center (KLETC) located in Hutchison, KS. KLETC provides the curriculum and classroom presenters, student room and board, snacks and finally a 40-hour certificate and CIT pin for their uniform. In FY19, we have trained over180 personnel stretching over 19 counties with a focus on the rural and frontier areas with little resources.

Crisis Intervention Teams (CIT) is a police training program created in 1988 in Memphis, TN. It was originally a partnership between NAMI and the Memphis Police Dept after a shooting of a mentally ill person. CIT is a program that utilizes community partnerships to provide consumers access to treatment systems and mental health advocates in the time of a crisis. Long term, CIT has led to additional options for inpatient treatment, including sub-acute care facilities and increased long term beds. These upgrades to the mental health system are the result of advocacy by NAMI and other agencies and can directly be attributed to the law enforcement officers of Kansas. The goals of the training are to give officers and mental health professionals the knowledge of the major diagnoses they would encounter on the street or in the jail and also to be able to identify these diagnoses in a crisis and how to best communicate with consumers at that time. Additionally, Officers are trained in de-escalation techniques for calming a crisis and choosing the best placement for the consumer within the proper system.

The KDADS Commissioner and the state CIT/Veterans Coordinator are leading a SAMHSA sponsored event called the Governor's Challenge in the state of Kansas. Kansas is one of seven states in the United States selected to receive technical assistance and resources to reduce Service Member, Veteran and

Family Member suicide. We also participate in the SAMHSA sponsored event called the Mayors Challenge in the capitol city of Topeka. Goals are the same in reducing Service Member, Veteran and Family Member suicide. The CIT/Veterans Coordinator is currently working on a Governors Proclamation for Veterans and an informational video with our Governor.

Crisis Intervention Team Locations and Proposed Training Sites:
Kansas Law Enforcement



Problem Gambling Services

The Kansas gambling industry is currently represented by four state-owned casinos, five tribal casinos, charitable gaming and the Kansas Lottery. In 2007 the Kansas Legislature enacted the Problem Gambling and Addictions Grant Fund. Two percent of the monthly net revenue from the four state-owned casinos is deposited into this fund. Resources to fund problem gambling specific services are limited however as the funding allocated for these services have remained at less than ten percent of the total dollars deposited into this fund. The dollars that are allocated for problem gambling services are used statewide to provide treatment for problem gamblers and their concerned others, prevention resources, education and awareness, and research and evaluation. During the state fiscal year for 2018, approximately $290,000 was spent to provide treatment services and helpline crisis services for those accessing services; $131,000 was spent to provide prevention resources and education services at the community level, $37,000 was spent to provide education, awareness and workforce development at a statewide level, and $188,000 was spent in statewide administrative costs. Kansas currently has thirty-six state certified gambling counselors, two gambling prevention specialists and one program administrator.

Diversity

The Kansas Department for Aging and Disability Services (KDADS) recognizes the unique needs and access challenges faced by racial and ethnic minority communities in Kansas. Thus, keeping abreast on research and best practices that impact race, ethnicity, religion, geography, sexual orientation, and gender identity, and socio-economic status is an ongoing focus. Being culturally competent is a major step to enhance awareness and ensure inclusion in meeting behavioral health needs. Committees and coalitions are created to be inclusive of racial and ethnic minorities, including American Indians/Alaskan Natives to ensure processes and policies are reflective of practices, beliefs, and needs.

The Kansas Citizen's Committee on Alcohol and other Drug Abuse (KCC) is a subcommittee of the Governor's Behavioral Health Services Planning Council. The subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as, the Secretaries of relevant state agencies. The Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC) bylaws require the membership to constitute a representative cross-section and shall take race, ethnicity and gender into consideration. The KCC has made recommendations in their annual report to the Secretary for a loan forgiveness program to help recruit a more diversified workforce.

Additionally, KDADS contracts with Beacon Health Options (BHO) to administer the SABG. Beacon's provider contract requires that services shall be provided by qualified staff and shall be clinically appropriate, and available for: (a) pregnant IVDU women, pregnant women, and (b) IV drug users; and (c) individuals with a positive TB screen or at high risk of tuberculosis; and (d) individuals at high risk to/or afflicted with HIV. Providers shall offer equal access to substance use disorder treatment for all eligible Members regardless of age, sex, ethnicity, disability, race, color, ancestry, political affiliation, religion, sexual orientation, mental health disability, or national origin. The Provider shall further comply with all provisions and applicable conditions of Title VII of the Civil Rights Act of 1964, as amended; the Age Discrimination and Employment Act of 1967, as amended; the Equal Pay Act of 1963; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990; the Civil Rights Act. Failure to comply with this requirement may result in contract termination. Furthermore, in delivering services, including outreach activities, SAPT Block Grant-funded religious organizations cannot discriminate against current or prospective Members based on religion, religious belief, refusal to hold a religious belief; and refusal to actively participate in a religious practice.

During BHOs Utilization Management, Beacon clinicians treat all cases equitably, and there are no processes or practices that specifically target racial or ethnic minorities differently than non-minorities. Each determination and managed case is considered on its unique merits which include viewing the member in the broad contexts of race, ethnicity, religion, geography, sexual orientation and gender identity, and socio-economic status.

Further, Kansas is rapidly growing the capacity of Peer Mentors through free bi-monthly certification trainings for persons in recovery with lived experience to become certified as Kansas Certified Peer Mentors and begin working for licensed Substance Use Disorder (SUD) programs. These trainings are offered in locations statewide to develop peers in all regions of the state. The peer workforce is much more diversified then the current SUD professional workforce and matches more effectively the diversity of the clients being served. We are actively encouraging providers to utilize peer services and to match mentors with treatment participants to better serve and relate to similar cultural, racial, and

environmental factors and whom are knowledgeable about naturally occurring resources in the community to assist in recovery supports.

An additional benefit is that some persons working as peer mentors are continuing to pursue additional education to become licensed as SUD counselors. We have also actively engaged the Kansas Oxford House Alumni Association to receive peer certification training. Kansas has 126 Oxford Houses that operate under the "Oxford House Model", a community-based approach to addiction treatment, which provides an independent, supportive, and sober living environment. Oxford Houses have provided several new participants into the Kansas peer workforce.

HIV-designated state

Kansas is not a FY 2020 HIV-designated state, or a state designated in any of the prior three fiscal years as HIV-designated.

Prevention Services addendum Step 1

Primary Prevention services reach non youth aged populations in the state

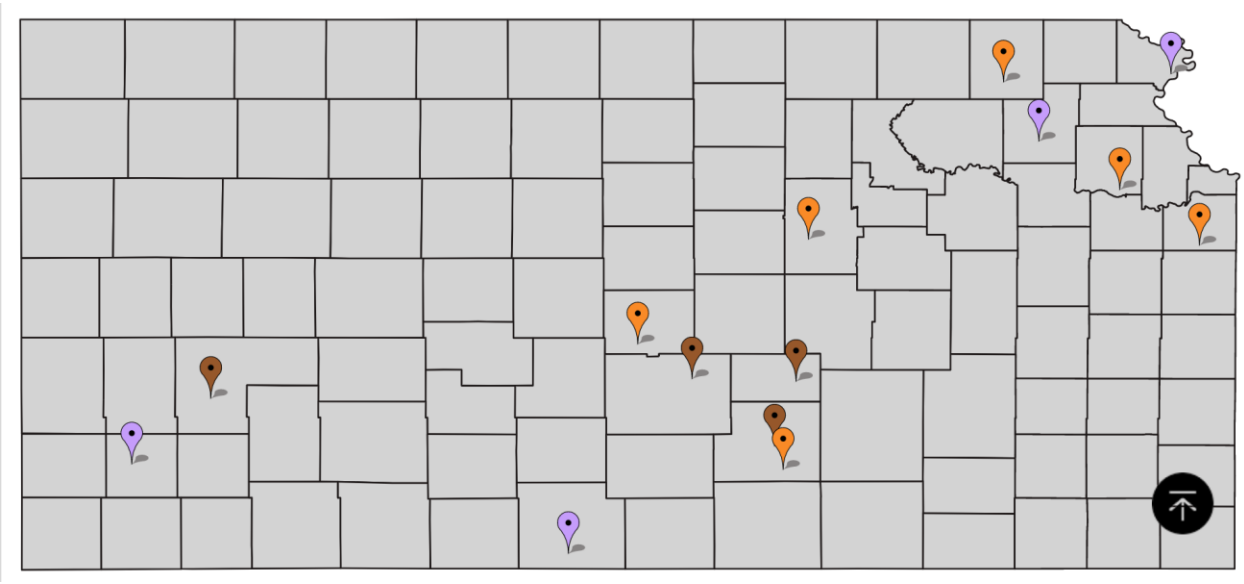
As it relates to older adults and prevention across the lifespan, Primary Prevention services included efforts surrounding Tobacco, Marijuana, and prescription drug misuse. However, Kansas recognizes the reach could be broader regarding Primary Prevention efforts for the non-youth aged populations in the state.

KDADS held a summit on this topic in 2018 that brought together stakeholders and discussed the issue. However, we continue to work towards the completion of our statewide assessment and strategic plan which will enable us to look at increasing our capacity, widening our focus and implementing activities that include non-youth aged populations in the state in need of Primary Prevention. One effort in that direction is the creation and posting of this page on our KPC website: http://kansaspreventioncollaborative.org/resources/prevention-topics-older-adult-substance-use-prevention

SABG primary prevention set-aside funds and suicide prevention services and activities

KDADS does not spend SABG funds on suicide prevention, so there is no supplanting of SP funds with SABG funds. KDADS focus' on the shared risk and protective factors for substance abuse and behavioral health. The focus has been on Prevention efforts that target shared factors that are more likely to have greater impact, as these factors have the potential to contribute to multiple outcomes.

Community Coalitions



Currently there are 14 Kansas Prevention Collaborative-Community Initiative (KPCCI) coalitions. Their goal is to increase and enhance local level capacity and readiness and to mobilize community members in an effort to enhance local level strategic planning. Their work also focuses on increasing the readiness of the community to implement comprehensive, data-driven community prevention approaches in an effort to decrease the incidence of underage and binge drinking and to increase the perception of harm for marijuana as well as to address associated risk and protective factors. KPCCI is

intended to reduce and prevent substance abuse in identified communities and enrich prevention efforts across the state through the implementation and sustainability of effective, culturally competent prevention strategies. Through the advancement of technological supports, learning processes, technical assistance, direct consultation, and other resources, grantees are supported through each of the five steps of the SPF. KDADS funds the partners of the Kansas Prevention Collaborative to support all Kansans as a public audience and offers more specific training and technical assistance services for those coalitions currently receiving funding from KDADS through prevention grants. The Substance Abuse Block Grant prevention funds are dispersed throughout the state through a Request for Proposals (RFP) process.

KPCCI funds approximately two-four planning grantees and multiple implementation grantees (at the time of this writing, there are 4 Planning Grantees and 10 Implementation Grantees among 3 cohorts). This initiative currently addresses primarily underage drinking, youth marijuana use, and shared risk and protective factors as identified by each coalition based on data specific to their community. Coalitions are currently funded by KDADS in the North Central, North East, South Central, and South West service regions of KDADS, and there are no coalitions currently receiving funding from KDADS in the Northwest and Southeast service regions of the state. However, the KPC includes contact information with 106 coalitions throughout the state currently and provides information dissemination and prevention education services at no cost, as well as other capacity-building prevention training and technical assistance.

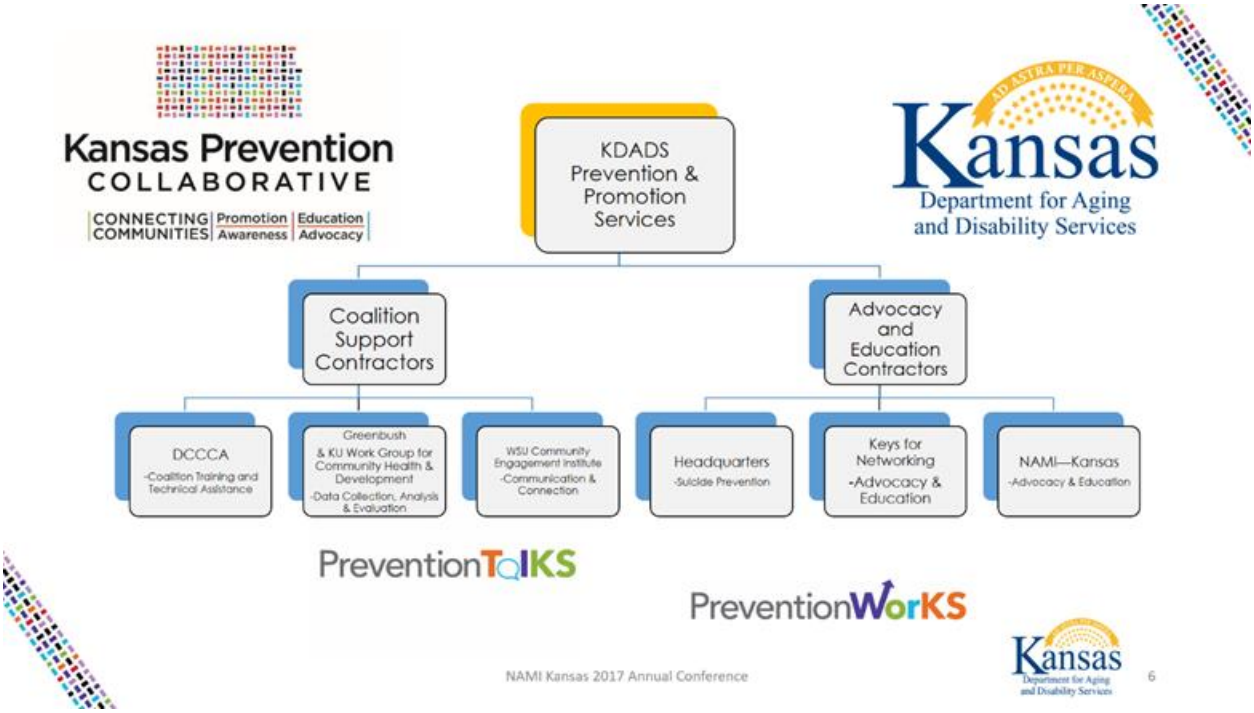
The support from the KDADS and the KPC provides coalitions with the tools to be better prepared to apply for, and secure, other state and national resources to support the implementation and evaluation of their comprehensive prevention plans. KDADS and the KPC provides support to achieve the best use and future application of their efforts throughout the Planning Grant phase, which includes capacity building and sustainability planning. Each coalition utilizes guidance, training, and technical assistance during the phases of the planning process and expedited review and approval of community plans. The KPC provides training and technical assistance, instructional designers, prevention consultants, and other resources which are available throughout each of the five steps of the Strategic Prevention Framework, with an emphasis on cultural competence and sustainability within each step. Community coalitions must demonstrate an ability and willingness to participate in all required training and technical assistance opportunities provided by the KS Prevention Collaborative. Training are offered both virtually and face to face.

Utilizing funding and technical assistance, community coalitions analyze local conditions that are contributing to substance abuse within their identified geographic area. Resources and technical assistance support are provided to develop a local assessment profile, logic model, and action plan to address these issues using the five- step SPF process (i.e., assessment, capacity building, planning, implementation, and evaluation). This also includes plans for sustainability and cultural competence.

In June of 2015, five contractors were selected to provide services as part of the collaborative. Since then the Kansas Prevention Collaborative (KPC) formed new partnerships and contracted with additional entities for providing the best support service to Kansas coalitions. The KPC has refined subcontracts with the University of Kansas Center for Community Health and Development (CCHD) and a contract with Headquarters, Inc. The KPC contractors and their role-summaries are included in the table and the graphic below.

Contractor	Purpose
DCCCA, Inc.	Provision of statewide training and technical assistance to community coalitions, community initiatives, and KDADS projects that may be focused on one or more behavioral health concerns (substance abuse prevention, problem gambling awareness and prevention, suicide prevention, mental health promotion)
The Center for Learning Tree Institute, Greenbush	Provision of statewide, regional, and local-level behavioral health data collection, analysis and evaluation, including the Administration of the Kansas Communities that Care Student Survey
Wichita State University-Community Engagement Institute	Provision of statewide behavioral health education, resource and information dissemination, consumer outreach and advocacy including the development of a communication's hub and the development and facilitation of a statewide prevention coalition (Since the origin of the KPC, this partner has been renamed Wichita State University's Community Engagement Institute.)
Keys for Networking	Provision of behavioral health education, resource and information dissemination, consumer outreach and advocacy with a specific focus on creating and maintaining adequate capacity to support families and individuals in crisis and providing guidance to families and individuals in accessing appropriate services within communities, educational entities, and home environments
NAMI, Kansas	Provision of behavioral health education, resource and information dissemination, consumer outreach and advocacy with a specific focus on creating and maintaining adequate capacity to support families and individuals in crisis and providing guidance to families and individuals in accessing appropriate services within communities, educational entities, and home environments

University of Kansas Center for Community Health and Development (CCHD)	The CCHD brings capacity-development tools and evaluation expertise through their workforce, the Community Check Box, and their management of the KPC WorkStation.
Headquarters, Inc.	Suicide prevention expertise and suicide prevention efforts throughout the state of Kansas. Headquarters, Inc. also provides counseling, education, and resources to improve public health and generate awareness.



American Indians/Alaska Natives (AI/AN)

Kansas is home to 4 federally recognized tribal nations. According to the most recent ACS, the racial composition of Kansas population identified as AI/AN people was .83%.

Prairie Band Potawatomi Nation is one of the KDADS funded coalitions through the Prairie Band Potawatomi Nation Boys & Girls Club. Their mission is to assist in the development and enhancement of

the spiritual, mental, emotional, physical and social well-being of all young people in the surrounding area by providing a safe and positive place for kids.

In addition, KDADS and KPC works with Prairie Band Potawatomi Nation to coordinate the prevention portion of the Substance Abuse Block Grant, to measure prevention needs and services. This includes supporting an infrastructure around data collection and analysis, resource allocation, planning, and prevention workforce training.

Currently there are 174 citizens that identify as Alaska Natives.

Diversity

Cultural competence training is a required component in the Planning stage for all funded coalitions to build capacity. Coalitions from across the state participate in an online training regarding cultural competence and sustainability offering concepts specific to the Strategic Prevention Framework's overarching components and tips and tools to carry these out in their community's. Additionally, web-based e-learning modules and toolkits on cultural competence also are available through the KPC on demand for coalitions to access at their convenience. This training prepares coalitions to assess the needs of diverse racial, ethnic and sexual minorities in their community throughout the SPF process.

Kansas administers the Behavior Health assessment which collects and aggregates data including but not limited to age, gender, and race/ethnicity.

Kansas continues to evaluate strategies and best practices to ensure the prevention system is inclusive of all citizens. Although Kansas has made great strides, the state recognizes a need to plan for future opportunities to evaluate what populations are being reached by prevention, which ones are not and how the state can guarantee saturation in all counties across the state.

All KDADS-funded coalitions are trained in Substance Abuse Prevention Skills Training and additional training events focused on addressing the needs of diverse racial, ethnic and sexual minorities as well as American Indian/Alaskan Native populations in the state. This area is a known opportunity for growth, and the next Cultural Competence training scheduled will introduce new plans to address Behavioral Health Disparities and preview future activities in the next State Fiscal Year. Curriculum and technical assistance resources are currently being developed to offer a more the KPC's most robust training on Behavioral Health Disparities in September 2020.

Strengths

The strength of Kansas prevention program lies in the commitment to listening to the voice of the community with a philosophy that communities know best what they need. Kansas ensures that voice is heard and respected by investing in community coalitions not only financially, but also through technical assistance and training which supports them through the process of assessing needs and capacity through the implementation stage of development. This level of engagement from the communities enhances the dialogue regarding prevention efforts in the state, helps to identify gaps, and defines how the state can partner with the local communities.

A way to ensure this collaboration is PreventionWorKS. PreventionWorKS believes in the power of passionate people working together to promote positive change by empowering collaboration, fostering

the sharing of creative and innovative resources, and inspiring hope. The programs vision is to have a vibrant Kansas empowered through community connectedness.

PreventionWorKS connects individuals and groups across the state of Kansas who are passionate about prevention work and making a difference in their communities. Since 2016, quarterly meetings have provided opportunities for mentoring and working collaboratively to integrate behavioral health promotion and the prevention of substance abuse, suicide, and problem gambling. These meetings have been attended by hundreds of people with ongoing evaluation and adaptation as recommended by attendees.

The Steering Committee of PreventionWorKS is composed of members from community prevention coalitions representing a balance of community size, geography, demographics and prevention focus areas. This group provides guidance to the full coalition, and benefits from expertise and influence offered by members of PreventionWorKS.

Another way community partnership has been fostered is through PreventionTalKS. PreventionTalKS was developed by a group of prevention-minded professionals seeking to provide an opportunity for community coalitions and other prevention-minded people across the state of Kansas to connect and learn from one another and from professionals with specific and relevant topic expertise – connecting our big state through a common interest of Prevention. Prevention Initiatives at Wichita State University's Community Engagement Institute organizes and provides PreventionTalKS for the Kansas Prevention Collaborative, guided by the PreventionWorKS Steering Committee and in partnership with KDADS. The purpose of PreventionTalKS is to promote citizen education and to increase public awareness of behavioral health promotion and prevention, consistent with the role and mission of the Kansas Prevention Collaborative, statewide behavioral health integration efforts, the Kansas Prevention Collaborative, and PreventionWorKS.

Over the past three years, PreventionTalKS has been offered through a monthly webinar series. In January 2019 the format of PreventionTalKS was revamped to reach a broader audience and increase effectiveness in a manner that participants and listeners have determined to be more user-friendly. PreventionTalKS currently offers a monthly podcast highlighting timely prevention-related topics of interest to stakeholders across Kansas.

Community members continue to remain an integral participant in the Governor's Behavioral Health Services Planning Council (GBHSPC). The mission of the GBHSPC is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

Members consist of community members, youth and adult, with lived experience in the areas of Severe and Persistent Mental Illness (SPMI), recovery from substances use disorder (SUD), peer mentors to persons with SUD, Serious Emotional Disturbance (SED). Also included are mental health service providers, SUD service providers, state agency staff (KDADS), Tribal representation, Judicial representation, advocacy representation for Behavioral Health Services and private citizens.

Much of the work of the Kansas Council is done by citizen volunteers that are members of subcommittees established to report and make recommendations to the Council. Through the Council, these subcommittee recommendations are reported to the Secretary of KDADS. One of the sub-

committees, Prevention, was established to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes, and to increase the effectiveness of State and local efforts to address prevention issues. This group serves as a broad, representative voice for behavioral health as it relates to prevention of a range of health and behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder prevention. The Prevention subcommittee's mission is to provide feedback, guidance, advocacy, and engagement at the State level for related behavioral health prevention outcomes and identification of systems changes to address challenges, barriers, issues, and needs at the State, regional, or community level. The Prevention subcommittee's vision is to ensure that key representatives and stakeholders are involved in the provision of reflection, feedback, and guidance relating to initiatives within Kansas Behavioral Health Prevention Initiatives to ensure enhanced collaboration, effectiveness, and impact on State and local level prevention and behavioral health outcomes.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

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

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

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

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Footnotes:

FFY2020 - 2021 Combined Block Grant Application

Section II: Planning Steps

Step Two Narrative

- ***SABG Instructions (Step Two Narrative)***

  From the guidance:

  "Step 2: Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps." The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's NSDUH, TEDS, NSSATS, the Behavioral Health Barometer, and state data.

  This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for HIV-designated states, Persons at Risk for HIV.

  In addition, this narrative must include a description of the composition of the State Epidemiological Outcomes Workgroup and its contribution to the state planning process.

- ***MHBG Instructions (Step Two Narrative)***

  From the guidance:

  Section II: Planning Steps
  The state should identify the unmet service needs and critical gaps in its current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. The state should also address how the state plans to meet the unmet service needs and gaps.

  1 At a minimum, the plan should address the following populations as appropriate for the MHBG:
  *☐Children with SED and their families**
  *☐Adults with SMI**
  *☐Older Adults with SMI**
  *☐Individuals with SMI or SED in the rural and homeless populations**
  ☐Individuals who have an Early Serious Mental Illness (ESMI) (10 percent MHBG set aside)

  (*Populations that are marked with an asterisk are required to be included in the state's needs assessment for the MHBG. To the extent that the other listed populations fall within any of the statutorily covered populations, states must include them in the plan)

Step Two Narrative
From the guidance
Step 2: Identify the unmet service needs and critical gaps within the current system.
This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

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

Mental Health Strengths and Needs

Federal Data

Kansas utilized the Behavioral Health Barometer Kansas, Volume 4 indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System found on the following link: https://store.samhsa.gov/system/files/sma17-barous-16-ks.pdf

The Behavioral Health Barometer report indicated Kansas was similar to the corresponding national annual average percentage for the following indicators:

YOUTH MENTAL HEALTH AND SERVICE USE		
Indicator	Kansas	National Average
Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12-17 in Kansas and the U.S.	11.2%	11.9%

Past Year Treatment for Depression Among Adolescents Aged 12-17 with Major Depressive Episode (MDE) in Kansas	40.2%	38.9%
MENTAL HEALTH AND SERVICE USE		
Indicator	Kansas	National Average
Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in Kansas and the U.S.	4.1%	4.0%
Past Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in Kansas and the U.S.	4.1%	4.1%
Past Year Mental Health Service Use Among Adults Aged 18 or Older with Any Mental Illness (AMI) in Kansas	47.2%	42.9%

The Behavioral Health Barometer report reported improved functioning from treatment received in the public mental health system was higher in Kansas than in the nation as a whole for the following indicators:

MENTAL HEALTH AND SERVICE USE		
Indicator	Kansas	National Average
Mental Health Consumers in Kansas and the United States Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2015) – Children and Adolescents (Aged 17 or younger)	79.4%	71.6%
Mental Health Consumers in Kansas and the United States Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2015) – Adults (Aged 18 or Older)	77.2%	71.8%

However, according to the Centers for Disease Control and Prevention, suicide is rising across the U.S. (https://www.cdc.gov/vitalsigns/suicide/index.html). The overall percentage change in the U.S. increased by 25.4%. Kansas increased 45% from 1999 to 2016. Kansas exceeded the nation as a whole.

State Data

To identify unmet service needs and critical gaps within the current Mental Health system in Kansas, KDADS relies upon resources such as the Governor's Behavioral Health Services Planning Council and subcommittees and the state mental health data system called AIMS. Community Mental Health Centers (CMHCs) provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. The Automated Information Management System (AIMS) is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans. Per the State Automated Information Management System (AIMS), CMHCs served 102,22 adults (>18) in state fiscal year 2019 throughout Kansas. In the same fiscal year, CMHCs served 43,644 youth (<19). KDADS's projected prevalence for state fiscal year 2020 is 6.3% increase for youth who are SED and 4.8% increase for adults who are SMI.

Governor's Behavioral Health Services Planning Council (GBHSPC)

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

The values of the GBHSPC is prevention, treatment, and recovery services:

- Allow people to direct their care and treatment;
- Are respectful and empowering;
- Are effective and influenced by evidence-based practices that lead to a personal process of recovery and resilience; and
- Are integrated, flexible, and accessible.

SAMHSA was onsite in May 2018 for a 10-year comprehensive onsite review. The SAMHSA Lead on the Review indicated onsite that Kansas has one of the best Planning councils in the country.

There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Supportive Employment and Vocational Services and 8) Veterans.

Each of the Council's subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

The subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these

recommendations to the Council body, as well as the Secretaries of relevant state agencies. In addition, the GBHSPC has approved forming three new subcommittees: Problem Gambling, Aging, and Evidence-Based Practices.

Subcommittee Reports and Recommendations

The GBHSPC's annual subcommittee's charter, bylaws and reports can be found on the KDADS website at this link: https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc. For more information, please click on the embedded subcommittee links to expand.

- Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC)

The Kansas Citizen's Committee on Alcohol and Other Drugs has been in existence for many years and is statutorily required. K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A's 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas. The Kansas Citizen's Committee Subcommittee Report for 2018 highlights several specific recommendations and action steps related to Increased Funding, Improved Access and Service Integration, the Workforce Crisis, and Prevention.

- Children's Subcommittee

The Children's Subcommittee is dedicated to maintaining the community-based family driven values of the Kansas children's public mental health system of care. The subcommittee makes recommendations to improve the Kansas public mental health system and ensure the needs of children and families are met. In the subcommittee's 2017 – 2018 annual report, there are four goals with recommendations related to identifying a process for the Children's subcommittee to link/communicate well with other subcommittees, making recommendations regarding caregiver, parent, and family engagement in navigating behavioral health systems, defining/describing the Kansas children's continuum of care, and identifying and describing the data elements that the children's subcommittee wants in an integrated data system.

- Housing and Homelessness Subcommittee (HHS)

The Housing and Homelessness Subcommittee (HHS) focuses on helping adults experiencing severe and persistent mental illness and children diagnosed with severe emotional disturbance and their families obtain and maintain safe, decent, affordable, and permanent housing. The HHS acts as the body in Kansas who offers guidance and recommendations to the Governor's Behavioral Health Services Planning Council and to KDADS, so they can effectively exercise leadership in this arena. The subcommittee recommendations for FY19 are that the subcommittee will work with KDADS to coordinate the Subcommittee's goals and strategies with the Kansas Interagency Council on Homelessness, the subcommittee will explore options for a centralized data system within the housing and homelessness field that other State and local entities have access to for finding housing

and services for our shared customers, and the subcommittee will ask the three Managed Care Organizations to recommend someone from their respective organizations to serve on the subcommittee with the intent to explore Evidence-Based Practices and/or Promising Practices that support the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders.

- Justice Involved Youth and Adult Subcommittee

The Governor's Behavioral Health Services Planning Council's Justice Involved Youth and Adult Subcommittee is a group of stakeholders and forensic professionals charged with examining pertinent issues in Kansas as they pertain to the justice involved population. The Justice Involved Youth and Adult Subcommittee prioritizes its goals and activities around transforming mental health policies, programs, and funding that address jail diversion, access to timely and appropriate services while incarcerated, and reentry. The subcommittee recommendations for 2017 include engaging community partners and related to creating an adult continuum of care subcommittee.

- Supportive Employment and Vocational Services Subcommittee

The Vocational Subcommittee evaluates outcomes to discover areas in which the system is doing well and where it can improve. It also makes recommendations on where to focus funding for vocational programs. In the subcommittee's 2017 report, subcommittee recommendations relate to the following goals for 2017 and 2018: recommend that the State use their KanCare 2.0 renewal application to implement a 1915(i)-"like" waiver to provide employment supports and other services for individuals with behavioral health issues; Mental Health Centers will use available resources to support getting consumers to work; the IPS Supported Employment model is the model of choice for the Kansas mental health system and should be made available at every Community Mental Health Center; Training and collaboration opportunities will be available across the state, to address areas of consistency of services and proper mental health and vocational rehabilitation training for all providers of supported employment services, and Increase engagement of stakeholders, consumers, families and employers.

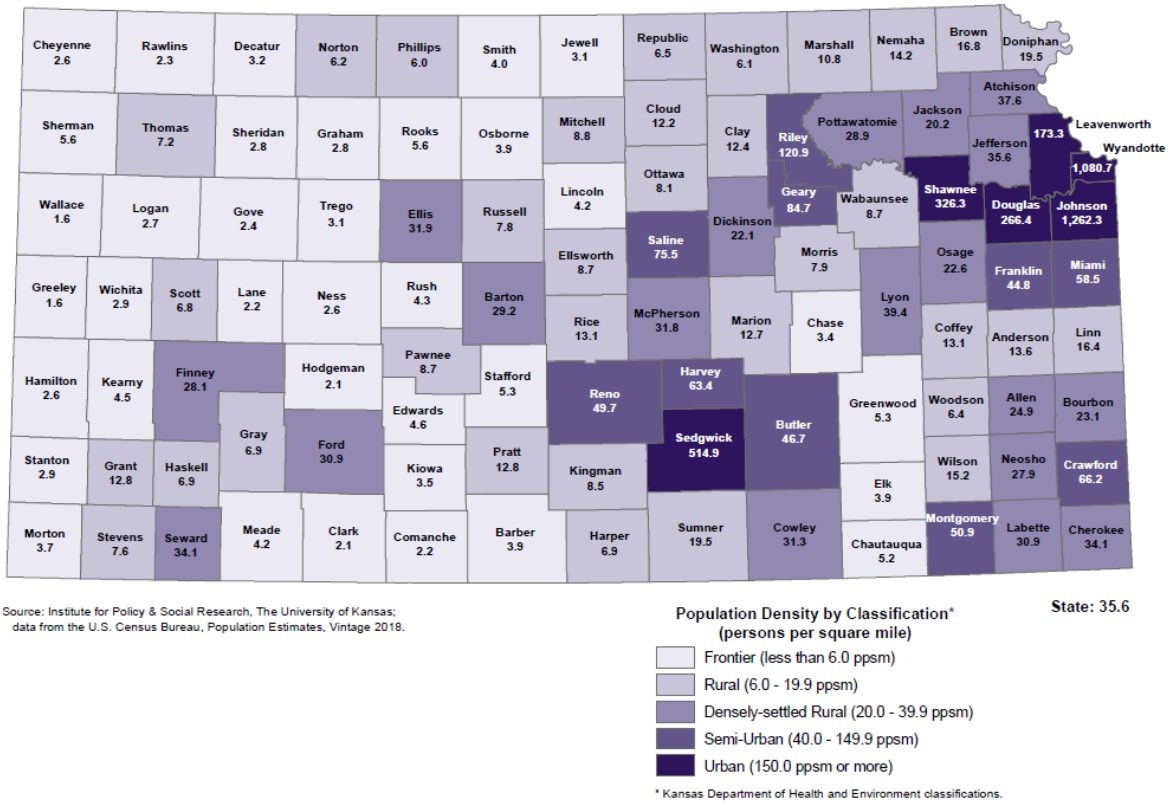
- Rural and Frontier Subcommittee

The Rural & Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, [the committee] assures accessibility/availability of mental health services in frontier/rural Kansas counties. The vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in mental health services. Rural issues are often misunderstood, minimized and not considered when forming mental health policy. In the Committee's 2018 annual report, FY2018 goals and recommendations include: statewide adoption of KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and

other subcommittees by Executive Order, strengthening continuum of care in rural/frontier areas, and continuing to diversify subcommittee membership to ensure that needs and resources are considered both within and alongside the behavioral health system.

Kansas consists of 105 counties with population density classifications in Kansas, by County, for 2018 as illustrated in the map from the Kansas University Institute for Policy & Social Research embedded below:

Population Density Classifications in Kansas, by County, 2018



- Veterans Subcommittee

The Veterans subcommittee's mission is to ensure that veterans, service members and their families are involved in developing recommendations to improve access to behavioral health services which are relevant to military culture in collaboration with key provider organizations and other stakeholders.

According to the history section of the 2018 Veteran's subcommittee annual report, this subcommittee reactivated in June of 2017. The state was divided into five regions with a designated mental health facility as the lead in that region. The plan of the subcommittee was to identify members in those five regions to help accomplish their goals. Many of the subcommittee members received training from SAMSHA technical assistance program for strategic planning in September 2017. From that training the committee established goals to identify quality resources for veterans,

their families and children across the state. this subcommittee was comprised of the chair, co-chair and 16 members from across the state. Goals for 2018 include: Identifying quality resources for veterans and their families; initiating digital outreach for veteran and family services using Facebook, Twitter, etc.; engaging veteran service organizations across the state such as VFW posts and American Legions; identifying current available courses that train providers in military culture; expanding the three-day crisis intervention training across the state for police/first responders concerning veterans in a mental health crisis, and communicating/partnering with the State of Kansas Department of Veterans Affairs.

SAMHSA technical assistance personnel came to Topeka for the Mayor's Challenge Site visit on August 30th and 31st [2018] to provide attendees training to identify other key players, set goals and objectives, implement strategies, identify other agencies to partner with etc. The training had representatives from the Topeka Police Department, Valeo, VA Eastern Kansas, State of Kansas, City of Topeka HR and Municipal Court and the Shawnee County Suicide Prevention Coalition. Once the Topeka Coalition is established the goal will be to expand this prevention/education effort to other cities in the state.

- Prevention Subcommittee

According to the Prevention Subcommittee's Charter, the Prevention Sub-Committee was established in an effort to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes, and to increase the effectiveness of State and local efforts to address prevention issues. The Prevention Sub-Committee will serve as the Advisory Council for Kansas Behavioral Health Prevention Initiatives.

This group will serve as a broad, representative voice for behavioral health as it relates to prevention of a range of health and behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder prevention. The Strategic Prevention Framework (SFP) will be used as a guiding mechanism for the work associated with this charter. The SPF is comprised of five distinct phases: assessment, capacity building, planning, implementation, and evaluation.

With a primary mandate to provide feedback and guidance to the Governor's Behavioral Health Services Planning Council related to KDADS BHS prevention initiatives, this workgroup also is responsible for the following key roles and responsibilities:

• Develop a statewide plan to address behavioral health prevention

• Guidance, research and recommendations relating to prevention across the lifespan

• Feedback on Substance Abuse Prevention and Treatment (SAPT) Block Grant prevention initiatives

• Feedback on Kansas behavioral health prevention initiatives including suicide prevention, problem gambling prevention and substance abuse prevention

Feedback related to strategic initiatives at the State level to infuse prevention efforts across the Institute of Medicine (IOM) continuum of care, integrating lifespan and developmentally-appropriate strategies into current prevention processes and supports.

• Guidance and feedback related to behavioral/mental health promotion and shared risk and protective factors. This could include Adverse Childhood Experiences (ACE's), evidence-based strategies, needs identified through assessment, outcomes of recent strategies, and relevant research.

FY18 recommendations include: improve shared access to data resources among state agencies and planning council subcommittees, better coordinating efforts and care transitions of behavioral health services, forming an evidence-based practices workgroup (EBW) for behavioral health promotion, and allocating resources to prioritized areas of need through data-driven decision making.

The Suicide Prevention Subcommittee became a workgroup of the Prevention Subcommittee in 2017.

Kansas Annual Summary of Vital Statistics, 2017

The Kansas Annual Summary of Vital Statistics, 2017 report by the Kansas Department of Health and Environment in November 2018 is found at this link:
http://www.kdheks.gov/phi/as/2017/Annual_Summary_2017.pdf

In the report, the ten leading causes of death in Kansas remained unchanged from 2016 to 2017, though their order changed in some cases. Suicide and nephritis, nephrotic syndrome and nephrosis changed places as 8th and 10th leading causes (suicide ranked 8th in 2017) but all other rankings in the ten leading causes remained unchanged.

Kansas recorded 544 resident suicide deaths in 2017 compared to 512 in 2016 (up 6.3 percent) and 477 in 2015. The suicide age-adjusted death rate increased from 17.8 deaths per 100,000 population in 2016 to 18.8 deaths per 100,000 population in 2017, but the change was not statistically significant (Table E8).

Almost four-fifths (78.3%) of suicide victims were male. The three age groups with the largest number of suicides were 25-34 (101 deaths), 35-44 (91 deaths), and 45-54 (91 deaths). The three most common methods of suicide were firearms (309 deaths), suffocation (150 deaths), and poisoning (64 deaths) (Tables E8, E14, E22).

Prevention System Strengths and Needs

The Kansas prevention system re-design in 2015, was based on the mindset that local communities solve local problems with the appropriate resources and support, and community coalitions are given the tools to sustain their efforts. This mindset is still very much consistent today and proves to be one of our biggest strengths. Community engagement, ownership and utilization of the SPF process have guided the strategic plan for this re-design. The use of a competitive RFP process for grantees is a key component to the needs driven and outcome-based performance system that we require. Our ability to monitor grantees expenditures and evaluate progress toward community outcomes has proven to be another strength of the re-design process. In 2019, Kansas was able to increase the Kansas Communities That Care survey to over 80% participation rate of all Kansas public schools. The increase in availability of this data will allow communities to better guide strategies and create outcomes. Kansas continues to strengthen relationships with other state agencies and develop new partnerships to promote a more comprehensive approach to prevention efforts.

In 2019, Kansas created the Evidence-Based Strategies Workgroup (EBSW). Its purpose is to support Kansans through promoting the use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services. The matrix is offered to the public with community coalitions in mind as a tool to support planning for effective and comprehensive prevention efforts. This matrix offers a blend of environmental strategies and curricula-based prevention education programs. This matrix does not encompass every evidence-based prevention strategy available to communities. Stakeholders may research and select other strategies that align better with identified risk and protective factors. It is important to select strategies that have appropriate fit and approval from designated funding sources. Evidence-based prevention strategies (programs, practices, and policies) are validated by documented evidence of effectiveness. The Kansas EBSW has adopted the Center for Substance Abuse Prevention's (CSAP's)/Substance Abuse Mental Health Services Administration's (SAMHSA's) three tiers of criteria for determining if a strategy is evidence-based (https://www.hcpcme.org/pubadmin/health/SPEP/CSAP4p56_Guidance_Jan04_2007.pdf).

i. Tier 1 – Strategy appears on a national registry of evidence-based strategies
ii. Tier 2 – Strategy appears in a peer reviewed publication with positive effects
iii. Tier 3 – Strategy includes documented effectiveness that is supported by other sources of information and the consensus judgment of informed experts

Other possible uses for this document by the State of Kansas and communities could include those outlined in the PEW Charitable Trusts report "How States Engage in Evidence-Based Policymaking – A national assessment", such as:

1) Distinguishing proven programs from those without evaluated effectiveness
2) Inventorying programs to manage resources strategically
3) Comparing program costs and benefits to calculate return on investment
4) Prioritize funds
5) Help implement and expand proven approaches
6) Sustain support for evidence-based policymaking

Kansas communities have lacked the ability to identify strategies that address sub-populations and gaps in service. In FY20-21, grantees will apply the data-driven Strategic Prevention Framework process to identify and address sub-populations these sub-populations to improve behavioral health outcomes by utilizing the at-risk population assessment. Another challenge Kansas will address in FY20-21, is the amount of funds allocated toward sustainable evidence-based strategies. Grantees often choose strategies that are easily implemented and produce little long-term outcomes. Through the support of the prevention system, Kansas will offer additional assistance to communities that will allow them to identify which strategies will be the most effective and sustainable in their community.

State Epidemiological Outcomes Workgroup

In 2018, the re-development of the State Epidemiological Outcomes Workgroup (SEOW) was created to integrate state efforts toward data collection. The intended purpose of the SEOW is to bring together a group of data experts responsible for data on substance use/misuse and related behavioral health problems to the forefront of the prevention planning process for the state. The SEOW strives to support the State's prevention infrastructure by enhancing the ability to acquire, integrate, disseminate, and

utilize a diverse set of behavioral health indicators and epidemiological data to inform and guide prevention efforts and build capacity to address substance abuse prevention, treatment, and mental health outcomes in a coordinated, data-driven fashion. To achieve its mission, the Kansas SEOW is charged with the following core tasks: Identifying, analyzing, profiling, and sharing data from existing state and local sources; Creating data-guided products that inform prevention planning and policies; Training communities in understanding, using, and presenting data in an effective manner; and Building state- and local-level monitoring and surveillance systems. Currently, the SEOW is working on a needs assessment for state data use including substance abuse prevention. It includes the following; Infrastructure: assess networks for data use and prevention improvement; Capacity: Assess capacity to provide uniform and high quality research, assessment, and evaluation services; Efficiency: what are the costs for efficiently and effectively use data for decision making; Time: What is the time required to access and to prepare data before it can guide prevention decisions; Ease of use: How hard is it to use data to inform decisions; Training: What are professional development needs to improve data literacy (i.e., analyze, display, interpret, and use data); Expertise and personnel: what is the required training, expertise and network related to research, evaluation, assessment, and data use needed to benefit policy makers, community and organizational leaders.

The 2017 Kansas Behavioral & Mental Health Profile revised and updated the prior 2015 profile through the efforts of the SEOW Support Team and guidance and recommendations of the State Epidemiological Outcomes Workgroup (SEOW). This project was supported through funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), awarded to enable the integration of an expanded data set inclusive of an array of behavioral health indicators. The 2017 Kansas Behavioral & Mental Health Profile significantly enhances and extends the scope of the original profile developed in 2006 and revised in 2011, 2013, and 2015 with behavioral health and mental health assessment and surveillance data that aligns with the Strategic Prevention Framework (SPF) and the inclusion of mental and behavioral health indicators through an update of data sets and sources. The 2017 profile expanded to include Kansas data for young adults (ages 18-25) and 2017 Kansas Gambling Survey data. With the support of KDADS, this report was developed to serve as a resource for planning that focuses on the prevention of substance abuse and related consequences among children, youth, and adults across the lifespan, as well as on the promotion of wellness and positive emotional and behavioral and mental health. The updated profile is designed to provide an in-depth, data-focused perspective on the extent of substance abuse consumption patterns and related consequences, with information presented that derives from state health agencies, treatment agencies, and law enforcement and revenue agencies. The intent is to illustrate, as completely as possible, the current state of behavioral and mental health which supports a data-informed prioritization process as part of comprehensive state-level and community-level assessment. Utilizing a broad range of information from multiple sectors, organizations, and data sets allows for the depiction of a more thorough picture of substance abuse-related consequence and consumption patterns. This profile includes an array of mental health treatment data, mental health and substance use disorder treatment availability indicators, problem gambling prevalence data, and a set of risk and protective factor indicators associated with substance abuse and related problems among children and youth.

Substance Use Disorder Treatment Strengths and Needs

Federal Data

Kansas utilized the Behavioral Health Barometer Kansas, Volume 4 indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System found on the following link: https://store.samhsa.gov/system/files/sma17-barous-16-ks.pdf

The Behavioral Health Barometer report indicated Kansas was similar to the corresponding national annual average percentage for the following indicators:

YOUTH SUBSTANCE USE		
Indicator	Kansas	National Average
Past Month Marijuana Use Among Adolescents Aged 12-17 in Kansas and the U.S.	6.4%	7.2%
Past Month Cigarette Use Among Adolescents Aged 12-17 in Kansas and the U.S.	4.8%	4.5%
Past Month Alcohol Use Among Adolescents Aged 12-17 in Kansas and the U.S.	10.5%	10.6%
SUBSTANCE USE AND SUBSTANCE USE DISORDERS		
Indicator	Kansas	National Average
Past Year Alcohol Use Disorder Among Individuals Aged 12 or Older in Kansas and the U.S.	6.0%	6.1%

The Behavioral Health Barometer report reported past year heroin use among individuals aged twelve or older in Kansas was lower than the corresponding national annual average percentage:

SUBSTANCE USE AND SUBSTANCE USE DISORDERS		
Indicator	Kansas	National Average
Past Year Heroin Use Among Individuals Aged 12 or Older in Kansas and the U.S.	0.14%	0.33%

Regarding single day counts, the Behavioral Health Barometer report also indicated the following increases:

- Number of individuals enrolled in substance use treatment (increase from 2011 and 2013, but a decrease from 2012)
- Number of individuals enrolled in Opioid Treatment Programs in Kansas receiving methadone
- Number of individuals enrolled in treatment at substance use treatment facilities in Kansas receiving buprenorphine

However, The National Survey on Drug Use and Health (NSDUH) reports increases in several categories:

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - Kansas		
Indicator	2015 - 2016	2016-2017
Kansans 18 or older reporting illicit drug use in the past month	172,000	181,000
18 or older marijuana use in the past year	235,000	255,000
NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - Kansas		
Indicator	2015 - 2016	2016-2017
18 or older marijuana use in the past month	149,000	145,000
18 or older perceptions of great risk from smoking marijuana once a month	553,000	519,000
Kansans 18 or older reporting illicit drug other than marijuana use in the past month	60,000	63,000
18 or older methamphetamine use in the past year	unknown	19,000
18 or older pain reliever misuse in the past year	100,000	100,000
18 or older binge alcohol use in the past month	595,000	605,000
18 or older illicit drug use disorder (per DSM-IV) in the past year	49,000	94,000
18 or older pain reliever use disorder (per DSM – IV) in the past year	16,000	14,000
18 or older alcohol use disorder (per DSM-IV) in the past year	115,000	125,000
18 or older substance use disorder (per DSM-IV) in the past year	150,000	155,000
18 or older needing but not receiving treatment at a specialty facility for substance use in the past year	135,000	141,000

In reviewing the Kansas Opioid Summary (https://www.drugabuse.gov/opioid-summaries-by-state/kansas-opioid-summary) by the National Institute on Drug Abuse (NIDA), the age-adjusted rate of

drug overdose deaths has not changed in Kansas over the past several years. In 2017, there were 11.8 drug overdose deaths per 100,000 persons.

Also, according to the Kansas Opioid Summary, opioid prescriptions have declined mirroring the national trend. However, in 2017, Kansas providers wrote 69.8 opioid prescriptions for every 100 persons. The national average in 2017 was 58.7 prescriptions for every 100 persons, so Kansas was above the national average in 2017.

State Data

The Kansas Client Placement Criteria (KCPC) was the centralized substance use disorder data system for the State of Kansas. The KCPC is an antiquated system and needed an upgrade. The KCPC system was managed by KDADS and brought down by the former Secretary of KDADS. The State is in the process of developing and procuring a new SUD data system to replace the KCPC.

To identify unmet service needs and critical gaps within the current Block Grant substance use disorder treatment system, KDADS relies primarily upon data reported by the Administrative Service Organization (ASO) with whom KDADS contracts to administer SAT Block Grant funds to providers. SAMHSA staff were onsite in May 2018 for a 10-year comprehensive review. The Center for Substance Abuse Treatment (CSAT) commented in the exit interview that a strength for the State is the strong relationships Kansas has formed between the State, the ASO, and SUD providers. CSAT reviewers were also impressed with the wealth of data the ASO provides the State.

Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC)

The Governor's Behavioral Health Services Planning Council (GBHSPC) is another mechanism used by KDADS to identify needs/gaps for SAT. The Kansas Citizen's Committee on Alcohol and Other Drug Abuse, a subcommittee of the GBHSPC, is the advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas. The Kansas Citizen's Committee has also agreed to function as the Quality Committee for KDADS substance use disorder treatment data submitted by the health plans to the State for Medicaid and the Block Grant.

A brief description of just some of the other data sources available within the state are described below.

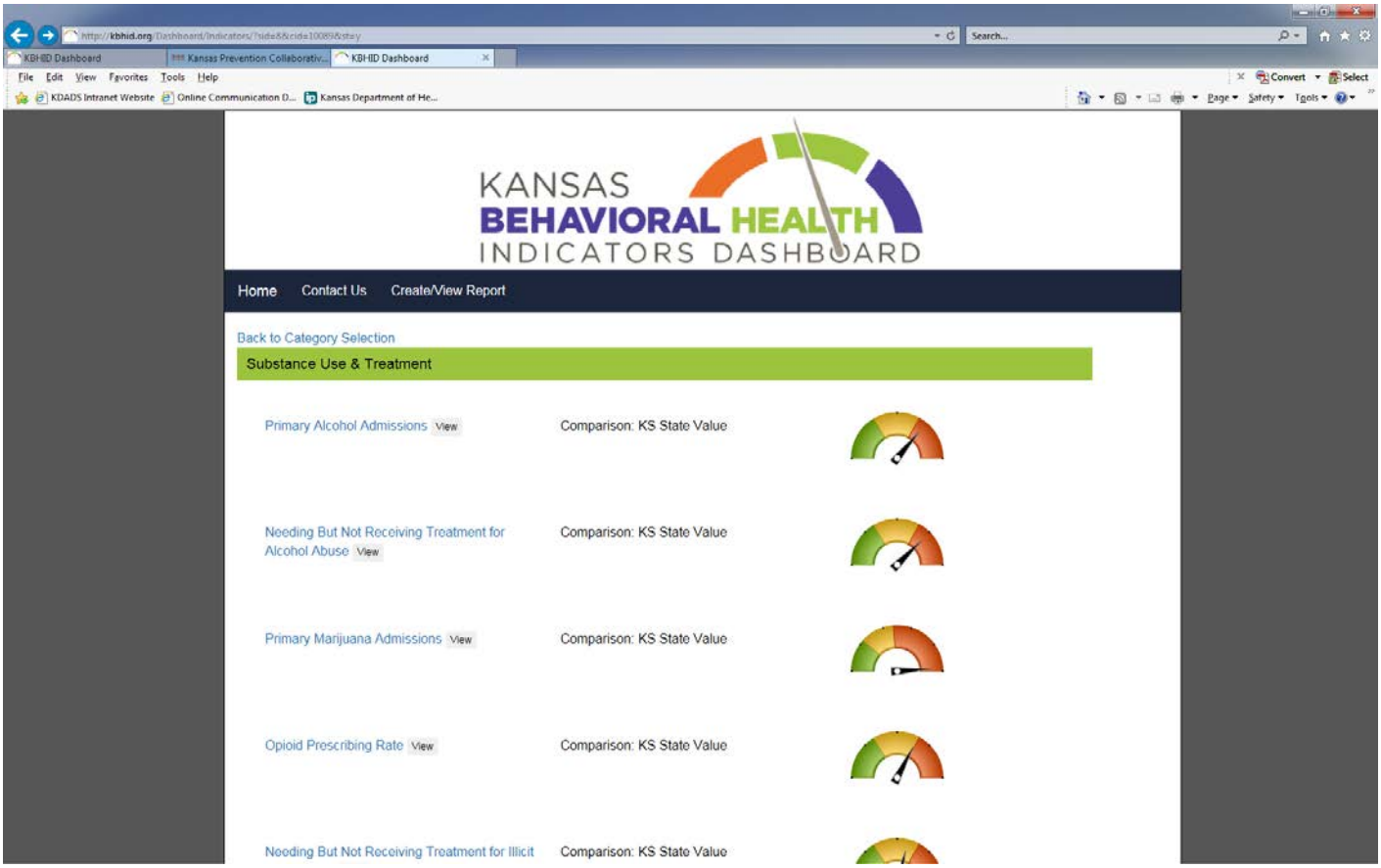
Kansas Behavioral Health Indicators Dashboard

The Kansas Prevention Collaborative Behavioral Health Indicators Map presents summarized data for several Behavioral Health indicators prioritized by the Kansas Behavioral Health Services Planning Council Prevention Subcommittee. The Kansas BH Indicators Dashboard was created and managed by a contractor, Greenbush or the Southeast Kansas Education Service Center.

The online dashboard is available at the following link: http://kbhid.org/.

The public can access Kansas data for a wealth of indicators on the following topics: Income/Poverty, Crime, Depression/Suicide, Problem Gambling, Family Functioning, Substance Use, Problem Gambling Treatment, Substance Use & Treatment, and Mental Health and Treatment. Substance Use & Kansas Substance Use and Treatment data that can be accessed on the site include needing but not receiving treatment for alcohol abuse, primary admissions by drug (alcohol, marijuana, opiates, tranquilizers,

cocaine, methamphetamine, etc.), opioid prescribing rates, needing but not receiving treatment for illicit drug abuse). A screen shot of the dashboard is displayed below:



Kansas Annual Summary of Vital Statistics, 2017

The Kansas Annual Summary of Vital Statistics, 2017 report by the Kansas Department of Health and Environment in November 2018 is found at this link:
http://www.kdheks.gov/phi/as/2017/Annual_Summary_2017.pdf

According to the report, twenty-two (22) Kansas residents died of HIV/AIDS in 2017, for an age-adjusted death rate of 0.7 per 100,000 population (Table E6). This surpasses the Healthy People 2020 target (HIV-12) of reducing the rate to 3.3 HIV/AIDS deaths per 100,000 population.

Also, according to the KDHE report, tobacco use contributed to 4,715 deaths in Kansas in 2017 (25.3 percent of the deaths where the tobacco contribution was known and reported on the death certificate). Tobacco use was a contributing factor in 31.5 percent of male deaths, and in 19.3 percent of female deaths. The causes of death showing the largest tobacco contribution were cancer of the trachea, bronchus and lung (86.1%), chronic lower respiratory disease (84.3%), cancer of the urinary tract (33.3%), and ischemic heart disease (33.2%). (Table E21) Physicians and coroners can state on the death certificate whether tobacco contributed to the death. Because information may not be available

at the time the death certificate is completed, tobacco's contribution may be subject to some underreporting.

Tobacco use at any time during pregnancy was reported for 3,680 births in 2017, amounting to 10.1 percent of births for which tobacco usage was reported. Tobacco use was known for 36,3741 of the 36,464 births (99.8%) in 2017. Reported tobacco usage was highest in the three months immediately prior to pregnancy (4,221, or 11.6%) and decreased gradually with each trimester: to 3,632, or 10.0 percent in the first trimester; then to 3,259, or 9.0 percent in the second trimester; and finally to 3,129, or 8.6 percent in the third trimester (Table C17).

Kansas Behavioral & Mental Health Profile November 2017

Greenbush – The Southeast Kansas Education Center develops and compiles the Kansas Behavioral & Mental Health Profile. The link to the November 2017 report is found at: https://www.kdads.ks.gov/docs/default-source/csp/bhs-documents/kansas-behavioral-health-profile-2018.pdf?sfvrsn=bf7407ee_0

This report includes Kansas data on prevalence, treatment admissions (adult and youth), consequences/crimes (suspension & expulsion, minor in possession, arrests (adult and youth) and deaths for the following substances: alcohol, tobacco, marijuana, prescription drug, other Illicit drug. This report also includes problem gambling data, mental health indicators and other related indicators.

Priority Populations

Beacon, the Administrative Services Organization, provides a vast array of reports for the SUD Block Grant including utilization reports, financial, adverse incident, appointment access, and diagnosis trends among others. Reports specific to priority populations include an Interim Services report and a Designated Women's Facility Report.

The Interim Services report provides quarterly and year-to-date data on modalities (crisis intervention, peer support, case management, and those admitting to a lower level of care than recommended) both number of people needing and number receiving services. The report breaks the information down into regional and priority populations (pregnant women, IV drug users, and all other SUD members).

The Designated Women's Facility report is also a quarterly report to the State. Women with children, Pregnant Women and total categories are reported. Women's treatment is drilled down into data such as those not recommended for treatment and total that are recommended and then into modality of treatment. Total admitted to DWF by modality are also reported.

The Kansas Department for Aging and Disability Services (KDADS) continues to work towards ensuring priority populations including Pregnant and Parenting Women, Injecting Drug Users and Persons at risk for tuberculosis access timely treatment. Ideally, we need to be able to get patients assessed and in treatment when they present in order to best engage individuals (including priority populations) into treatment services. The ASO is contractually required to manage a waitlist to help ensure timely access to inpatient treatment for all individuals with substance use disorder. The priority populations are monitored and tracked separately. Beacon reports regularly to KDADS on any members waiting to include priority populations. Barriers to timely treatment for priority populations are similar to those of other individuals with substance use disorder such as workforce shortage issues and the lack of some

modalities of service especially in the rural and frontier areas. The last Behavioral Health workforce study in Kansas is dated. Therefore, KDADS in partnership with Wichita State University, will be conducting another study in FY2019.

Kansas was awarded the STR (State Targeted Response)/SOR (State Opioid Response) grant by SAMHSA. Kansas then awarded grants to four programs that represent a Health System/Methadone Clinic, a community-based substance use disorder provider, a regional drug assessment center, and a community mental health center. The grantees cover all 105 counties in Kansas. The number of persons served for opioid use disorder treatment services are monitored, tracked and submitted to SAMHSA including the number of pregnant women, veterans and members of tribal communities. Areas of unmet service needs and critical gaps include the location and number of medication-assisted treatment providers and/or methadone clinics primarily in the rural and frontier areas of the state. The majority of the methadone clinics in Kansas are in urban areas and serve self-pay clients.

Tobacco Cessation treatment for people with Behavioral Health conditions

The Centers for Disease Control and Prevention note that people with behavioral health conditions:

1. Are more likely to smoke, and rates are even higher among individuals with serious mental health disorders and addictions
2. Smoke more than people who smoke and do not have a behavioral health condition
3. Want to quit but may face extra challenges in successfully quitting
4. Die prematurely – Individuals with serious mental health disorders who smoke die almost 15 years earlier than individuals without these disorders who don't smoke
5. Die from smoking related illness – People with behavioral health conditions account for over half of tobacco related deaths each year nationwide. The most common cause of death among people with behavioral health conditions are heart disease, cancer and lung disease – all of which can be caused by smoking.

According to the NAMI – Kansas report titled, "The economics of proactive smoking cessation treatment for individuals with serious mental illness and/or substance use disorder in the Medicaid population", SAMHSA estimated Kansans with SMI and/or SUD is 291,773 people. Based upon national literature review estimates of tobacco use at 40% of this population which would equal 116,709 Kansans. This accounts for medical costs, productivity losses, loss from premature death, neonatal pregnancy costs for pregnant women – estimated economic loss for this population is $4,730.58 per person or $76 million. Further, the American Lung Association, State of Tobacco Control, 2019 reported Kansas's State Quit Line invests 44 cents per smoker compared with the national average of $2.21.

Consistently over several years, behavioral health treatment needs for the uninsured/underinsured in Kansas exceed the allotted Federal Block Grant funding. Kansas supplements the funding using a combination of funding sources including State General funds, State Fee funds, and Problem Gambling Other Addictions funds. Kansas Behavioral Health providers have been very creative in their approach to address the physical health needs of those they serve, however, unmet service needs around tobacco cessation exist including: 1) Tobacco cessation is not covered by the Block Grant but is by Medicaid 2) Medicaid reimbursement for both medication and counseling reported as insufficient by behavioral health providers and 3) Expanding the trained tobacco cessation workforce

In 2016, the Kansas Health Foundation awarded more than $1.4 million to seven organizations throughout the state to address tobacco treatment and recovery in behavioral health. Stakeholders recognized that smoking disproportionately affects individuals with a behavioral health diagnosis, which may contribute to Kansans with serious mental health conditions dying 25 years earlier than other Kansans.

Collaborations across the state included integrating cessation services in behavioral health programming, training tobacco treatment specialists, creating tobacco-free recovery environments for behavioral health consumers, and information campaigns related to KanCare tobacco cessation treatments. In 2018, Kansas expanded tobacco cessation benefits for those in KanCare. Individuals wishing to quit using tobacco can now receive up to four rounds of nicotine replacement therapy with no lifetime caps, as well as, ongoing cessation counseling services. Previously, Kansas limited KanCare quit benefits to once-per-year and only pregnant women could receive the counseling benefit. Behavioral health tobacco initiatives have been focused on promoting and expanding awareness of these additional benefits.

One major outcome of the work so far has been the creation of the Kansas Tobacco Guideline for Behavioral Health Care. The Guideline was created as a roadmap for behavioral health providers to support Kansans motivated to end their dependence on tobacco products. Endorsed by the Kansas Department for Aging and Disability Services, the guideline has also been endorsed by 26 different behavioral health providers across the state. As the project moves into its second phase, the central focus of the work will be on expanding the number of providers who have endorsed or actively implemented the guidelines and continuing to advocate for systems and policy changes.

Problem Gambling Strengths and Needs

The Kansas gambling industry is represented by four state-owned casinos, five tribal casinos, charitable gaming and the Kansas Lottery. The first gambling prevalence study of gambling behaviors and attitudes in Kansas was conducted in 2012. The main purpose of this survey was to estimate the scope of at-risk gambling statewide and within defined gaming zones. The results of this study provided information about problem gambling awareness, attitudes toward gambling and problem gambling services, and information about how problem gambling is impacting Kansans. Survey findings are useful to State agencies and other stakeholders in efforts to mitigate gambling related harm.

The survey found that 75% of survey respondents gambled in the past year including 35% who played casino machine games such as slot machines, suggesting the rate of casino visitation among survey respondents is at least 30% higher than the national average. Similar to most U.S. states, almost half of respondents (45%) played lottery games in the past year. When recent gamblers were asked if they thought they had a gambling problem, one percent said that “most of the time” they feel they “have a problem with gambling,” and six percent said “sometimes.” The consequences of problem gambling can be emotional, physical, and financial. These consequences can extend to the friends, families, co-workers and even the employers of those affected. About 26% of survey respondents said they have been personally affected by the gambling of others.

Forty four percent of respondents gambled in the past 30 days. A series of nine problem gambling screening questions were asked of this group. Approximately 19 % of this group responded yes to at least one of these nine questions. Positive endorsement of just one problem gambling screening

question suggests the person is at heightened risk for developing a gambling problem. Several links were found between casino patronage and problem gambling risk. About one fifth (21%) of respondents who endorsed casino machine games (slots, video poker, etc.) as their favorite form of gambling also replied “yes” to at least one problem gambling screening question. About one-third (32% of respondents that patronized a casino in the past 30 days) endorsed one or more problem gambling screening questions suggesting a large portion of casino gamblers are at heightened risk of having a gambling disorder or developing one. Also, there is a strong correlation between endorsing problem gambling screening questions and membership in casino groups. More than one third of all respondents who were casino club/program members may be considered at heightened risk for manifesting or developing a gambling problem.

Many subgroups of the population have problem gambling prevalence above the adult average, including adolescents, African-Americans, individuals who are Hispanic, Asians, American Indians, lower socioeconomic groups, men, those with substance use and mental health co-morbid conditions, military, college students and casino workers. The impact of problem gambling on the elderly is also an area of attention. The African American community appears to be impacted more by problem gambling than other ethnic groups. One in five African American survey respondents reported being personally affected by the gambling behaviors of a family member, a rate 60 % greater than among Caucasian survey respondents.

While most people who gamble do so without experiencing or causing harm, it is clear that a sizeable portion of respondents have been negatively impacted by problem gambling, and respondents showed widespread support to address the problem. Most respondents said they believe it is either “very important” or “important” to use public funds to make problem gambling treatment available and affordable (98%) and to educate young people in school about the risks of gambling (81%).

Aside from the adult prevalence study, Kansas has included eleven gambling specific question on the Kansas Communities that Care Youth Survey since 2007 and most recently two questions on the Kansas Young Adult (18 to 25-year-old) Survey. Seven percent of Kansas youth indicate they have gambled for money or something of value in the last 30 days. Every day in the past year, one percent of youth felt they would like to stop gambling but did not thing they could. Over twelve percent of young adults indicate they have gambled for money or something of value in the last 30 days. Every day in the past twelve months, five percent of young adults felt they would like to stop gambling but did not think they could.

Stigma continues to remain a major barrier to people seeking treatment thus the need for statewide prevention, awareness and education. In 2007 the Kansas Legislature enacted the Problem Gambling and Addictions Grant Fund. Two percent of the monthly net revenue from the four state-owned casinos is deposited into this fund. Resources to fund problem gambling specific services are limited however as the funding allocated for these services have remained at less than ten percent of the total dollars deposited into this fund. The dollars that are allocated for problem gambling services are used statewide to provide treatment for problem gamblers and their concerned others, prevention resources, education and awareness, and research and evaluation. Kansas currently has thirty-six state certified gambling counselors, two gambling prevention specialists and one program administrator.

HIV-designated state

Kansas is not a FY 2020 HIV-designated state.

Prevention Services addendum Step 2

Cultural competency and sustainability are at the heart of all steps of the Strategic Prevention Framework. The Kansas Prevention Collaborative provides training to grantees around both topics annually and technical assistance is available to grantees as requested. Grantees are required to assess cultural competence during the assessment phase and prepare an action plan for at least one specific area targeted for improvement. Activities implemented related to the action plan are documented in the Community Check Box. Coalition capacity and cultural competence action plans are assessed annually and revised if needed. Additionally, all grantees are required to have a sustainability action plan during the first year of implementation and through their funding cycle.

The Kansas State Epidemiological Outcomes Workgroup (SEOW) is a group of data experts and prevention stakeholders responsible for bringing data on substance misuse and related behavioral problems to the forefront of the prevention planning process. To achieve their mission, SEOWs are charged with the following four core tasks:

1. Identifying, analyzing, profiling, and sharing data from existing state and local sources
2. Creating data-guided products that inform prevention planning and policies
3. Training communities in understanding, using, and presenting data in an effective manner
4. Building state- and local-level monitoring and surveillance systems

The Kansas SEOW meets quarterly. Current membership includes representatives from the following:

- The University of Kansas Center for Community Health and Development
- Greenbush – The Southeast Kansas Education Service Center
- Kansas Department of Health and Environment
- Kansas Depart for Aging and Disability Services
- Kansas Board of Pharmacy
- The University of Kansas Poison Control Center
- Kansas Board of Emergency Medical Services
- Kansas Racing and Gaming Commission
- Kansas Bureau of Investigation
- The University of Kansas Center for Telemedicine and Telehealth
- Sedgwick County Health Department

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

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

4. If not, what changes will the state need to make to be able to collect and report on these measures?
Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

FFY 2020-2021 Behavioral Health Assessment and Plan

Kansas Response

Planning Steps: Quality and Data Collection Readiness

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

Prevention

State Epidemiological Outcomes Workgroup

In 2018, the re-development of the State Epidemiological Outcomes Workgroup (SEOW) was created to integrate state efforts toward data collection. The intended purpose of the SEOW is to bring together a group of data experts responsible for data on substance use/misuse and related behavioral health problems to the forefront of the prevention planning process for the state. The SEOW strives to support the State's prevention infrastructure by enhancing the ability to acquire, integrate, disseminate, and utilize a diverse set of behavioral health indicators and epidemiological data to inform and guide prevention efforts and build capacity to address substance abuse prevention, treatment, and mental health outcomes in a coordinated, data-driven fashion. To achieve its mission, the Kansas SEOW is charged with the following core tasks: Identifying, analyzing, profiling, and sharing data from existing state and local sources; Creating data-guided products that inform prevention planning and policies; Training communities in understanding, using, and presenting data in an effective manner; and Building state- and local-level monitoring and surveillance systems. Currently, the SEOW is working on a needs assessment for Kansas state data use for substance abuse prevention. It includes the following; Infrastructure: assess networks for data use and prevention improvement; Capacity: Assess capacity to provide uniform and high quality research, assessment, and evaluation services; Efficiency: what are the costs for efficiently and effectively use data for decision making; Time: What is the time required to access and to prepare data before it can guide prevention decisions; Ease of use: How hard is it to use data to inform decisions; Training: What are professional development needs to improve data literacy (i.e., analyze, display, interpret, and use data); Expertise and personnel: what is the required training, expertise and network related to research, evaluation, assessment, and data use needed to benefit policy makers, community and organizational leaders.

Kansas Behavioral Health Indicators Dashboard

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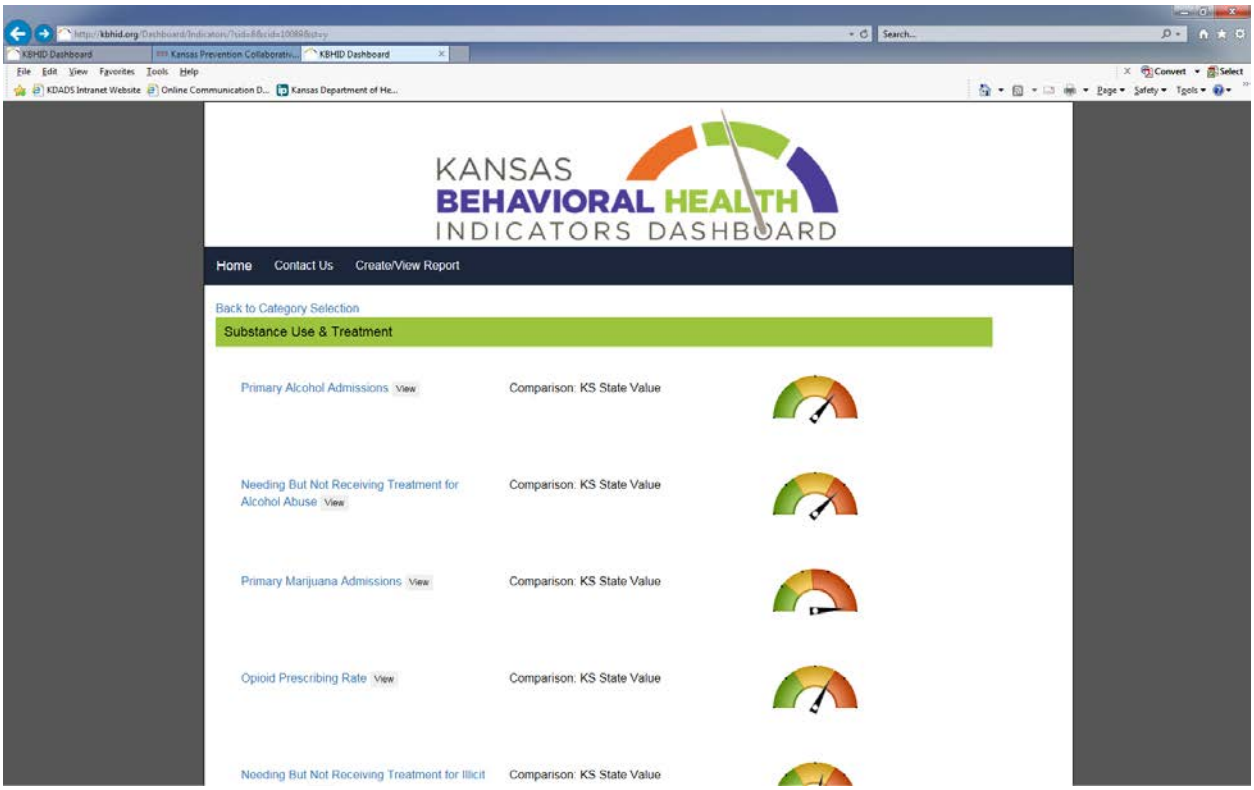
The public can access Kansas data for a wealth of indicators on the following topics: Income/Poverty, Crime, Depression/Suicide, Problem Gambling, Family Functioning, Substance Use, Problem Gambling Treatment, Substance Use & Treatment, and Mental Health and Treatment. Substance Use & Kansas

Substance Use and Treatment data that can be accessed on the site include needing but not receiving treatment for alcohol abuse, primary admissions by drug (alcohol, marijuana, opiates, tranquilizers, cocaine, methamphetamine, etc.), opioid prescribing rates, needing but not receiving treatment for illicit drug abuse). A screen shot of the dashboard is displayed below:



<u>Substance Use Disorder (SUD) Treatment</u>

<u>State Substance Use Disorder Data System</u>

The Kansas Client Placement Criteria (KCPC) was the centralized substance use disorder data system for the State of Kansas. The KCPC is an antiquated system and an upgrade was needed. The KCPC system, managed by the Kansas Department for Aging and Disability Services (KDADS), was brought down by the former Secretary of KDADS in October of 2018 based upon provider concerns and complaints. The State is in the process of developing and procuring a new SUD data system called the Kansas Substance Use Reporting Solution (KSURS) to replace the KCPC.

The State of Kansas has been preparing both a short-term and a long-term solution to replace the KCPC. The first project was identified as a short-term solution to enable the providers to utilize a web-based system to key in the required client-level data for the submission of the federally required Treatment Episode Data Set (TEDS) and federal Block Grant data reporting. The second project will be a longer-term modernization project. The scope of the modernization project is still being determined.

Administrative Service Organization

KDADS also relies upon data reported by the Administrative Service Organization (ASO) with whom KDADS contracts to administer SAT Block Grant funds and Problem Gambling funds to providers. SAMHSA staff were onsite in May 2018 for a 10-year comprehensive review. The Center for Substance Abuse Treatment (CSAT) commented in the exit interview that a strength for the State is the strong relationships Kansas has formed between the State, the ASO, and SUD providers. CSAT reviewers were also impressed with the wealth of data the ASO provides the State. Beacon, the Administrative Services Organization, provides a vast array of reports for the SUD Block Grant including utilization reports, financial, adverse incident, appointment access, and diagnosis trends among others. Reports specific to priority populations include an Interim Services report and a Designated Women's Facility Report.

The Interim Services report provides quarterly and year-to-date data on modalities (crisis intervention, peer support, case management, and those admitting to a lower level of care than recommended) both number of people needing and number receiving services. The report breaks the information down into regional and priority populations (pregnant women, IV drug users, and all other SUD members).

The Designated Women's Facility report is also a quarterly report to the State. Women with children, Pregnant Women and total categories are reported. Women's treatment is drilled down into data such as those not recommended for treatment and total that are recommended and then into modality of treatment. Total admitted to DWF by modality are also reported.

Kansas Citizen's Committee on Alcohol and Other Drug Abuse – Quality Committee

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services.

There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Suicide Prevention and 8) Veterans and Vocational.

Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

The Kansas Citizen's Committee on Alcohol and Other Drugs (KCC) has been in existence for many years and is statutorily required. K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A's 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas.

An arm of the KCC serves as the State Quality Committee. The Administrative Services Organization for the SA Block Grant, Beacon, presents reports to the Quality Committee for review and feedback. In the May 2019 meeting, the three Medicaid plans also attended. The State Quality Committee explored the Medicaid Plans developing a Provider Report Card for their network similar to the Provider Report Card currently provided by the ASO to providers and the State.

Mental Health Treatment

State Mental Health Data System

The state mental health data system is called the Automated Information Management System (AIMS). Community Mental Health Centers (CMHCs) provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health outpatient services provided by the CMHCs to the population they serve.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g. Medicaid, child welfare, etc.).

Currently, the substance use disorder and mental health systems are specific to substance use and mental health respectively. The data systems collect statewide data.

Medicaid

The Kansas Department of Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waiver programs: Autism, Frail Elderly, Intellectual/Developmentally Disabled (I/DD), Physical Disability, Serious Emotional Disturbance, Technology Assisted, and Brain Injury. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance use disorder, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. Kansas requires that their health plans not only receive National Committee for Quality Assurance (NCQA) Health Plan Accreditation, but that the Medicaid plans also obtain NCQA Long Term Services and Supports (LTSS) Distinction. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. The KanCare 2.0 Quality Management Strategy and other related quality measurement information can be found on the KanCare website at: https://www.kancare.ks.gov/policies-and-reports/quality-measurement

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

Kansas is able to report down to the client-level detail in the AIMS database for mental health. The short-term data solution for substance use (described above) is also able to report down to the client-level detail.

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

Please see above.

Prevention Services addendum Quality and Data Collection Readiness

The Community Check Box (CCB) is a web-based recording, measurement, and reporting tool used to support participatory evaluation of community health and development initiatives. The CCB enables documentation of prevention and behavioral health activities at multiple levels, including by local partners and community coalitions, as well as the state training and technical assistance teams that are supported by the Kansas Prevention Collaborative. The CCB supports KDADS coalition grantees and contractors in online documentation of their work, including their efforts to develop, implement, and or provide support for prevention strategies and activities, including capacity-building activities. Lists of accomplishments, graphs, success stories, and characterization of community and system changes are available on demand for all those doing and supporting the work. Participant level data is reported through the system and is used to help track number of people served. Technical support is provided when documenting to provide estimates when needed for environmental or population-based strategies.

Prevention education programs use pre and post surveys evaluation forms that capture demographic data from participants. This information is also used to report or confirm number of individuals served through participant level data.

Finally, the Kansas Communities That Care (KCTC) Student Survey is administered annually to capture many of the outcome measures for behavioral health and prevention efforts. The survey has been administered in school districts since 1994 to middle and high school students across the state with high rates of participation.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Reduce underage drinking in Kansas

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce the percentage of students in grades 6, 8, 10, and 12 that report drinking alcohol in the past 30-days.

Objective:

Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address underage alcohol use through the implementation of evidence-based prevention programs, practices, and policies.

Strategies to attain the objective:

Kansas does not implement any one strategy statewide, aside from our "It Matters" media campaign, rather communities complete the planning phase of the SPF and utilize their needs assessment to create a logic model and identify strategies that identify with their particular community needs and capacity. All strategies must be evidence based and Kansas utilizes SAMHSA's definition when reviewing individual strategic plans.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: On how many occasions, if any, have you had beer, wine, or hard liquor in the past 30 days? (at least once)

Baseline Measurement: State = 16.36%; KPCCI Communities 14.20%

First-year target/outcome measurement: State = 16.12%; KPCCI Communities = 13.45%

Second-year target/outcome measurement: State = 15.91%; KPCCI Communities = 12.8%

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

The Kansas Communities That Care (KCTC) youth survey has been administered annually free of charge throughout the state since 1994. The survey tracks teen use of harmful substances such as alcohol, tobacco and other drugs. In addition, the survey provides a baseline for teen participation in, perception of, and attitudes toward both prosocial and antisocial behavior at the peer, school, family and community levels. It provides a measurable level of risk and protective factors that influence behavior, attitudes, and opinions of Kansas teens.

Data issues/caveats that affect outcome measures::

In 2015 active consent legislation was passed, initially creating challenges for local school districts to obtain the required parental consent and significantly impacting statewide participation rates as well as many local participation rates. Since then, the prevention system has worked with both school districts across the state to implement strategies to streamline the consent process and increase participation; this focused effort has led to increased participation statewide and among many school districts. There are however a few districts that are outliers and the state is working continuously to engage them and significant progress has been made within the last year. Funded communities are required to achieve a 60 percent participation rate; if at time they are not at 60 percent they must create specific action plans demonstrating that they will implement strategies to increase participation.

Priority #: 2

Priority Area: Reduce adolescent marijuana use in Kansas

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce the percentage of students in grades 6, 8, 10, and 12 that report using marijuana in the past 30-days.

Objective:

Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address adolescent marijuana use through the implementation of evidence-based prevention programs, practices, and policies.

Strategies to attain the objective:

Kansas does not implement any one strategy statewide, aside from our "It Matters" media campaign. Communities complete the planning phase of the SPF and utilize their needs assessment to create a logic model and identify strategies that identify with their particular community needs and capacity. All strategies must be evidence-based and Kansas utilizes SAMHSA's definition when reviewing individual strategic plans.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: On how many occasions, if any, have you used marijuana in the past 30 days? (at least once)

Baseline Measurement: State = 7.24%; KPC Communities = 8.70%

First-year target/outcome measurement: State = 7.00; KPC Communities = 8.20%

Second-year target/outcome measurement: State = 6.50%; KPC Communities = 7.45%

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

The Kansas Communities That Care (KCTC) youth survey has been administered annually free of charge throughout the state since 1994. The survey tracks teen use of harmful substances such as alcohol, tobacco and other drugs. In addition, the survey provides a baseline for teen participation in, perception of, and attitudes toward both prosocial and antisocial behavior at the peer, school, family and community levels. It provides a measurable level of risk and protective factors that influence behavior, attitudes, and opinions of Kansas teens.

Data issues/caveats that affect outcome measures::

In 2015 active consent legislation was passed, initially creating challenges for local school districts to obtain the required parental consent and significantly impacting statewide participation rates as well as many local participation rates. Since then, the prevention system has worked with both school districts across the state to implement strategies to streamline the consent process and increase participation; this focused effort has led to increased participation statewide and among many school districts. There are however a few districts that are outliers and the state is working continuously to engage them and significant progress has been made within the last year. Funded communities are required to achieve a 60 percent participation rate; if at time they are not at 60 percent they must create specific action plans demonstrating that they will implement strategies to increase participation.

Priority #: 3

Priority Area: Reduce low perception of harm from alcohol and marijuana use among Kansas youth

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce percentage of students in ages 6, 8, 10, and 12 that report there is "no risk" of harm from taking one or two drinks of an alcoholic beverage nearly every day.

Objective:

Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address low perceived risk of harm from regular alcohol use through the implementation of evidence-based prevention programs, practices, and policies.

Strategies to attain the objective:

Kansas does not implement any one strategy statewide, aside from our "It Matters" media campaign. Communities complete the planning phase of the SPF and utilize their needs assessment to create a logic model and identify strategies that identify with their particular community needs and capacity. All strategies must be evidence-based and Kansas utilizes SAMHSA's definition when reviewing individual strategic plans.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: How much to you think people risk harming themselves, physically or in other ways, if they take one or two drinks of an alcoholic beverage nearly every day ? (no risk)

Baseline Measurement: State = 14.41%; KPC Communities = 16.92%

First-year target/outcome measurement: State = 13.91%; KPC Communities = 16.42%

Second-year target/outcome measurement: State = 13.41%; KPC Communities = 15.92%

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

The Kansas Communities That Care (KCTC) youth survey has been administered annually free of charge throughout the state since 1994. The survey tracks teen use of harmful substances such as alcohol, tobacco and other drugs. In addition, the survey provides a baseline for teen participation in, perception of, and attitudes toward both prosocial and antisocial behavior at the peer, school, family and community levels. It provides a measurable level of risk and protective factors that influence behavior, attitudes, and opinions of Kansas teens.

Data issues/caveats that affect outcome measures::

In 2015 active consent legislation was passed, initially creating challenges for local school districts to obtain the required parental consent and significantly impacting statewide participation rates as well as many local participation rates. Since then, the prevention system has worked with both school districts across the state to implement strategies to streamline the consent process and increase participation; this focused effort has led to increased participation statewide and among many school districts. There are however a few districts that are outliers and the state is working continuously to engage them and significant progress has been made within the last year. Funded communities are required to achieve a 60 percent participation rate; if at time they are not at 60 percent they must create specific action plans demonstrating that they will implement strategies to increase participation.

Indicator #: 2

Indicator: Reduce percentage of students in ages 6, 8, 10, and 12 that report there is "no risk" of harm from regular marijuana use.

Baseline Measurement: State = 16.66%; KPC Communities = 22.32%

First-year target/outcome measurement: State = 16.16%; KPC Communities = 21.82%

Second-year target/outcome measurement: State =15.66%; KPC Communities =21.32%

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

The Kansas Communities That Care (KCTC) youth survey has been administered annually free of charge throughout the state since 1994. The survey tracks teen use of harmful substances such as alcohol, tobacco and other drugs. In addition, the survey provides a baseline for teen participation in, perception of, and attitudes toward both prosocial and antisocial behavior at the peer, school, family and community levels. It provides a measurable level of risk and protective factors that influence behavior, attitudes, and opinions of Kansas teens.

Data issues/caveats that affect outcome measures::

In 2015 active consent legislation was passed, initially creating challenges for local school districts to obtain the required parental consent and significantly impacting statewide participation rates as well as many local participation rates. Since then, the prevention system has worked with both school districts across the state to implement strategies to streamline the consent process and increase participation; this focused effort has led to increased participation statewide and among many school districts. There are however a few districts that are outliers and the state is working continuously to engage them and significant progress has been made within the last year. Funded communities are required to achieve a 60 percent participation rate; if at time they are not at 60 percent they must create specific action plans demonstrating that they will implement strategies to increase participation.

Priority #: 4

Priority Area: KPCCI at-risk population identification and implementation of appropriate evidence-based strategies

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Apply the data-driven Strategic Prevention Framework process to identify and address sub-populations with gaps in service or at high risk to improve behavioral health outcomes.

Objective:

Communities will use data to identify at least one at risk population (e.g. ethnicity, race, gender, age group, etc.) in their community and then implement programs, policies, or practices to reduce risk.

Strategies to attain the objective:

Communities will utilize their KCTC data to identify and target at risk populations and identify appropriate evidence based strategies. Each community's assessment will be unique to their individual needs and data outcomes. All strategies must be evidence-based as Kansas utilizes SAMHSA's definition when reviewing individual strategic plans.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of KPCCI communities completing at risk population assessment

Baseline Measurement:

First-year target/outcome measurement: All (100%) funded KPCCI communities will complete assessment to identify one 'at risk' population within their community and plan for appropriate prevention strategies to reduce risk. Community-level data will be used to measure progress.

Second-year target/outcome measurement: All (100%) funded KPCCI communities will implement prevention strategies to reduce risk among identified at risk population. Community-level data will be used to measure risk reduction.

Data Source:

Kansas Communities That Care (KCTC) Student Survey; Behavioral Health Report

Description of Data:

The Kansas Communities That Care (KCTC) youth survey has been administered annually free of charge throughout the state since 1994. The survey tracks teen use of harmful substances such as alcohol, tobacco and other drugs. In addition, the survey provides a baseline for teen participation in, perception of, and attitudes toward both prosocial and antisocial behavior at the peer, school, family and community levels. It provides a measurable level of risk and protective factors that influence behavior, attitudes, and opinions of Kansas teens.

Data issues/caveats that affect outcome measures::

In 2015 active consent legislation was passed, initially creating challenges for local school districts to obtain the required parental consent and significantly impacting statewide participation rates as well as many local participation rates. Since then, the prevention system has worked with both school districts across the state to implement strategies to streamline the consent process and increase participation; this focused effort has led to increased participation statewide and among many school districts. There are however a few districts that are outliers and the state is working continuously to engage them and significant progress has been made within the last year. Funded communities are required to achieve a 60 percent participation rate; if at time they are not at 60 percent they must create

specific action plans demonstrating that they will implement strategies to increase participation.

Priority #: 5

Priority Area: Provide access to community-based services for children/youth with SED allowing them to remain in their homes and communities with services and supports

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Children with SED are able to remain in home by building a community-based system of care to meet their needs.

Objective:

Increase the utilization of community-based services in order to reduce the utilization of inpatient services.

Strategies to attain the objective:

Kansas does not implement any one strategy statewide. Continue to identify culturally-competent, person-centered services to meet the child's/youth's needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of children/adolescents, age 17 or younger, that received crisis intervention services (30) calendar days prior to a screen resulting in inpatient psychiatric admission, excluding PRTF.

Baseline Measurement: Establishing a baseline for FY2020

First-year target/outcome measurement: Establishing a baseline for FY2020

Second-year target/outcome measurement: Based upon the baseline, determine a realistic target/outcome measurement

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System)
AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of children/adolescents that received crisis services (30) calendar days prior to crisis screen resulting in admission within reporting period. The following codes will be utilized: H2011, H2011-HK and/or H2011-HO (code numbers are subject to change by CMS)

Denominator: Number children/adolescents with a screen resulting in admission to inpatient within reporting period

Data issues/caveats that affect outcome measures::

This measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate.

Indicator #: 2

Indicator: The percentage of children/adolescents that received therapeutic intervention services (includes more than initial assessment and diagnosis such as Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, Therapy and/or Intake) within thirty (30) calendar days prior to a screen resulting in an inpatient psychiatric admission, excluding PRTF.

Baseline Measurement: Establishing a baseline for FY2020.

First-year target/outcome measurement: Establishing a baseline for FY2020.

Second-year target/outcome measurement: Based upon the established baseline, determine a realistic target/outcome measure.

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System)
AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of children/adolescents receiving a therapeutic intervention within 30 calendar days prior to a screen resulting in admission within reporting period. Services codes are as follows: 90791, H0036-HA, H0036-HB, H0036-HH, H0036-HJ, H0036-HK, H2017, H2017-HQ, H2017-TJ, H0038, H0038-HG, 90832, 90834, 90837, 90839, 90840, 90847, 90847HK, 90853, 90832, 90834, 90837, 90839, and/or 90840. (code numbers are subject to change by CMS)

Denominator: Total number of children/adolescents with a screen resulting in an inpatient psychiatric admission, excluding PRTF, within reporting period

Data issues/caveats that affect outcome measures::

This measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate.

Priority #: 6

Priority Area: Provide access to community-based services for adults with SMI allowing them to remain in their homes and communities with services and supports

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Adults with SMI are able to maintain community living and build a support system of care to improve their quality of life.

Objective:

Increase the utilization of community-based services in order to reduce the utilization of inpatient services.

Strategies to attain the objective:

Kansas does not implement any one strategy statewide. Continue to identify culturally-competent, person-centered services to meet the person's needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults, age 18 and older, that received crisis intervention services (30) calendar days prior to a screen resulting in admission to a State Mental Health Hospital (SMHH) or State Hospital Alternative (SHA) as utilized by the Osawatomie Temporary Census Diversion Funds (OTCDF).

Baseline Measurement: Establishing a baseline for FY2020.

First-year target/outcome measurement: Establishing a baseline for FY2020.

Second-year target/outcome measurement: Based upon the baseline, determine a realistic target/outcome measurement.

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System)
AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of adults that received crisis services within (30) calendar days of a crisis screen resulting in admission within

reporting period. The following codes will be utilized: H2011, H2011-HK and/or H2011-HO (code numbers are subject to changes by CMS)

Denominator: Screens resulting in admission to inpatient within reporting period

Data issues/caveats that affect outcome measures::

This measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate.

Indicator #: 2

Indicator: The percentage of adults that received therapeutic intervention services (includes more than initial assessment and diagnosis such as Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, Therapy, and/or Intake) within seven calendar days of discharge from a State Mental Health Hospital (SMHH) or State Hospital Alternative (SHA) as utilized by the Osawatomie Temporary Census Diversion Funds (OTCDF).

Baseline Measurement: Establish a baseline for FY2020.

First-year target/outcome measurement: Establish a baseline for FY2020.

Second-year target/outcome measurement: Based upon the baseline, determine a realistic target/outcome measurement.

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System)
AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of adults receiving CSS services who had a therapeutic intervention within seven business days of discharge from a SMHH within reporting period. Services codes are as follows: 90791, H0036-HA, H0036-HB, H0036-HH, H0036-HJ, H0036-HK, H2017, H2017-HQ, H2017-TJ, H0038, H0038-HG, 90832, 90834, 90837, 90839, 90840, 90847, 90847HK, 90853, 90832, 90834, 90837, 90839, and/or 90840. seven calendar from start the day after discharge however if a CMHC provides one of these services the same day as discharge then that will count toward the seven days. (code numbers are subject to changes by CMS)

Denominator: Total number of adult discharges from SMHH or SHA within the reporting period.

Data issues/caveats that affect outcome measures::

Measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate.

Priority #: 7

Priority Area: Pregnant Women and Women with Dependent Children receive treatment that targets the PWWDC population

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Ensure that pregnant women and women with dependent children have access to specialty services.

Objective:

Increase PWWDC being served by a Designated Women's Facility.

Strategies to attain the objective:

Increase DWF program information and interim services information to referral sources.
Encourage greater collaboration and sharing of program success within network of DWFs.
Increase intra-agency collaboration with other state programs for families.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children admitted to a Designated Women's Facility (DWF)

Baseline Measurement: Proportion of total pregnant women and women with dependent children (PWWDC) served with Block Grant funds in SFY18 by designated women's facilities.

First-year target/outcome measurement: 5% increase from baseline

Second-year target/outcome measurement: 10% increase from baseline

Data Source:

Administrative Services Organization (ASO) Designated Women's Facility Report

Description of Data:

Designated Women's Facility Report - Summary/Total Admitted to DWF percentage to increase

Data issues/caveats that affect outcome measures::

Kansas is developing a new substance use disorder data system. The outcomes of the data that will be collected within the system is still being determined at this time.

Priority #: 8

Priority Area: Recovery Oriented System of Care

Priority Type: SAT

Population(s): PWWDC, PWID, TB

Goal of the priority area:

Kansas Behavioral Health system supports a recovery-oriented system of care.

Objective:

More individuals have access to peer mentoring services.

Strategies to attain the objective:

Increase the peer mentoring workforce capacity.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Kansas Certified Peer Mentors increase.

Baseline Measurement: Set a baseline (FY19)

First-year target/outcome measurement: Increase the percentage of Kansas Certified Peer Mentors by 10% in FY20

Second-year target/outcome measurement: Increase the percentage of Kansas Certified Peer Mentors by 10% in FY21 from FY20

Data Source:

Adult Consumer Affairs tracking spreadsheet

Description of Data:

Certified Peer Mentor roster

Data issues/caveats that affect outcome measures::

Training contractor reporting timeliness and accuracy.

Priority #: 9

Priority Area: Expand access to youth experiencing their first psychotic episode and offer treatment and support within two years of the episode.

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Youth who have experienced their first psychotic episode are free from the adverse effects of their mental illness.

Objective:

Increase the number of youth who receive early intervention increasing their chance of successful recovery.

Strategies to attain the objective:

Identify opportunities to increase access to services for ESMI.

Examine adequacy of ESMI-related service rates.

Establish care coordination and case management requirements for our contractors that are provided through treatment and continuing care.

Identify potential partners who may have contact with young people in this age group to educate and build awareness around early intervention and treatment availability such as the Kansas Department of Children and Families, colleges, schools and social media.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: ESMI served with Block Grant funded intervention.

Baseline Measurement: Number of youth experiencing ESMI served with Block Grant funded intervention in SFY19.

First-year target/outcome measurement: 5% increase in number of youth experiencing ESMI served with Block Grant funded intervention in SFY20

Second-year target/outcome measurement: 5% increase in number of youth experiencing ESMI served with Block Grant funded intervention in SFY21 from number in SFY20.

Data Source:

KDADS' Automated Information Management System (AIMS)

Description of Data:

Proportion of total number of youth experiencing ESMI served with Block Grant funded intervention in a given State Fiscal Year (SFY).

Data issues/caveats that affect outcome measures::

Individuals not correctly identified as being ESMI

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

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

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

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$17,850,457		$34,729,354	$0	$18,258,876	$0	$0
a. Pregnant Women and Women with Dependent Children**	$4,101,337		$0	$0	$1,899,380	$0	$0
b. All Other	$13,749,120		$34,729,354	$0	$16,359,496	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$4,760,122		$0	$8,929,922	$1,530,572	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$1,190,031		$89,552	$543,114	$1,136,872	$0	$0
10. Total	**$23,800,610**	**$0**	**$34,818,906**	**$9,473,036**	**$20,926,320**	**$0**	**$0**

* Prevention other than primary prevention

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

Footnotes:

Medicaid projections are based upon FY18 claims paid by Managed Care Organizations.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

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

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

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$997,682	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$223,946,770	$0	$0
7. Other 24 Hour Care		$0	$70,088,651	$0	$46,547,014	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$8,480,297	$519,557,895	$7,110,025	$101,088,683	$0	$0
9. Administration (Excluding Program and Provider Level)***		$498,841	$1,055,914	$30,787	$502,111	$0	$0
10. Total	**$0**	**$9,976,820**	**$590,702,460**	**$7,140,812**	**$372,084,578**	**$0**	**$0**

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

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

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

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2649	305
2. Women with Dependent Children	87512	70
3. Individuals with a co-occurring M/SUD	75035	3616
4. Persons who inject drugs	57380	2277
5. Persons experiencing homelessness	1443	1360

Please provide an explanation for any data cells for which the state does not have a data source.
Aggregate Number Estimated in Need Resources: Pregnant Women - Calculated using data from the Kansas PRAMS 2017 Surveillance Report (March 2019) and the 2017 NSDUH report (September 2018); Women with Dependent Children - 2018 U.S. Census Bureau estimates on Kansas households and The CBHSQ Report 8/24/17 Children Living with Parents Who Have a Substance Use Disorder report "7.8% of children residing in mother-only households lived with a mother who had a past year SUD"; Individuals with a co-occurring M/SUD - U.S. Census Bureau 2018 Population Estimates and the 2017 NSDUH Report (September 2018); Persons Who Inject Drug - U.S. Census Bureau 2018 Population Estimates and the U.S. National Library of Medicine National Institute of Health www.ncbi.nlm.nih.gov; Persons Experiencing Homelessness - The 2018 Annual Homeless Assessment Report (AHAR) to Congress (December 2018); Aggregate Number in Treatment Source: State Substance Use Disorder System (KCPC)
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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

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

Expenditure Category	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$8,925,229	$8,925,229
2 . Primary Substance Abuse Prevention	$2,380,061	$2,380,061
3 . Early Intervention Services for HIV**		$0
4 . Tuberculosis Services		$0
5 . Administration (SSA Level Only)	$595,015	$595,015
6. Total	**$11,900,305**	**$11,900,305**

* Prevention other than Primary Prevention

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

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

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

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

	A	B	C
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**	**FFY 2021 SA Block Grant Award**
1. Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified	$222,740	$102,340
	Total	**$222,740**	**$102,340**
2. Education	Universal		
	Selective		
	Indicated		
	Unspecified	$102,340	$102,340
	Total	**$102,340**	**$102,340**
3. Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified	$18,060	$20,200
	Total	**$18,060**	**$20,200**
4. Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified	$12,040	$9,000
	Total	**$12,040**	**$9,000**
	Universal		

5. Community-Based Process	Selective		
	Indicated		
	Unspecified	$120,400	$120,400
	Total	**$120,400**	**$120,400**
6. Environmental	Universal		
	Selective		
	Indicated		
	Unspecified	$102,340	$222,740
	Total	**$102,340**	**$222,740**
7. Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified	$0	$0
	Total	**$0**	**$0**
8. Other	Universal		
	Selective		
	Indicated		
	Unspecified	$12,040	$12,040
	Total	**$12,040**	**$12,040**
Total Prevention Expenditures		**$589,960**	**$589,060**
Total SABG Award*		**$11,900,305**	**$11,900,305**
Planned Primary Prevention Percentage		**4.96 %**	**4.95 %**

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

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Footnotes:

Kansas chooses to use a portion of the primary prevention set-aside to fund Non Direct Services/System Development activities.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

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

Activity	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Column Total	**$0**	
Total SABG Award*	**$11,900,305**	**$11,900,305**
Planned Primary Prevention Percentage	**0.00 %**	**0.00 %**

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

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

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

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

Footnotes:

On our FY18-19 SABG application, we included methamphetamines for age population of 18-25 as a target priority. Due to the inability to gather data and resources to measure treatment for methamphetamine use in the college-age population, we utilized the outcomes of our current youth data to determine our FY20-21 Targeted Priorities.

Planning Tables

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

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

Activity	FY 2020			FY 2021		
	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems		$119,837			$314,780	
2. Infrastructure Support		$363,279			$0	
3. Partnerships, community outreach, and needs assessment		$371,571			$644,226	
4. Planning Council Activities (MHBG required, SABG optional)					$0	
5. Quality Assurance and Improvement		$140,961			$388,388	
6. Research and Evaluation		$422,882			$314,781	
7. Training and Education		$371,571			$340,523	
8. Total	**$0**	**$1,790,101**	**$0**	**$0**	**$2,002,698**	**$0**

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

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Footnotes:

Planning Tables

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

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant
1. Information Systems	$0	$0
2. Infrastructure Support	$0	$0
3. Partnerships, community outreach, and needs assessment	$0	$0
4. Planning Council Activities (MHBG required, SABG optional)	$0	$0
5. Quality Assurance and Improvement	$0	$0
6. Research and Evaluation	$0	$0
7. Training and Education	$0	$0
8. Total	**$0**	**$0**

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Footnotes:

No updates for the Mental Health Block Grant.

Environmental Factors and Plan

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

Narrative Question

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

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.
Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.
SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]
One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

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

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Behavioral Health Treatment Providers - Consistently over several years, behavioral health treatment needs for the uninsured/underinsured in Kansas exceed the allotted Federal Block Grant funding. Kansas supplements the funding using a combination of funding sources including State General funds, State Fee funds, and Problem Gambling other addictions funds. Kansas Behavioral Health providers have been very creative in their approach to address the physical health needs of those they serve.

Many behavioral health providers (mental health and substance use disorder) are partnering with Federally Qualified Health Centers (FQHCs) and other primary medical providers to offer SBIRT (Screening, Brief Intervention and Referral to Treatment) services, integrated treatment, and facilitated access to ongoing medical care.

SBIRT - Screening, Brief Intervention and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other substances at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents and injuries. SBIRT is designed to identify an individual who has an alcohol and/or substance use disorder or is at risk for developing one by evaluating responses to questions about alcohol and/or other substance use.

Approved provider service locations include primary medical care practices, acute medical care facilities, rural health clinics, critical access hospitals, federally qualified health centers, licensed substance use disorders treatment centers, Indian Health Centers, and community mental health centers.

To become approved to provide SBIRT services to Medicaid-eligible patients in Kansas, a health care professional shall be currently licensed in good standing as a physician, physician’s assistant, nurse practitioner, psychiatrist, nurse, dentist, or certified health educator in the state of Kansas or currently licensed in good standing by the Kansas Behavioral Sciences Regulatory Board as a psychologist, social worker, professional counselor, marriage and family therapist or addiction counselor.

Designated Women’s Facilities - There are five Designated Women's Facilities (DWFs) in Kansas located across the state in nine locations. Designated Women’s Facilities receiving Block Grant funds give priority admission to pregnant women, women with dependent children and women using IV drugs. DWFs provide a full continuum of services:
1) Treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate
2) Provide or arrange for primary medical care for women, who are receiving substance abuse services, including prenatal care,

3) Provide or arrange for child care while the women are receiving services,
4) Provide or arrange for primary pediatric care for the women's children, including immunizations,
5) Provide or arrange for gender-specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting,
6) Provide or arrange for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect,
7) Provide or arrange for sufficient case management and transportation services to assure that the women and their children have access to the services provided by (2-6) above,
DWFs also provide pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of services to include: Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments, employment and training programs, education and special education programs, drug-free housing for women and their children, prenatal care and other health care services, therapeutic day care for children, Head Start and other early childhood programs.

Medicaid - The Kansas Department for Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waivers. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use disorder services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. Addressing Social Determinants of Health and Independence are key themes in the current waiver application.

Health Homes – The Health Homes program for Kansas (called "OneCare Kansas") stems from a Legislative Proviso to reinstate Health Home services in Kansas. OneCare Kansas will provide coordination of physical and behavioral health care with long term services and supports for people in KanCare with chronic conditions. OneCare Kansas expands upon medical home models to include links to community and social supports. OneCare Kansas focuses on the whole person and all his or her needs to manage his or her conditions and be as healthy as possible. All the caregivers involved in a OneCare Kansas member's health communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.

OneCare Kansas is intended for people with certain chronic conditions, like diabetes, asthma, or mental illness. They can be members who also receive Medicare along with Medicaid. One Care will be an opt-in program. The target populations are being determined.

State Opioid Response (SOR) grant - Kansas was awarded the State Opioid Response (SOR) grant to help address the opioid crisis. Increases in opioid-related drug misuse and deaths parallel the increase in prescription opioid availability. According to data from Kansas Tracking and Reporting of Controlled Substances (K-TRACS), the Kansas prescription drug monitoring program, there were more than 5.4 million Schedule II-IV prescriptions and more than 332 million pills dispensed in Kansas in 2018. Kansas is using this funding to invest in expanding access to treatment, particularly evidence-based treatment, and reducing the number of opioid-related deaths across our state. KDADS' Behavioral Health Commission oversees and monitors grant activities. KDADS is currently using SOR award funding to provide medication- assisted treatment (MAT) services to uninsured patients in Kansas. Four grantees cover treatment services for all 105 counties in Kansas in different geographical locations and include a medical center/methadone clinic, a substance use disorder provider, a regional alcohol and drug assessment center, and a mental health center.

Governor's Behavioral Health Services Planning Council (GBHSPC) - SAMHSA conducted a 10-year onsite review for the Block Grant in May 2018. The Mental Health onsite reviewer did ask the Planning Council about integration of primary care. Although a few of the GBHSPC subcommittees had included primary care integration as a focus (ex. the children's subcommittee), the GBHSPC Executive Council agreed to review physical health integration and make recommendations.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Please see section above #1.

Crisis Centers - KDADS also funds several Behavioral Health Crisis Centers across the state with impressive early outcomes. These centers with detox beds and beds for stabilizing people in mental health crises give police officers and medical teams a place to take people where they can stay up to 23 hours instead of housing them in jails or emergency rooms. For example, the Sedgwick County Community Crisis Center (a joint endeavor between a Community Mental Health Center and a Regional Alcohol Drug Assessment Center) is estimated by the Wichita State University Public Policy and Management Center to have resulted in community cost avoidance to hospitals, EMS, and law enforcement of between $13.2 and $21.6 million in its first three years of operation. The full report can be found here: https://www.wichita.edu/administration/diversity/ppmc/documents/SACK.pdf

Community Mental Health Centers - Many substance use disorder providers are dually licensed as Community Mental Health

Centers (CMHCs) enabling them to coordinate both mental health and substance use disorder care for those with co-occurring diagnoses.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Kansas Insurance Commissioner is ultimately responsible for ensuring that insurance plans sold to the public under the Marketplace are qualified health plans and approved by the Commissioner.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ○ Yes ◉ No

iii) hypertension ○ Yes ◉ No

iv) high cholesterol ○ Yes ◉ No

v) diabetes ○ Yes ◉ No

c) Recovery supports ◉ Yes ○ No

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

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

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

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

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

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

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

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

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

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(●) Yes ( ) No
b) Ethnicity	(●) Yes ( ) No
c) Gender	(●) Yes ( ) No
d) Sexual orientation	( ) Yes ( ) No
e) Gender identity	( ) Yes ( ) No
f) Age	(●) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes ( ) No

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

Please indicate areas of technical assistance needed related to this section

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3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

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

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

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

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

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

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

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

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

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

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

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

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

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

Currently, there are three teams in Kansas. Two of the funded MHS providers are in their third and fourth year and are located in large, urban areas. These two programs have well established, specialized teams to provide services and supports to individuals with an early serious mental illness (ESMI). The new third team is in a location that is more of a multiple county facility in a designated rural and frontier region. This program is still in the developmental stage as we are hoping to establish a rural and frontier model that can be duplicated in the state. Eligible individuals are those with early psychotic disorders, specifically first episode psychosis.

This year the eligibility age was raised from 15 to 25-years-old to 15 to 36-years-old as we were seeing few women in the program. It was felt that more women would be eligible for the program with the change in age as they tend to have a later onset of first episode presentation.

This project includes the use of multiple EBP's including: “Recovery After First Schizophrenia Episode” (RAISE), NAVIGATE,

Supportive Employment, and Cognitive Behavioral Therapy for Psychotic Disorders (CBTp). RAISE involves coordinated specialty care (CSC) treatments for people experiencing first episode psychosis. According to the NIMH RAISE website, CSC is a recovery-oriented treatment that "promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and team work together to make treatment decisions that involve family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin."

NAVIGATE is a team-based approach to implement CSC for early psychosis. The team is comprised of members that include: a Program Director who educates the community, recruits individuals who have begun to experience psychosis, and leads the team; a Prescriber, trained in using low doses of medications and addressing special issues of clients with first episode psychosis; an Individual Resiliency Trainer (IRT), who helps individuals identify and work towards their goals, teaching them strategies and skills to build their resiliency in coping with psychosis while staying on track with their lives; a Family Education (FE) Clinician, who helps the whole family learn about psychosis and how to manage it, and also how to support each other and build family resiliency; a Supported Employment and Education (SEE) Specialist, who helps people identify and achieve their educational and/or employment goals; and, Case Management, provided either by a separate case manager or by a specified NAVIGATE team member.

Cognitive Behavioral Therapy for Psychosis (CBTp) is a person-centered, time limited, evidence-based therapy for psychosis that involves the following components: engagement and assessment, coping strategy enhancement, new perspectives on psychosis, exploration of beliefs about/relationships to unusual experiences, and relapse prevention.

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

The three funded programs provide education and outreach in their communities via: hospitals, schools, colleges, and a large social media campaign. They also have developed and distributed flyers and made presentations at conferences and to other behavioral health organizations.

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

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

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

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

At this time, no modifications have been made to the original EBPs.

RAISE involves coordinated specialty care (CSC) treatments for people experiencing first episode psychosis. According to the NIMH RAISE website, CSC is a recovery-oriented treatment that "promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and team work together to make treatment decisions that involve family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin."

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Cognitive Behavioral Therapy for Psychosis (CBTp) is a person-centered, time limited, evidence-based therapy for psychosis that involves the following components: engagement and assessment, coping strategy enhancement, new perspectives on psychosis, exploration of beliefs about/relationships to unusual experiences, and, relapse prevention.

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

Education by the funded programs for behavioral health professionals across the state is the highest priority as it should increase the number of providers who are offering similar interventions. The providers will continue to do ongoing outreach to stakeholders and make marketing materials available in Spanish and other languages that are needed to reach consumers and stakeholders in their catchment areas. They will also provide updates when requested on programs and outcomes to the Governor's Behavioral Health Services Planning Council (GBHSPC).

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

ESMI.

Programs collect treatment data monthly and report quarterly. Reports include: achievements, outcomes, and goal progress for each individual. Agencies also provide narrative on overall performance of the program, achievements, barriers and plans for the next quarter's report.

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

Diagnoses include: schizophrenia, schizoaffective disorder, unspecified schizophrenia spectrum disorder, other psychotic disorders, and bipolar disorder with psychotic features.

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

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

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

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

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

Kansas continues to engage consumers in the decision-making processes, providing the opportunity for individuals to be active participants in their health care plans through four general steps: 1) consumers receive clear and unbiased information that describes their overall health conditions, providing them the opportunity to envision how their life may change based on their own decisions; 2) provider and stakeholder support of consumers' decision-making processes; 3) provider encouragement of consumers in asking questions about their health conditions; and, 4) provider recognition of consumers as the decision-makers regarding health care.
In addition to other peer support programs, Kansas has a network of Consumer Run Organizations (CROs) dedicated to improving the lives of adults with SPMI using Peer Support as the cornerstone of its programs and services. CROs are legally incorporated nonprofit consumer governed and operated organizations using a peer recovery model built on self-direction, empowerment, peer support, and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. CROs provide an array of services to its members which include: one on one peer support, peer support groups, self-help groups, employment support, life skills training, health and wellness activities; act as bridge supports from state institutions to life in the community, and education about Medicaid and other community resources to connect members to services.

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

In the 1980s, researchers at the University of Kansas' School of Social Welfare developed the Strengths Model, which empowers individuals to focus on their strengths and set goals for recovery instead of fixating on a problem or diagnosis. For several decades, Kansas community mental health center (CMHC) case managers have received training in how to use the Strengths Model in their work. The Kansas network of Consumer Run Organizations (CROs) also work to develop an individualized plan supportive of wellness recovery goals and behavioral health needs with their members.

For several of the home and community based waivers (Autism, Frail Elderly, Physical Disability, Technology-Assisted, Traumatic Brain Injury), KDADS has a policy for Person-Centered planning posted on our website at: https://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs)/hcbs-policies. A specific policy for the SED Waiver participants is in process.

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

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6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

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

Please indicate areas of technical assistance needed related to this section

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7. Tribes - Requested

Narrative Question

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

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

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

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

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [ ] Adults (ages 27-54)
- [ ] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

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

- [ ] Archival indicators (Please list)

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

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

KDADS supports the ability to make data-driven decisions by identifying trends, hotspots, geographic prevalence, sub-populations and associated risk and protective factors concerning substance abuse prevention priorities at both the state and local level. Utilizing needs assessment data allows KDADS to address gaps and disparities which allow for a comprehensive more effective prevention system. Community level allocation of SABG funds are based on variables that include the SPF process and demonstrated completion of benchmarks from each steps within the planning phase (Assessment, Capacity and Planning). These local level needs assessment require the identification and prioritization of at least 1 to 2 local prevalence outcomes, and approx. 2-5 targeted local risk and protective factors, completion of a logic model and action plans for each primary evidence-based strategy, along with an evaluation framework outlining key process and outcome indicators corresponding with data collection needs. KDADS staff and other prevention subject matter experts evaluate for accuracy, alignment, prioritization integrity, saturation intensity and appropriateness of proposed strategies. As needed requested revisions are completed and resubmitted and funding allocations are made to support to each community's proposed line-item budget for strategy implementation. Needs assessment data at the community level is vital to the process of awarding funding to communities to support local prevention efforts in a manner that is both data-driven, outcome based and maintains fidelity to the SPF process.

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

Narratve Question

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

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

Capacity Building

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

If yes, please describe

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

If yes, please describe mechanism used

The Kansas Prevention Collaborative (KPC) provides support for community based prevention education by offering trainings, technical assistance and resources to community based organizations that help allow them to engage in prevention efforts tailored to their specific needs. This is accomplished through skill-building activities, coaching, e-learning models, toolkits, workshops, and demonstrations. These trainings are provided so the individual is able to learn a specific skill-set and acquire sufficient content information that it easily utilized at the local level.

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

If yes, please describe mechanism used

Kansas utilizes the Tri-Ethnic Community Readiness model as the primary measure of community readiness. This involves the completion of a series of local key informant surveys, with data that is obtained and scored on the basis of six dimensions of community readiness. This includes, community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue of concern and resources related to the issue. The scoring of the data across these dimensions indicate a range on a nine point scale, beginning with no awareness, through initiation, to high community ownership. This provides qualitative and quantitative data, collected as part of a repeated evaluation measure in funded communities. This enables communities to build local capacity development plans specific to strategies for increasing and enhancing readiness. Kansas has also developed a Coalition Capacity Survey that is utilized during the assessment phase, to help coalitions identify their own internal coalition capacity.

Narratve Question

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

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

Planning

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

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

In 2018, the Governor's Behavioral Health Planning Council Prevention Subcommittee developed a statewide prevention plan. This plan is currently being updated to reflect current data and reflect accomplishments that were suggestions in 2018 plan.

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

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** [ ] Timelines
- **c)** [ ] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component
- **g)** [x] Sustainability component
- **h)** [ ] Other (please list):

  The state plan works toward expanding prevention efforts to be more inclusive of behavioral health promotion, suicide prevention, and problem gambling education and awareness. through increasing the availability of resources to adequately fund local level prevention.
- **i)** [ ] Not applicable/no prevention strategic plan

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

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

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

In 2019, Kansas developed an Evidence Based workgroup that consists of experienced prevention professionals who are knowledgeble on strategies that work across collaborative priority target areas. The Evidence Based Strategies Matrix has been developed by the Kansas Evidence Based Strategies Workgroup (EBSW). The EBSW's purpose is to support Kansans through

promoting the use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services. The matrix is offered to the public with community coalitions in mind as a tool to support planning for effective and comprehensive prevention efforts. This matrix offers a blend of environmental strategies and curricula-based prevention education programs. This matrix does not encompass every evidence-based prevention strategy available to communities. Stakeholders may research and select other strategies that align better with identified risk and protective factors. The EBSW promotes the importance of selecting strategies that have appropriate fit and approval from designated funding sources. Evidence-based prevention strategies (programs, practices, and policies) are validated by documented evidence of effectiveness. The Kansas EBSW has adopted the Center for Substance Abuse Prevention's (CSAP's)/Substance Abuse Mental Health Services Administration's (SAMHSA's) three tiers of criteria for determining if a strategy is evidence-based (https://www.hcpcme.org/pubadmin/health/SPEP/CSAP4p56_Guidance_Jan04_2007.pdf).

i. Tier 1 – Strategy appears on a national registry of evidence-based strategies

ii. Tier 2 – Strategy appears in a peer reviewed publication with positive effects

iii. Tier 3 – Strategy includes documented effectiveness that is supported by other sources of information and the consensus judgment of informed experts. Other Anticipated Uses of the EBS Matrix:

Other possible uses for this document by the State of Kansas and communities could include those outlined in the PEW Charitable Trusts report "How States Engage in Evidence-Based Policymaking – A national assessment", such as:

1) Distinguishing proven programs from those without evaluated effectiveness
2) Inventorying programs to manage resources strategically
3) Comparing program costs and benefits to calculate return on investment
4) Prioritize funds
5) Help implement and expand proven approaches
6) Sustain support for evidence-based policymaking

The Evidence-Based Strategies (EBS) Matrix has been developed by the Kansas Evidence-Based Strategies Workgroup and in partnership with Kansas Substance Abuse Prevention Coalitions, the Kansas Prevention Collaborative, and the Kansas Department of Aging and Disability Services. Initially drafted by prevention staff at DCCCA, the Matrix was revised during 2018 and early 2019, with the first draft being completed and released by the following group of prevention professionals.

Narratve Question

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

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

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Multiple community coalitions across the state implement "It Matters" media campaign. The campaign originally focused on underage drinking prevention but has since been revised to include messaging on marijuana, opioids, binge drinking, and suicide prevention.

b) Education:

The Kansas Prevention Collaborative is largely responsible for providing support for community-based prevention education efforts by developing the capacity of coalitions and other prevention partnerships to engage in effective local prevention activities. A KPC partner, "DCCCA", will continue to offer support, technical assistance, training, and other resources to community coalitions that enable them to engage in prevention education efforts tailored to local needs. Community capacity for the implementation of prevention education initiatives include, trainings, presentations, coaching, or other activities intended to affect life or social skills and will be cultivated among prevention staff.

c) Alternatives:

he Kansas Prevention Collaborative will continue to support alternatives. This includes, at the local level, opportunities for children and youth to participate in activities that exclude the use of alcohol, tobacco, and other drugs, and allows for meaningful involvement, leadership development, community service, or positive social engagement and interaction. These

activities will be coordinated and implemented via community coalitions through a comprehensive, local assessment process, identifying those activities most appropriate and likely to produce a positive impact, garnering resources to support implementation of the activity, and evaluating efforts. Additionally, mechanisms for increasing youth involvement in the implementation of evidence-based prevention strategies will serve a secondary purpose of enhancing the availability of drug-free alternatives as well as prevention education opportunities for other youth through involvement in prevention programs.

d) Problem Identification and Referral:

No statewide system for problem identification and referral will be funded. Each sub-state recipient has its own system for problem identification and referral to their own prevention education programs.

e) Community-Based Processes:

Kansas continues to fund community coalitions through a competitive request for proposal (RFP) process. We have provided awards for planning grantees (utilizing the SPF process), and implementation grantees. Communities will be supported by a statewide project team throughout this process enabling them to effectively implement prevention programming and achieve outcomes.

f) Environmental:

Community coalitions that receive SABG funding and have completed a strategic plan and identified appropriate evidence-based strategies will be supported through an array of environmental strategies that include programs, practices, and policy changes.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

Funded community coalitions are required to complete a comprehensive needs assessment, capacity assessment, readiness assessment and assessment of existing community resources. This assessment is reviewed by multiple Kansas Prevention Collaborative partners for internal review as well as it is clearly stated within their grant agreement that SABG funds do not supplant prior sources of funding for prevention services and programming.

Narratve Question

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

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

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

While no formal evaluation plan is in place, the Kansas Prevention Collaborative (KPC) partner, The Southeast Kansas Resource Center provides evaluation support to all community coalitions that receive funding through the SABG grant as part of a service provided by the KPC. As well as, all funded community coalitions are required to submit regular documentation for evaluation purposes through the workstation and Community Checkbox system.

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

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use

- [x] Binge use
- [x] Perception of harm

c) [x] Disapproval of use

d) [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) [ ] Other (please describe):

Footnotes:

SABG Primary Prevention funding in Kansas supports the implementation of evidence-based primary prevention strategies to local level community coalitions that are determined by the collection of local-level data. Community logic models and associated comprehensive plans that align with the local priorities in terms of targeted risk and protective factors, align with the prevalence outcomes at the state level. Communities are guided through the SPF process to ensure that evidence-based prevention strategies are appropriately selected and implemented. These strategies include multiple primary and secondary environmental and individual approaches, they are implemented with fidelity while responsive to the need for cultural adaptations and address effectiveness gaps. In addition, plans developed at the local level that is more broad-based and inclusive of multiple core strategies with EBS infused throughout. While the state does have a formal written evaluation plan, the communities that are funded with SABGS dollars have written evaluation questions that are to be answered and they prepared a logic model and action plans with measurable goals and objectives, and a data collection plan which includes data sources and timelines. As well as there are data sources that monitor and track progress that are in place.

KANSAS BEHAVIORAL HEALTH PREVENTION PLAN

October 2018

Governor's Behavioral Health Services Planning Council
Prevention Sub-Committee

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SECTION 1: Executive Summary

Behavioral health prevention services in Kansas have evolved over the past several years. This evolution came about as an effort to become more inclusive of substance use prevention, mental health promotion, suicide prevention and problem gambling prevention. As part of our work to integrate behavioral health prevention services, the Governor's Behavioral Health Services Planning Council tasked the Prevention Sub-Committee with developing a Kansas Behavioral Health Prevention Strategic Plan.

The purpose of this document is to help guide behavioral health prevention efforts in Kansas. There are many moving parts to the prevention infrastructure and the Prevention Sub-Committee continues to identify new partners and leverage resources to make an impact in the prevention infrastructure. This document outlines our process for developing the plan, highlights data points relevant to prevention work, outlines current prevention efforts, and highlights strengths and gaps within those efforts. There are also a set of recommendations based on system gaps that the Prevention Sub-Committee will continue to work with key stakeholders to systematically improve.

The Prevention Sub-Committee utilized the Strategic Prevention Framework as a model for plan development. We began with a needs assessment process which included an extensive review of available data in the state. Based on this data review, we identified five areas of focus for our plan. These areas of focus include suicide and depression prevention, alcohol use, marijuana use, attitudes and beliefs about marijuana use, prescription drug misuse and problem gambling. We also reviewed priority block grant data established prior to the development of this plan. This data aligned well with our chosen priorities and we will continue to review data on an annual basis to monitor trends.

This document is designed to offer a course of action for implementation of evidence-based strategies to address a comprehensive approach to behavioral health prevention in Kansas.

While these items will be described in more detail in the Call to Action of this plan, the following are the recommendations of this Prevention Sub-Committee in 2018:

1. Improve Shared Access to Data Resources Among State Agencies and Planning Council Sub-committees
2. Better Coordinate Efforts and Care Transitions of Behavioral Health Services
3. Form an Evidence-Based Practices Workgroup (EBW) for Behavioral Health Promotion
4. Allocate Resources to Prioritized Areas of Need Through Data-driven Decision Making

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SECTION 2: Behavioral Health Prevention Planning Process

Kansas has a strong history of innovative approaches to prevention work. In 2015, the scope of prevention work in the state shifted to respond to the changing needs of Kansas communities. This shift allowed communities to be more comprehensive in their approach to prevention and focus on shared risk and protective factors in behavioral health.

The Governor's Behavioral Health Services Planning Council Prevention Sub-Committee was established in the fall of 2016 to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes, and to increase the effectiveness of State and local efforts to address prevention issues. The Prevention Sub-Committee serves as the Advisory Council for Kansas Behavioral Health Prevention Initiatives.

Initial sub-committee members focused on recruiting a diverse cross-section of individuals engaged in behavioral health prevention work in Kansas. The committee began meeting regularly in November 2016. One area of focus for the committee was preliminary development of a statewide plan to address behavioral health prevention. Strategic plan development will allow sustainable use of prevention resources in challenging times.

The Prevention Sub-Committee serves as a broad, representative voice for behavioral health as it relates to prevention of health and behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder prevention. With a primary mandate to provide feedback and guidance to the Governor's Behavioral Health Services Planning Council related to KDADS BHS prevention initiatives, this workgroup also is responsible for the following key roles and responsibilities:

- Develop a statewide plan to address behavioral health prevention
- Guidance, research and recommendations relating to prevention across the lifespan
- Feedback on Substance Abuse Prevention and Treatment (SAPT) Block Grant prevention initiatives
- Feedback on Kansas behavioral health prevention initiatives including suicide prevention, problem gambling prevention and substance abuse prevention
- Feedback related to strategic initiatives at the State level to infuse prevention efforts across the Institute of Medicine (IOM) continuum of care, integrating lifespan and developmentally-appropriate strategies into current prevention processes
- Guidance and feedback related to behavioral/mental health promotion and shared risk and protective factors including:
    - Adverse Childhood Experiences (ACEs)
    - Evidence-based strategies
    - Needs identified through assessment

- Outcomes of recent strategies
- Relevant research

Workgroup recommendations and feedback on prevention initiatives align with the following guiding principles:

1. Data-driven and outcomes-focused
2. Culturally competent, responsive, and inclusive
3. Evidence-based strategies and best practices
4. Sustainable, with a focus on population-level change
5. Consistent with current prevention research and the Strategic Prevention Framework
6. Aligned with State outcome priorities and SAMHSA's Strategic Directions and Priority Populations

At the inaugural meeting of the prevention sub-committee, we provided an overview of the committee purpose and the importance of focusing on a comprehensive approach to behavioral health prevention. We learned about the work of the Suicide Prevention Sub-Committee and began to discuss appropriate integration of the two committees. This process laid the framework for ensuring more behavioral health aspects of prevention were represented on the prevention sub-committee including substance abuse prevention, mental health promotion, suicide prevention and problem gambling prevention.

Early meetings of the committee also focused on data sharing. Committee members expressed a desire to learn more about available data points related to behavioral health prevention and to identify potential data gaps. The committee continues to review available prevention data and note trends within the data to make informed recommendations and data-driven decisions.

The committee has gathered information on behavioral health prevention efforts in the state, both funded initiatives and grassroots efforts. It was important to conduct an initial assessment of current efforts to determine potential gaps in services and to identify efforts of which some committee members were not aware. Having a clear picture of prevention initiatives allowed the committee to begin laying the framework for a statewide plan to address behavioral health prevention.

The bulk of the committee work focused on developing a template for the statewide prevention plan and connecting with other Governor's Behavioral Health Services Planning Council Sub-Committees (Veterans, Early Childhood, Rural and Frontier, Housing and Homeless, Kansas

Citizen's Committee, Justice Involved Youth and Adults, Vocational). We reviewed plans from several other states to determine areas that were essential for the Kansas plan. We also identified emerging areas for prevention efforts and those areas which were no longer considered priorities to develop the first comprehensive behavioral health prevention strategic plan for Kansas.

SECTION 3: Mission, Vision and Values Statement

A high-quality behavioral health prevention system must have a clear mission and vision to guide and define the current and future opportunities for prevention services. In Kansas, we have outlined the following mission and vision statements to guide our work –

MISSION: To provide feedback, guidance, advocacy, and engagement at the State level for related behavioral health prevention outcomes and identification of systems changes to address challenges, barriers, issues, and needs at the State, regional, or community level.

VISION: To ensure that key representatives and stakeholders are involved in the provision of reflection, feedback, and guidance relating to initiatives within Kansas Behavioral Health Prevention Initiatives to ensure enhanced collaboration, effectiveness, and impact on State and local level prevention and behavioral health outcomes.

To support our mission and vision, we have highlighted eight values that are intrinsic to the functioning of our behavioral health prevention system –

- **Committed**
  Behavioral health needs in Kansas are not easily solved with just one right answer. We are committed to responding to behavioral health prevention and promotion needs in Kansas through difficulty, trial and success. We have dedicated professionals who work tirelessly to support prevention efforts at the local level, committing a variety of resources to communities.
- **Community**
  Prevention efforts are a vital component of communities across Kansas. Communities can embrace their resources and build upon those resources to support those in need of behavioral health services. Local community prevention networks are the planners and problem-solvers of our state, and actively engaging these networks supports our overall goal of comprehensive behavioral health prevention.

- **Diversity**
  Behavioral health services across the continuum of care must be available to people of diverse populations reflective of their community. Diversity includes a variety of important characteristics informing citizens' perspectives, values and beliefs such as race, ethnicity, age, gender, sexual orientation, disability, religion, income level, education, geographical location and occupation. We are committed to engaging diverse voices, perspectives and experiences, including those of people served, to adapt behavioral health prevention services in Kansas equitably and inclusively.
- **Education**
  Public education efforts are crucial for community providers. Developing educational training opportunities for agencies to provide tools for sustainable programs, policies and practices to serve individuals with behavioral health needs is a key piece to removing stigma associated with substance abuse, mental illness, suicide and problem gambling.
- **Leadership**
  We identify ways that Kansans can take a leadership role within prevention in their communities and support leadership development efforts to advance prevention initiatives. Our committee leads the way in ensuring that community members have or can gain access to the resources they need to advance prevention efforts in their communities across the state.
- **Partnership**
  No one person or organization can do the difficult and complex work of behavioral health prevention and promotion services alone, and we are here to foster partnerships across Kansas to address behavioral health needs with the best our state has to offer. We promote partnerships and information sharing among providers and community based-coalitions to develop the capacity of our workforce.
- **Quality**
  The Governor's Behavioral Health Services Planning Council Prevention Sub-Committee is a source of accountability to the State to ensure access to the highest quality of behavioral health care and prevention resources possible for all communities and citizens. We believe that high quality prevention work utilizing evidence-based practices is vital to the success of all behavioral health prevention initiatives.
- **Sustainability**
  A plan that is sustainable will ensure behavioral health prevention efforts are consistent and ongoing. As we develop plans and invest resources in prevention initiatives, it is crucial to ensure that we are investing in strategies that are sustainable to maintain growth and development of prevention infrastructure in Kansas.

SECTION 4: Guiding Principles

The Governor's Behavioral Health Services Planning Council Prevention Sub-Committee has identified several principles to support the development of the statewide behavioral health prevention plan. These principles describe our beliefs and philosophy pertaining to our work. These principles guide how our committee functions and supports the development of our strategic plan. The principles also highlight why we are engaging in this work and how we will function in our current environment and future opportunities.

In Kansas, the following principles guide the implementation and evaluation of behavioral health prevention services –

- We utilize the Strategic Prevention Framework as our planning model to reduce the incidence of substance abuse, suicide and problem gambling. This model is also used to promote good mental health and well-being for all citizens. The five-step model offers a comprehensive process for addressing behavioral health problems in our communities.
- Services and systems are collaborative in nature, each working together to efficiently use available resources to make the most significant impact.
- Communities and providers are engaged in best practices and innovative approaches to develop an integrated, comprehensive approach to behavioral health prevention
- Communities and providers share information on prevention initiatives and training on evidence-based practices occurs regularly and is easily accessible.
- Prevention services are delivered in a manner that exemplifies respect for all members of the community, with acceptance of differing opinions and an agreement to work toward consensus.
- We believe in quality prevention work within the State of Kansas, therefore we will promote the use of evidence-based practices and comprehensive approaches to the work.
- We recommend evidence-based prevention strategies to serve the behavioral health needs of individuals and communities.
- Decisions about allocating resources are based on data and outcomes are measured at the local and state-level.

SECTION 5: Goals and Priorities

To assess, identify, and prioritize behavioral health challenges in Kansas, the Prevention Sub-Committee reviewed the *November 2017 Kansas Behavioral and Mental Health Profile.* (http://www.kdads.ks.gov/commissions/behavioral-health/publications-and-reports). The profile combines data and information from multiple sources to provide a comprehensive picture of the impact of behavioral health challenges in Kansas.

Where possible, information is presented by gender, race, ethnicity and age to help identify disparate populations. The committee completed a review of over 75 data indicators related to the prevalence, impact, and consequences of substance use, mental health, gambling, and treatment. Because of this data review, the committee identified 25 significant areas of concern based on the following criteria and considerations:

- **Significant Magnitude** describes the numbers of people affected by a problem. Using magnitude to prioritize problems seeks to address problems that affect the greatest number of people.
- **Significant Impact** describes the severity or end result of a problem. For example, while underage drinking has a larger magnitude than youth suicide, the impact of suicide is much larger than underage drinking.
- **Trend** describes the general direction an indicator is developing or changing. Five years of data is used to create a trend line indicating whether an indicator is increasing, decreasing, or staying the same across that timespan. A behavior is more likely to be targeted if it shows an increase or decrease in an undesired direction than a behavior that is showing an increase or decrease in the desired direction.
- **Comparison to National Average**. State indicator data is compared to national data when possible. This provides an important point of reference to help determine the status and significance of a problem or behavior. State data that is higher or lower than the national average in an undesired direction could represent an area of concern depending on the size of the gap between the two measures.
- **Changeability** describes the degree to which an indicator may be changed. Issues related to access, availability, and capacity can impact changeability. Policy, social and cultural norms may also impact the feasibility of change.
- **Health Disparities** adversely affect groups of people who have systematically experienced greater obstacles to health (including behavioral health) care based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Disparities relating to *behavioral health status* refer to differences in the rate of behavioral health problems

(e.g., substance use disorders, emotional health problems, suicide rates) as well as higher levels of illness and death compared with the behavioral health status of the general population.

- **Data Gaps**. Data available for prioritization were from reliable sources with ongoing data collection. The Prevention Sub-Committee acknowledges there are gaps in data availability, quality, and reliability that might interfere with the identification and prioritization of particular problems, behaviors, or sub-population challenges existing in the state.

To further pare down the list of targeted indicators, the Prevention Sub-Committee completed a secondary prioritization process to narrow the scope of the identified challenges in the state. Areas of priority for prevention include 1) suicide, 2) alcohol, 3) marijuana, 4) prescription drug misuse, and 5) problem gambling. Specific indicators identified by the largest number of Sub-Committee resulted in the priorities identified below. All identified indicated priorities have equal weight or importance and are not presented in any particular order.

1. Suicide Prevention

1.a. Measure: Number of deaths from suicide per 100,000 population

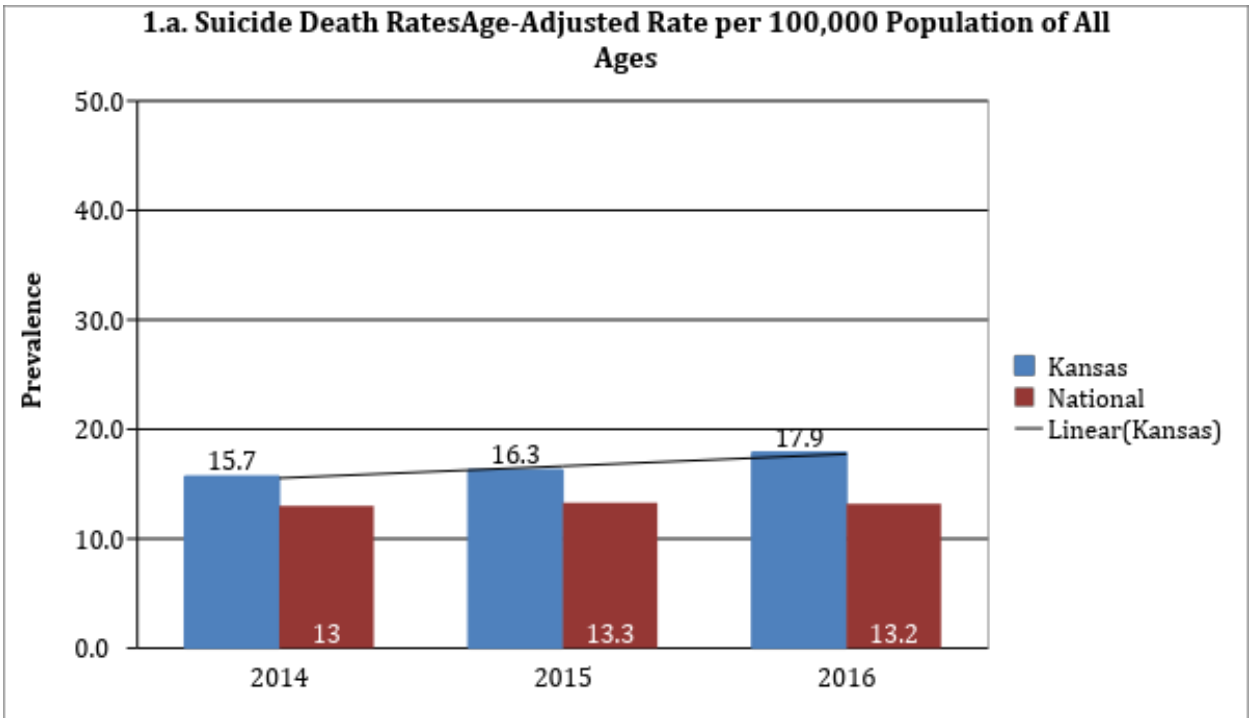
Why is this indicator important?
Suicide rates are highly correlated to alcohol and illicit drug abuse (e.g., Norström & Rossow, 2016). Individuals suffering from chronic depression may begin to self-medicate, causing a higher than expected suicide rate (e.g., Marschall-Levesque et al., 2016).

Data Source
National and trend data from Centers for Disease Control and Prevention, National Center for Health Statistics - CDC WONDER online database, detailed mortality statistics 1999-2016 Multiple Cause of Death Files.
Rural suicide disparity data taken from: Kansas Health Institute (April, 2018). Deaths by Suicide: Disparities in the Sunflower State. Issue brief #3 in a series of three on health disparities in Kansas.

Important findings:

- Rates of death by suicide have been increasing both nationally and in Kansas over the past five years.
- From 2014 to 2016 the rate of suicide in Kansas is higher than the national average.

Graph of Three-Year Trend



1.b. Measure: Major Depressive Episodes: Percent of population reporting having at least one major depressive episode in the past year (ages 12-17).

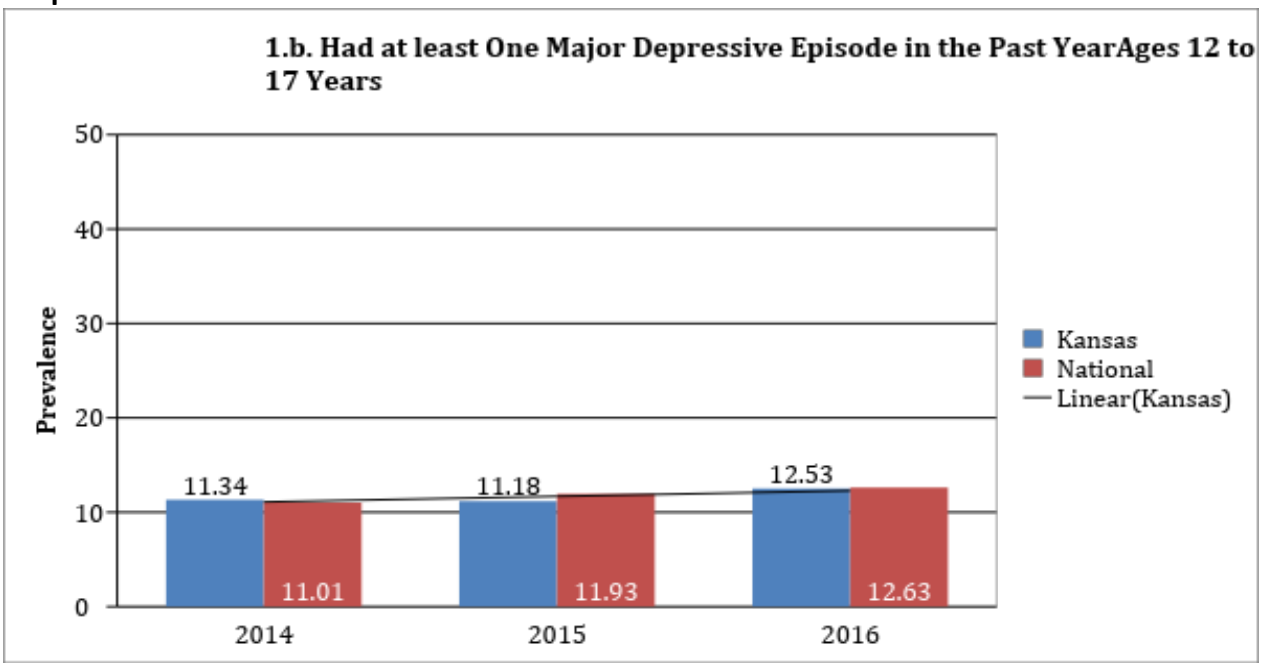
Why is this indicator important?
The link between mental health and substance abuse is well established. Experiencing episodes of depression or anxiety in the past year is associated with higher rates of substance abuse. Adolescence and young adulthood is a time of great change and is associated with greater risk of mental health problems (e.g., Shain, 2016).

Data Source
SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2011 – 2016

Important findings

- The percentage of Kansas youth reporting major depressive episodes in 2016 (12.5%) is higher than reported in 2009 (8.6%). **The 2009 to 2016 increase is statistically significant (p=0.003)** (SAMHSA, 2016 Table 13).
- Percent of adults reporting having had at least one depressive episode in the last year is higher for Kansas residents than the national average and percent of Kansas youth ages 12-17 is higher than Kansas adults.

Graph of Three-Year Trend



1.c. Additional Measure: Depression - Youth: Percentage of students in grades 6, 8, 10 and 12 responding 'Yes' to the question: During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?

Why is this indicator important?

Indicator 1.b. reported youth depression based on 5 of 9 criterion to define a major depressive episode using national data. Indicator 1.c. includes data reported directly from Kansas students regarding their feelings of depression as stated in the question above. Inclusion of this indicator of youth depression is important as it allows not only for state level data but also for sub-state information to monitor and address youth depression and suicide.

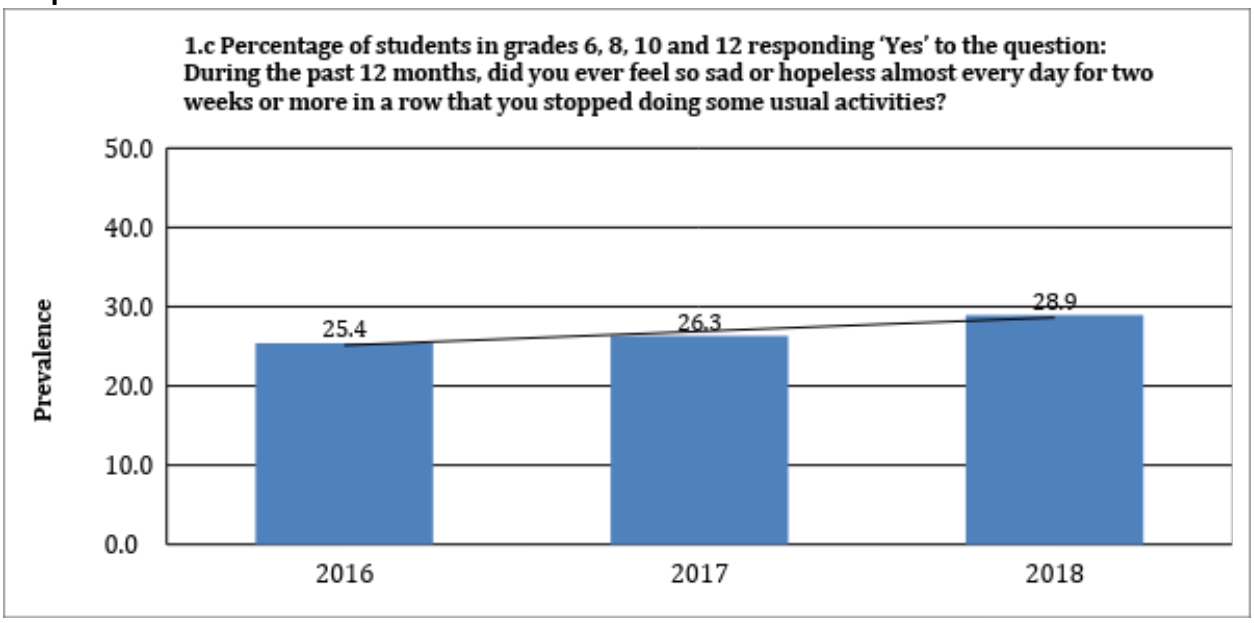
Data Source

Kansas Department for Aging and Disability Services, Behavioral Health Services, Kansas Communities That Care (KCTC) Survey, 2016-2018.

Important Findings

- The percentage of youth reporting depression has increased from 2016 to 2018.
- A larger percentage of females reported depression than males.
- Reported depression is not subject to typical maturation or growth with age.

Graph of Three-Year Trend



Year	Overall	Grade Level				Gender	
		6th Grade	8th Grade	10th Grade	12th Grade	Male	Female
2016	25.4	19.0	26.1	29.1	28.9	18.5	32.1
2017	26.3	22.3	26.5	29.9	27.6	19.4	33.1
2018	28.9	24.2	29.0	33.4	30.2	21.7	35.9
3-Year Average	**25.9**	**20.6**	**26.3**	**29.5**	**28.3**	**18.9**	**32.6**

Year	Single Race					Hispanic (of any race)	Non-Hispanic
	White	African American	Hawaiian / Pacific Islander	Asian	Native American / Alaska Native		
2016	24.2	22.0	35.9	24.0	31.5	30.1	24.5
2017	24.8	24.9	32.9	22.4	35.9	29.9	25.6
2018	27.1	29.1	42.0	26.7	40.3	34.5	27.4
3-Year Average	**25.4**	**25.3**	**36.9**	**24.4**	**35.9**	**31.5**	**25.8**

2. Alcohol

2.a. Measure: 30-Day Alcohol Consumption – Youth: Percentage of students in grades 6, 8, 10 and 12 reporting any use of alcohol within the past 30 days

Why is this indicator important?

Early initiation of alcohol consumption has been shown to increase the risk of drinking problems later in life (Patrick & Schulenberg, 2014; Bolland et al., 2013). Alcohol is a known Central Nervous System (CNS) depressant and influences cognitive reasoning and abilities. In addition, alcohol is associated with violent behaviors (e.g., Graham & Livingston, 2011). Additionally, the purchase or consumption of alcohol by any individual under the age of 21 is illegal in Kansas (Kansas Liquor Control Act, 1985).

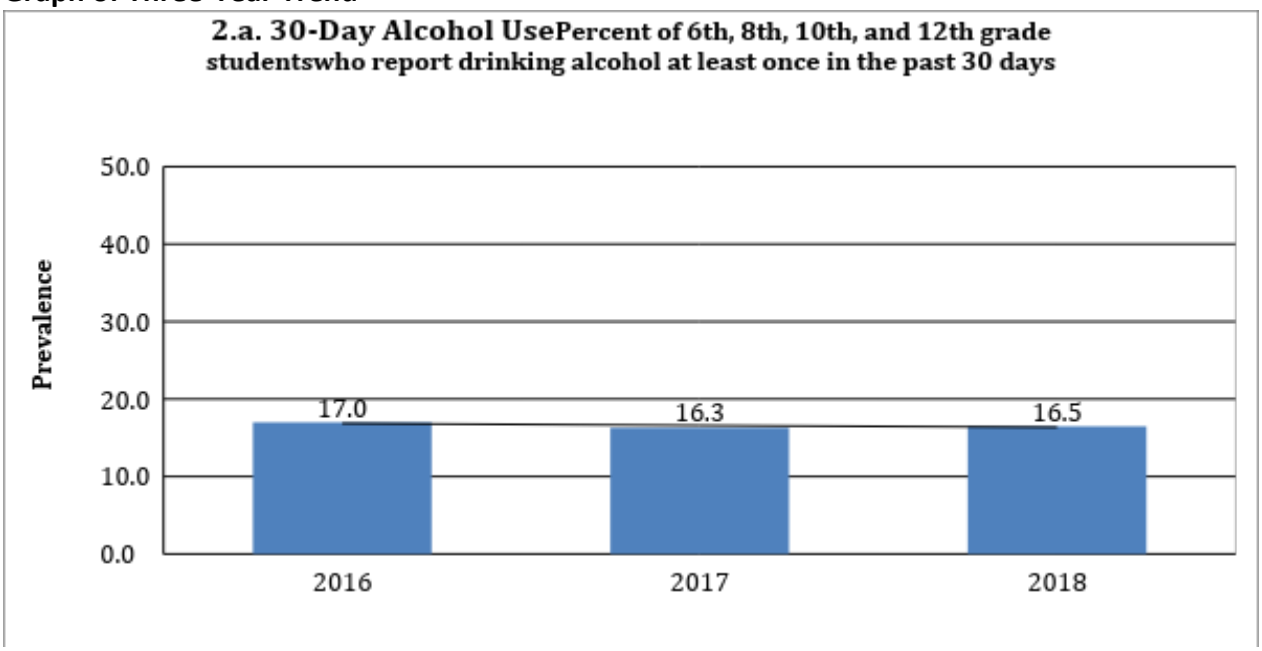
Data Source

Kansas Department for Aging and Disability Services, Behavioral Health Services, Kansas Communities That Care (KCTC) Survey, 2016-2018.
National comparison data taken from the Monitoring the Future student survey, 2016-2017.

Important findings

- There has been a reduction in the percentage of Kansas youth who report drinking alcohol in the past month from 15.9% in 2009 to 10.3% in 2016. **This reduction is statistically significant ($p < 0.05$)** (SAMHSA, 2016 Table 5).
- While the percentage of youth reporting drinking alcohol has decreased, it is still the number one drug of choice for Kansas adolescents and Kansas rates of use are above the national average.
- As grade level increases, the prevalence of alcohol consumption significantly increases.
- Females have a slightly higher prevalence of 30-day alcohol consumption.
- Hispanics previously reported a higher prevalence of alcohol consumption as compared to Whites, African Americans, Native Americans and Asians/Pacific Islanders. White students have since surpassed Hispanics in 2016.

Graph of Three-Year Trend



Year	Overall	Grade Level				Gender	
		6th Grade	8th Grade	10th Grade	12th Grade	Male	Female
2016	17.0	4.0	11.1	24.3	38.7	16.1	17.9
2017	16.3	3.7	10.6	22.8	36.8	15.0	17.5
2018	16.5	3.8	11.1	22.2	35.6	15.6	17.3
3-Year Average	**16.6**	**3.8**	**10.9**	**23.1**	**37.0**	**15.6**	**17.6**

Year	Single Race					Hispanic (of any race)	Non-Hispanic
	White	African American	Hawaiian / Pacific Islander	Asian	Native American / Alaska Native		
2016	18.6	12.5	11.3	6.9	15.1	16.5	17.2
2017	18.2	9.2	12.4	7.7	13.3	15.3	16.6
2018	17.5	10.5	13.0	7.7	12.4	17.7	16.2
3-Year Average	**18.1**	**10.7**	**12.2**	**7.4**	**13.6**	**16.5**	**16.7**

3.Marijuana Use – Youth:

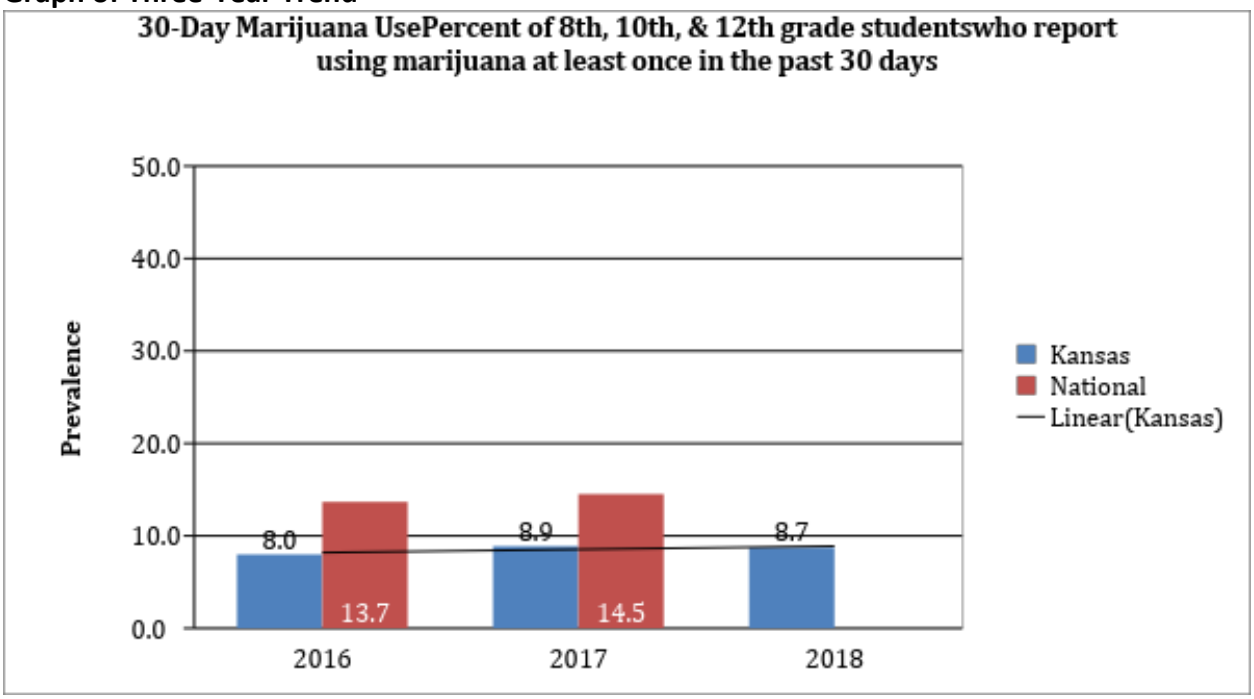
3.a. Measure: 30-Day Marijuana Use: Percentage of students in grades 6, 8, 10 and 12 reporting any use of marijuana within the past 30 days

Why is this indicator important?
Research has shown that marijuana use can have a negative impact on physical health, psychological well-being, and multiple psychosocial outcomes. Adolescents who used marijuana more frequently and began using marijuana at an earlier age experience worse outcomes and long-lasting effects (e.g., Feeney & Kampman, 2016).

Data Source
Kansas Department for Aging and Disability Services, Behavioral Health Services, Kansas Communities That Care (KCTC) Survey, 2016-2018.
National comparison data taken from the Monitoring the Future student survey, 2016-2017.

Important Findings
- In 2018 over 12% of Kansas 10th and 12th graders reported using marijuana in the past month.
- Reported youth use of marijuana has increased over the past three years.
- There is little difference in youth use between males and females

Graph of Three-Year Trend



Year	Overall	Grade Level				Gender	
		6th Grade	8th Grade	10th Grade	12th Grade	Male	Female
2016	5.9	0.6	3.2	9.1	14.8	6.3	5.5
2017	6.6	0.7	4.0	9.6	15.8	6.6	6.4
2018	6.5	0.6	3.7	9.8	15.2	6.5	6.5
3-Year Average	**6.3**	**0.7**	**3.6**	**9.4**	**15.3**	**6.5**	**6.0**

Year	Single Race					Hispanic (of any race)	Non-Hispanic
	White	African American	Hawaiian / Pacific Islander	Asian	Native American / Alaska Native		
2016	5.8	7.6	4.6	3.8	6.8	7.3	5.6
2017	6.4	8.0	7.5	2.7	7.8	7.8	6.3
2018	6.1	8.3	7.6	3.5	8.5	8.5	6.0
3-Year Average	**6.1**	**8.0**	**6.5**	**3.3**	**7.7**	**7.9**	**6.0**

3.b. Measure: Perception of Great Risk of Harm from Marijuana - Youth*:* Percent of 6th, 8th, 10th, and 12th grade students responding, "Great Risk" when asked "How much do you think people risk harming themselves if they smoke marijuana regularly?"

Why is this indicator important?

Marijuana is the most commonly used illicit drug in the United States and many Americans do not perceive it as potentially harmful (Hughes, Lipari & Williams, 2016). Additionally, data from a collection of cross-sectional surveys of middle and high schools students indicated that attitudes about the risks associated with substance use are closely related to use (et al., Miech, Johnston, O'Malley, Bachman & Schulenberg, 2015).

Data Source

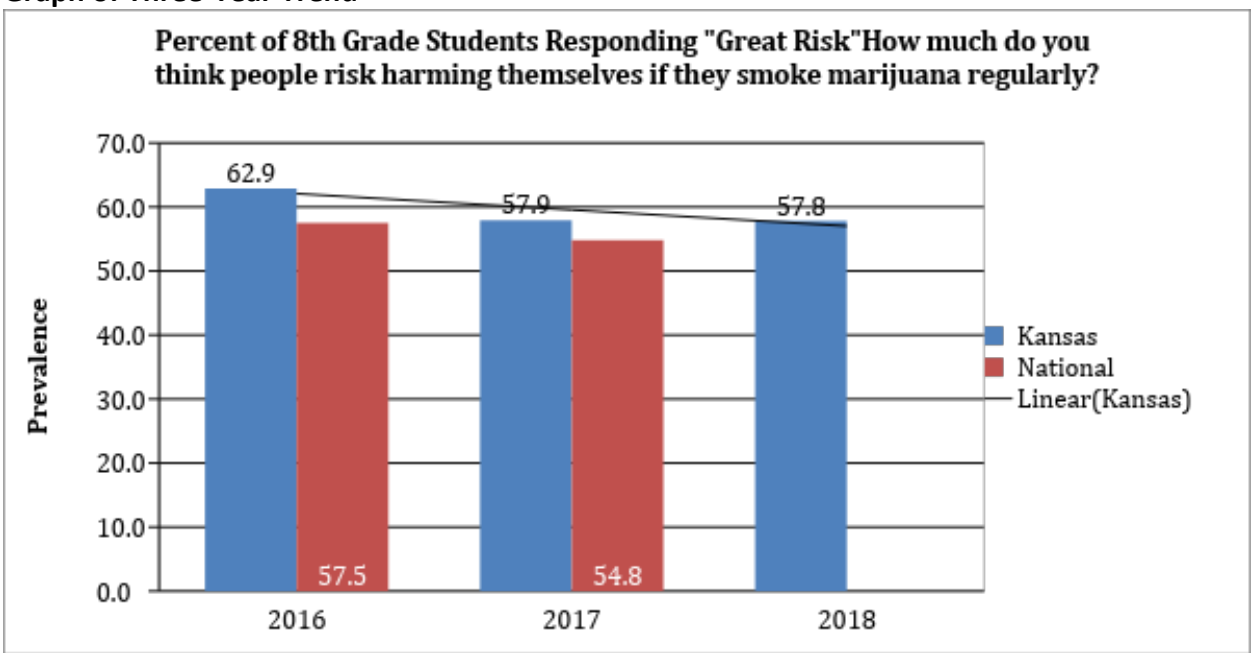
Kansas Department for Aging and Disability Services, Behavioral Health Services, Kansas Communities That Care (KCTC) Survey, 2016-2018.
National comparison data taken from the Monitoring the Future student survey, 2016-2017.

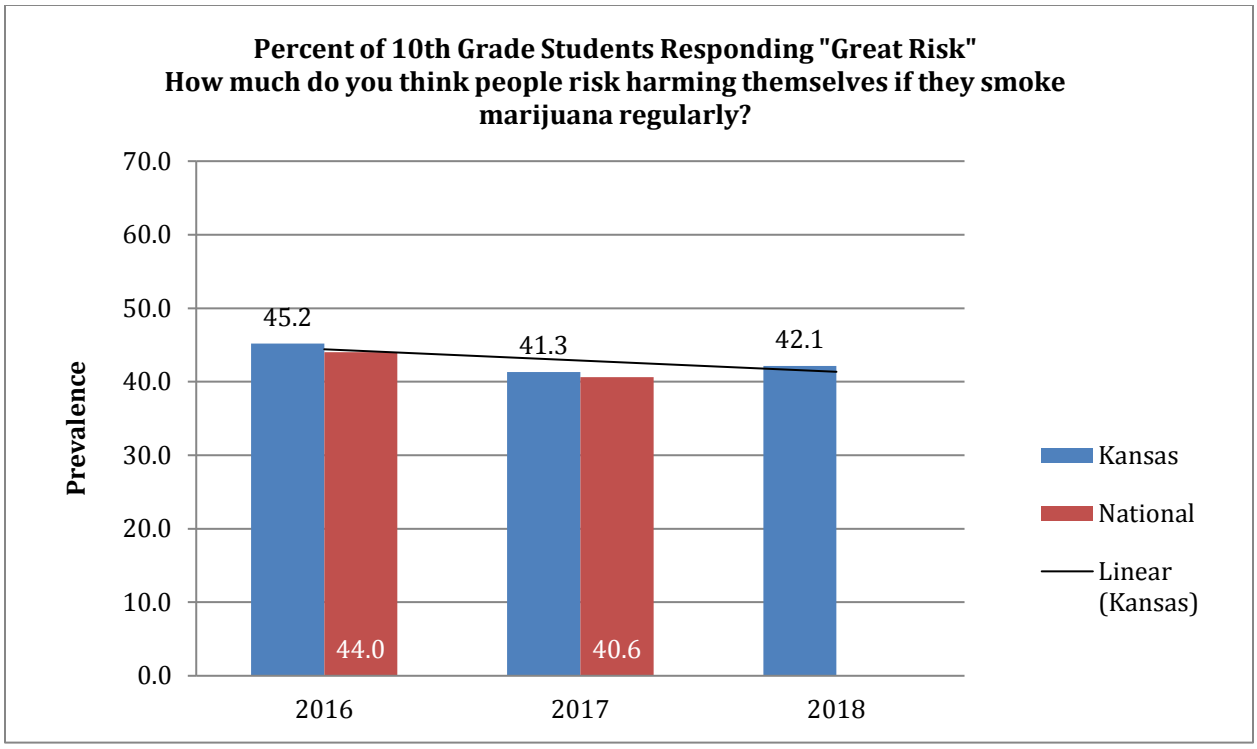
Important Findings

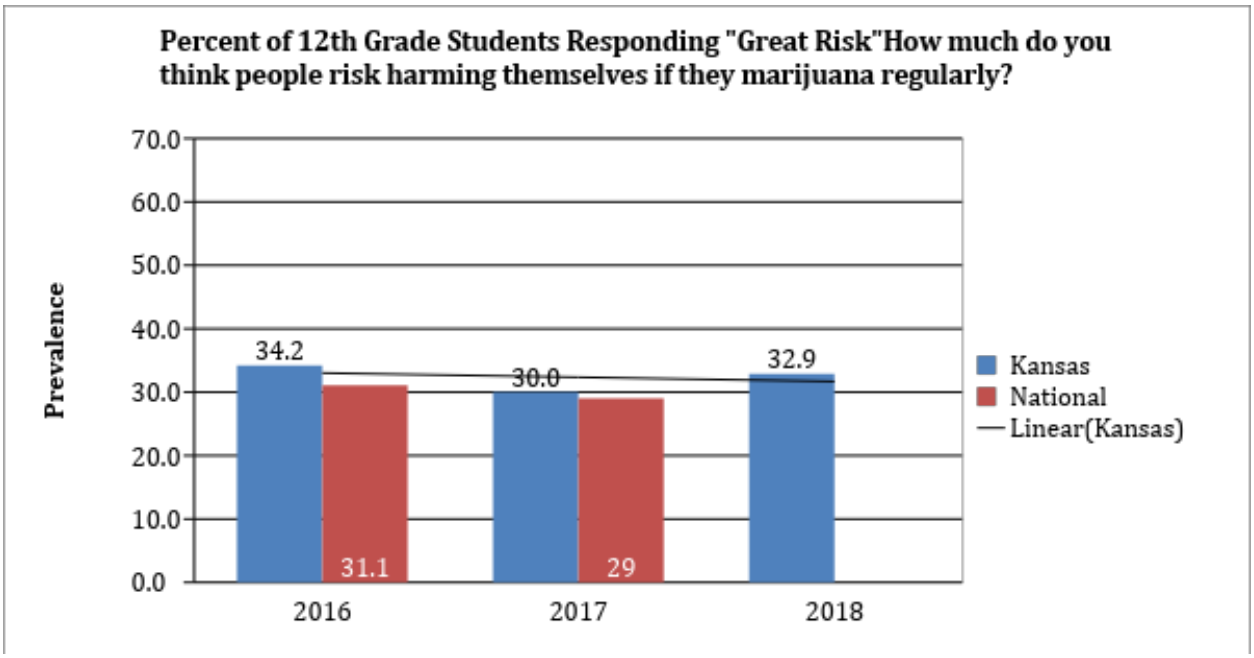
- Less than one percent of youth (0.7%) that said there was 'great risk' of harm from regular marijuana use in the reported past 30-day use compared to 14.3% of youth that reported no risk, slight risk or moderate risk.

- Students reporting great risk of harm from regular marijuana use has decreased over the past five years.
- Perception of risk of marijuana use decreases with age.
- African-American and Native American students have lower rates of risk perception than white students.
- Females are more likely to report great risk of harm from regular marijuana use than males.

Graph of Three-Year Trend




Percent of 10th Grade Students Responding "Great Risk"
How much do you think people risk harming themselves if they smoke marijuana regularly?
Prevalence
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
45.2
41.3
42.1
44.0
40.6
2016
2017
2018
Kansas
National
Linear (Kansas)


Percent of 12th Grade Students Responding "Great Risk"How much do you think people risk harming themselves if they marijuana regularly?
Prevalence
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
34.2
30.0
32.9
31.1
29
2016
2017
2018
Kansas
National
Linear(Kansas)

Year	Overall	Grade Level				Gender	
		6th Grade	8th Grade	10th Grade	12th Grade	Male	Female
2016	56.4	71.6	62.9	45.2	34.2	53.5	59.3
2017	52.0	68.4	57.9	41.3	30.0	48.5	55.5
2018	52.5	69.3	57.8	42.1	32.9	49.6	55.3
3-Year Average	**54.2**	**70.0**	**60.4**	**43.3**	**32.1**	**51.0**	**57.4**

3.*c. Measure: Attitudes Favorable to Marijuana Use - Youth:* Percent of 6th, 8th, 10th, and 12th grade students responding, "Not Wrong at All" when asked "How wrong do you think it is for someone your age to: smoke marijuana?

Why is this indicator important?

There is a national trend toward young people taking more permissive views about marijuana (Schmidt, Jacobs & Spetz, 2016). Favorable attitudes toward marijuana use has been identified as a risk factor associated with experimentation or more regular use, as indicated by measures of past 30-day or lifetime use. Additionally, favorable attitudes toward marijuana use send tacit messages relating to the pervasiveness and social acceptability of this issue (Roditis, Delucci, Chang & Halpern-Felsher, 2016).

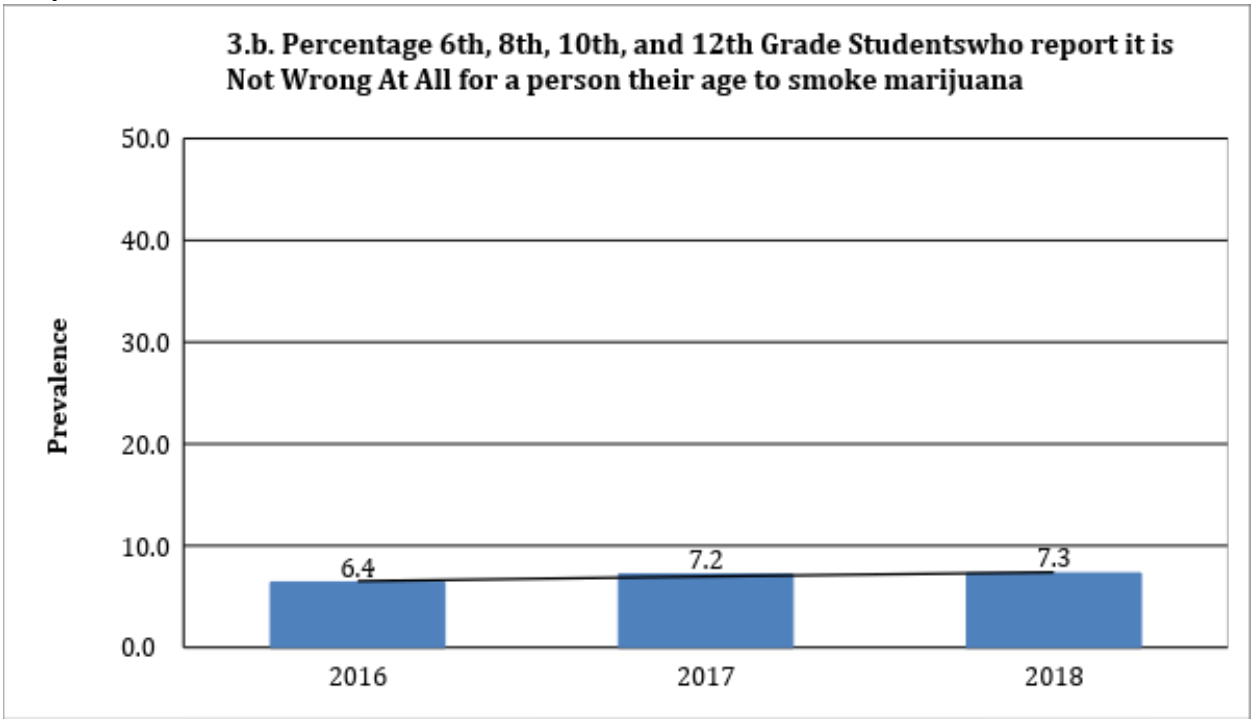
Data Source

Kansas Department for Aging and Disability Services, Behavioral Health Services, Kansas Communities That Care (KCTC) Survey, 2016-2018.

Important Findings:

- Over 52% of youth that reported it is 'not wrong at all' to smoke marijuana also reported past 30-dau use of marijuana, compared to 3.8% of youth that said smoking was 'very wrong', 'wrong', or 'a little wrong and also reported past 30-day use.
- The percentage of students who feel it is 'not wrong at all' for someone their age to use marijuana has increased over the past five years.
- Favorable attitude toward marijuana use increased with age.

Graph of Three-Year Trend



Year	Overall	Grade Level				Gender	
		6th Grade	8th Grade	10th Grade	12th Grade	Male	Female
2016	6.4	0.6	3.5	10.0	17.1	7.3	5.5
2017	7.2	0.8	4.3	11.0	17.4	7.9	6.3
2018	7.3	0.8	4.3	11.1	17.2	8.1	6.5
3-Year Average	**6.8**	**0.7**	**3.9**	**10.5**	**17.3**	**7.6**	**5.9**

Year	Single Race					Hispanic (of any race)	Non-Hispanic
	White	African American	Hawaiian / Pacific Islander	Asian	Native American / Alaska Native		
2016	6.4	7.3	7.0	4.7	7.2	7.4	6.3
2017	7.1	9.0	7.6	4.0	6.8	7.5	7.1
2018	6.8	8.9	7.2	5.1	7.6	8.9	6.9
3-Year Average	**6.8**	**8.4**	**7.2**	**4.6**	**7.2**	**7.9**	**6.7**

4. Prescription Drug Misuse

4.a. Measure: Opioid Prescribing Rates: Estimated rate of opioid prescriptions per 100 residents

Why is this indicator important?

The opioid epidemic is considered the deadliest drug crisis in American history. Prescription and illicit opioids are driving the U.S. drug overdose epidemic – accounting for 66 percent of drug poisoning deaths nationwide in 2016. (CDC, 2017). According to the 2018 Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan, an estimated 100,000 Kansans, or three out of every ten, have used prescription pain medication other than as directed or more than prescribed.

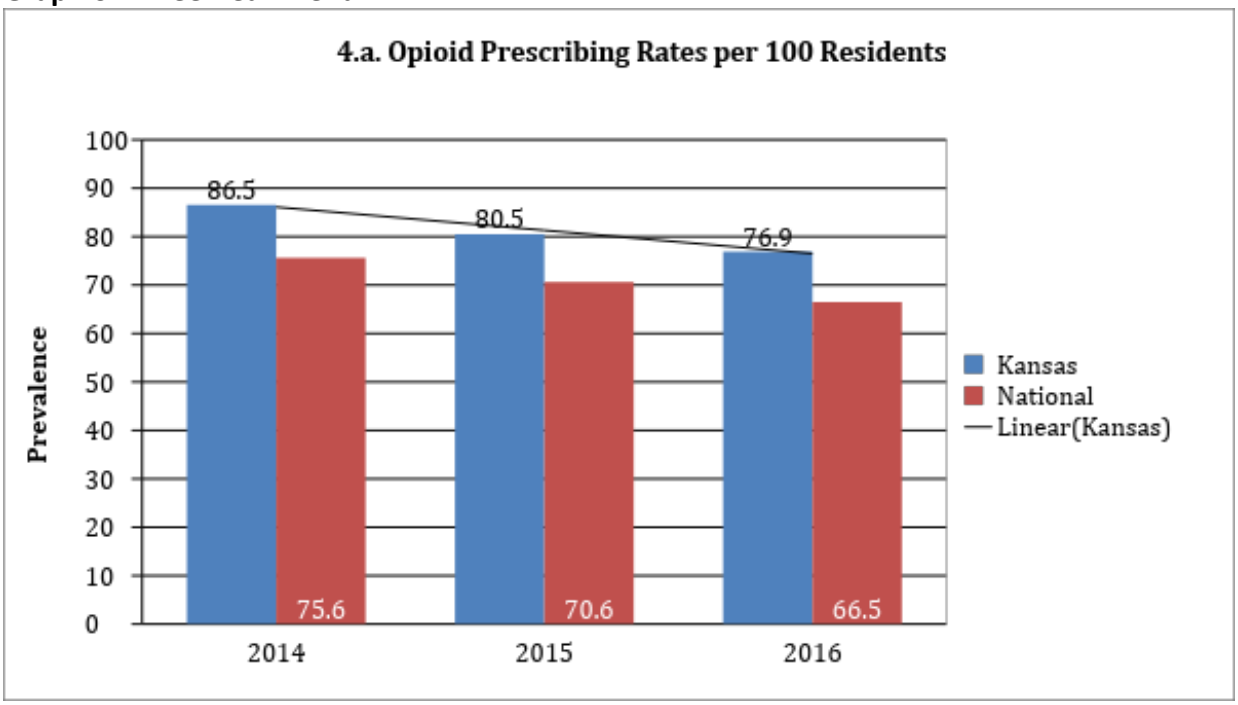
Data Source

Centers for Disease Control and Prevention – National Center for Injury Prevention and Control: U.S. Prescribing Rate Maps by State, 2012-2016

Important findings

- Prescribing rates for Kansas and nationally have been decreasing over the past five years, however Kansas rates remain higher than the national average.
- Kansas prescribing rates have remained approximately 10 persons per 100 higher than the national average over time.

Graph of Three-Year Trend



5. Problem Gambling

5.a. Measure: Lack of Awareness of Gambling Treatment

Percent of Kansas adults who disagreed with the statement "I know about gambling treatment options in my community."

Why is this indicator important?

Almost three quarters of pathological gamblers have never sought professional treatment or assistance in self-help groups. Reasons why they do not initiate treatment are complex (e.g., Dabrowska Moskalewica & Wieczorek, 2016). In Kansas, problem gambling treatment is available to problem gamblers, their families, and concerned others who reside in Kansas at no out-of-pocket cost, however, the majority of adults surveyed were not aware of treatment options.

Data Source

Kansas Department for Aging and Disability Services, Behavioral Health Services, Kansas Gambling Survey, 2017.

Important findings

- Almost 80% of adults in Kansas are not aware of no cost gambling treatment options in their community.
- Across gaming regions (counties based on proximity to state-owned casinos), the range of those who are unaware of treatment is 74.2% to 80.7%. These percentages are lower than the 82.4% of unaware individuals in the non-gaming region.

Gambling Treatment Options	Unassigned	Southwest	South Central	Northeast	Southeast	State Total
I know about gambling treatment options in my community (disagree/strongly disagree)	82.4%	74.2%	74.2%	80.7%	78.0%	79.2%
Have you ever seen or heard information regarding assistance for problem gamblers or their families?	43.2%	27.0%	43.0%	30.6%	41.2%	38.4%
Have you ever seen or heard of the gambling helpline, 1-800-522-4700?	46.0%	39.8%	44.2%	34.3%	45.3%	42.1%

Block Grant Priorities

The Prevention Sub-Committee reviewed these identified priorities with the following block grant priority areas to ensure commonality in planning and prevention efforts in the state.

1. **Reduce underage drinking in Kansas**

   Goal: Reduce percentage of students in grades 6, 8, 10, and 12 that report drinking alcohol in the past 30-days.

   Objective: Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address underage alcohol use through the implementation of evidence-based prevention programs, practices, and policies.

   Indicator 1: On how many occasions, if any, have you had beer, wine, or hard liquor in the past 30 days?
   Data Source: Kansas Communities That Care (KCTC) Student Survey
   Baseline year: 16.31% (2017)
   Average year-to-year change (including 4 years): 1.14%
   First-year target/outcome measurement: 15.17%
   Second-year target/outcome measurement: 14.03%

   Indicator 2: Increase the total number of aggregate program, policy, practice and service activities related to implementation of evidence-based strategies designed to reduce underage drinking
   Data Source: Community Check Box
   Baseline: 12 (2017 communities were in SPF assessment and planning phase); 4 community activities per funded community
   First-year target/outcome measurement: 24 (per three funded communities); 8 community activities per funded community
   Second-year target/outcome measurement: 36 (per three funded communities); 12 community activities per funded community

2. **Reduce low perception of harm from marijuana used among Kansas Youth**

   Goal: Reduce percentage of students in ages 6, 8, 10, and 12 that report there is “No risk” of harm from regular marijuana use.

Objective: Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address low perceived risk of harm from regular marijuana use through the implementation of evidence-based prevention programs, practices, and policies.

Indicator 1: How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly? (No risk)
Data Source: Kansas Communities That Care (KCTC) Student Survey
Baseline year: 16.78% (2017)
Average year-to-year change (including 4 years): +0.63 (indicating is increasing on average .63 per year, we want it to decrease, choosing .50 reduction per year)
First-year target/outcome measurement: 16.28 %
Second-year target/outcome measurement: 15.78%

Indicator 2: Increase the total number of aggregate program, policy, practice and service activities related to the implementation of evidence-based strategies targeting perceived risk of harm associated with regular marijuana use.
Data Source: Community Check Box
Baseline: 1 (2017 communities were in SPF assessment and planning phase)
First-year target/outcome measurement: 5 community level activities per funded community
Second-year target/outcome measurement: 10 community level activities per funded community

3. **Reduce methamphetamine use among young adults**
   Goal: Reduce the percentage of young adults aged 18-25 that report using methamphetamine in the past 30 days.

   Objective: Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address young adult methamphetamine use through the implementation of evidence-based prevention programs, practices, and policies.

Indicator 1: Have you used methamphetamines in the last 30 days?
Data Source: Kansas Young Adult Survey (KYAS)
Baseline: 1.7% (2017)
First-year target/outcome measurement: 1.5%
Second-year target/outcome measurement: 1.0%

Indicator 2: Increase the total number of aggregate program, policy, practice and service activities related to the implementation of evidence-based strategies targeting young adult methamphetamine use.
Data Source: Community Check Box
Baseline: 0 (2017 communities were in SPF assessment and planning phase)
First-year target/outcome measurement: 5 community-level activities per funded community
Second-year target/outcome measurement: 10 community level activities per funded community

Indicator 3: Rate of Kansas community mental health treatment admissions for methamphetamine as primary substance per 100,000.
Data Source: Kansas Community Mental Health Center Treatment Admissions
Baseline: 70/100k methamphetamine admissions (2014)
First-year target/outcome measurement: 67/100k
Second-year target/outcome measurement: 64/100k

4. Behavioral Health Prevention and Promotion

Goal: Educate, increase awareness, promote, advocate, and disseminate resources to support suicide prevention, mental health promotion and the reduction of co-occurring risk factors.

Objective: Increase collaborations and initiatives that promote awareness of behavioral health co-occurring risk and protective factors and use of evidence-based strategies that address multiple behavioral health issues.

Indicator 1: Increase the number of Kansas school districts participating in the systematic data collection of youth depression, suicidal thoughts, plans, attempts, and co-occurring risk factors.
Data Sources: Kansas Communities That Care (KCTC) Student Survey participation rate and KCTC Optional Depression/Suicide Module participation rate.

Baseline: KCTC 190 districts; KCTC Depression/Suicide Module 134 districts (2017)
First-year target/outcome measurement: 195/140
Second-year target/outcome measurement: 198/145

Indicator 2: Collect to assess Kansas adult population behavioral health co-occurring risk factors including perception of gambling, gambling practices, knowledge of treatment options, level of substance use and depression.
Data Sources: 2017 Kansas Gambling and Behavioral Health Survey
Baseline: Current baseline is 0 participants (2017)
First-year target/outcome measurement: 1600 participants (complete at end of fiscal year)

Indicator 3: Increase the total number of aggregate program, policy, practice, service, and media activities related to suicide prevention, mental health, and ATOD outcomes and risk factors that support information dissemination and prevention education strategies.
Data Source: Community Check Box
Baseline: Unavailable (2017 communities were in SPF assessment and planning phase)
First-year target/outcome measurement: 8 community level activities per funded community
Second-year target/outcome measurement: 12 community level activities per funded community

SECTION 6: Current Behavioral Health Prevention Systems

The KDADS Behavioral Health Services Commission manages mental health services in Kansas, working with 26 community mental health centers across the state. In addition, it oversees addiction and prevention service programs for the State of Kansas, including targeted workforce development initiatives. In addition, the commission works in close collaboration with the Governor's Behavioral Health Services Planning Council. The commission is also charged with overseeing the state's two psychiatric hospitals, Larned State Hospital and Osawatomie State Hospital.

This work is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), and KDADS. KDADS is responsible by statute and holds the authority and responsibility to coordinate and provide substance abuse and mental health services in Kansas.

We promote effective public policy and develop and evaluate programs and resources for behavioral health prevention, treatment and recovery services[1].

The Kansas Prevention Collaborative (KPC) was created in 2015 to integrate and innovate behavioral health prevention efforts. Partner organizations provide contracted prevention and promotion services supportive of KDADS-funded substance abuse prevention coalitions and universal strategies. Education, outreach, advocacy, technical assistance, evaluation, assessment support, information dissemination and suicide prevention guidance are examples of the services provided.

THE KANSAS PREVENTION COLLABORATIVE HAS TWO MAIN GOALS:

Expanding prevention efforts to be more inclusive of behavioral health promotion, suicide prevention, and problem gambling education and awareness.

Increasing the availability of resources to adequately fund local level prevention and promotion strategic plans

All services provided by the Collaborative partners are designed to support capacity development, increase engagement and involvement and expand opportunities in terms of fiscal and other resources to communities across the state.

The new Kansas Prevention Collaborative (KPC) website was created to serve as a communication hub for behavioral health coalitions across the state; it will allow coalition members to exchange resources and information and lead the conversation about prevention in the state. The website is also designed to ensure that coalitions have access to the tools necessary to do sustainable work within their communities.

The Collaborative and its member organizations will support capacity development as we seek to increase and advance local prevention efforts. Engagement and involvement will be supported by the Collaborative and its member organizations as we work to engage diverse

[1] https://www.kdads.ks.gov/commissions/behavioral-health

stakeholders in our prevention efforts. We will work with communities of place and practice and focus on building collaborative relationships across the state.

By creating efficiencies in our support systems and focusing on locally driven initiatives, we have created opportunities for communities to implement comprehensive level strategic plans with adequate funding to ensure success.

SECTION 7: Assessment of System Strengths and Gaps

The Prevention Subcommittee researched and analyzed various components of the prevention infrastructure. During this review, the following strengths and gaps surfaced:

SYSTEM STRENGTHS

1. Block Grant Funding Supports Evidence-Based Practices to Community Coalitions
   The State of Kansas offers a competitive request for proposals process for community coalitions in Kansas to receive block grant dollars to address substance abuse issues at the local level. Coalitions are required to implement the Strategic Prevention Framework process with fidelity to ensure positive outcomes for community-level change. Kansas strives to meet SAMHSA's recommendation that 85 percent of prevention block grant dollars are spent on evidence-based practices at the community level.

2. Kansas Prevention Collaborative Supports
   The prevention support infrastructure in Kansas is called the Kansas Prevention Collaborative. The Collaborative consists of one evaluation contractor to support statewide and community level assessment and evaluation efforts; one communication contractor to facilitate coordination between state and community partners; and one training and technical assistance provider to provide direct support to community coalitions receiving block grant dollars. These contractors work in tandem with KDADS to ensure we are meeting federal block grant requirements and meeting identified outcomes. This infrastructure helps to ensure more federal dollars at the community level.

3. Kansas Web-Based Resources
   a. *KPC Website*
      The Kansas Prevention Collaborative includes partner support to develop, support, maintain, and update a behavioral health communication hub promoting consistent and coordinated messages. This is done with a combination of technology tools and platforms, united by the KPC's website, made available to the

public and for use by coalitions: www.kansaspreventioncollaborative.org. This website offers the following services and resources:

- Promote and provide information about the Strategic Prevention Framework, share information on statewide and national awareness campaigns supported by KDADS, and provide other topics and resources identified by PreventionWorKS and KDADS
- Host the KPC Coalition Map and Coalition Registry, to share contact information on all prevention coalitions and task forces supported by KDADS.
- Provides an online Resource Library and E-Learning Portal for promotion and distribution of statewide and regional information and training
- Promotes a network of information, referral, and consumer advocacy services through the electronic messaging system of the Kansas Prevention Collaborative, to which anyone in the public can subscribe at no cost
- Collect contact information and provide regular online training and networking events for community coalition representatives and other prevention stakeholders
- Assure consumer- and family-friendly information is available and promoted in consistency with KDADS methods and campaigns (e.g., It Matters)
- Promote local and national resources on evidence-based strategies
- Maintain a process for requesting KDADS-funded problem gambling print materials

b. *Kansas Prevention Collaborative Workstation*

The Kansas Prevention Collaborative WorkStation is a SharePoint based tool that supports quarterly report development and provides storage and data dashboards. The WorkStation enables users to easily respond to reporting requests, share materials, make announcements, access tools, learn from others' success stories, and access guidance from peer and contractor discussion in a secure hosting environment. In short, the KPC WorkStation solves needs for community and contractor online collaboration.

c. *Kansas Suicide Prevention Resource Center Website*

The Kansas Suicide Prevention Resource Center (KSPRC) at www.kansassuicideprevention.org provides information related to suicide prevention in Kansas. Information available includes suicide rate and death data, listings for the suicide prevention coalitions in Kansas and links to resources related to preventing suicide in specific populations. Additionally, information on suicide warning signs, risk factors and safety plan components is available. The

KSPRC website also includes a listing of available support groups for suicide loss survivors across the State of Kansas.

d. *Kansas Gambling Help Website*

The Kansas Responsible Gambling Alliance (KRGA) website (http://www.ksgamblinghelp.com/) provides information about no-cost treatment and other resources available for the problem gambler as well as their affected family and friends. There is a short self-assessment tool and information about the warning signs of problem gambling. This website also provides the Helpline phone number so those interested in treatment can find a counselor near them. A description of the voluntary exclusion program is provided with the phone number for the Kansas Racing and Gaming Commission (KRGC) if more information is desired. The website also contains information about the statewide Kansas Coalition on Problem Gambling (KCPG) and the state's four gaming region Task Forces: Northeast, Southwest, Southeast and South Central.

5. <u>High Quality Data</u>

a. *Kansas Communities That Care (KCTC) Student Survey Data*

The Kansas Communities That Care (KCTC) Student Survey has been administered annually since 1994-95. It tracks teen use of harmful substances such as alcohol, tobacco and other drugs, bullying, school climate, and social-emotional/character development. The KCTC provides communities and agencies structure in making informed decisions concerning prevention services through annual surveys. This survey is used by state agencies, counties, schools and communities in Kansas to monitor the incidence and prevalence of adolescent problem behaviors and the environmental factors that put children at risk or protect them from developing those behaviors. This comprehensive data collection method serves as the main source of outcome data for the Kansas Prevention Collaborative initiative.

The KCTC data can be accessed at www.kctcdata.org. This web-based information management system reports the millions of aggregated records from the past 24 years from students that have participated in the KCTC student survey. The website reports risk and protective factor indicators and prevalence of alcohol, tobacco, other drug use and violence in addition to other data. The site displays 'buttons' or 'tabs' that allow users to easily see and select questions by each of the four domains (school, community, peer/individual, family), by substance (alcohol, marijuana, prescription drugs, etc.), or by risk or protective

factor scale scores. In 2016, the survey offered an optional four-question module to gain insight into youth mental health. Specifically, questions for depression, suicidal thoughts, suicide plans, and suicide attempts were added.

b. *Kansas Young Adult Survey*

The 2017 Kansas Young Adult Survey measures behavioral health among Kansans aged 18-25. In addition to asking about use of alcohol, tobacco, and other drugs, this survey addresses major sources of stress, general health, mental health and depression, and perceived risk of harm from substance use. It also includes questions related to prescription drug misuse, knowledge of proper disposal of unused drugs, gambling, and driving safety. Subsequent administration is planned for 2019 and 2021. Data can be viewed online at (www.http://kctcdata.org/YoungAdultsDisplay.aspx).

c. *Problem Gambling Survey*

Kansas has four state-owned Casinos and Problem Gambling Task Forces designed to monitor and raise awareness of problem gambling prevention and treatment. An initial statewide survey was conducted in 2012 with a sample size of 1,600 to gather information about Kansas adults' gambling behavior, attitudes, and knowledge. The survey was administered again in 2017 with a sample size of 1,755. Data for both survey years are weighted for comparison based on age to be representative of the age of the regional and state populations as per the 2010 US Census. Statewide and regional data are available for monitoring and evaluation.

d. *Community Check Box (CCB)*

The CCB is a web-based recording, measurement, and reporting tool used to support participatory evaluation of community health and development initiatives. The CCB enables documentation of prevention and behavioral health activities at multiple levels, including by local partners and community coalitions, as well as the state training and technical assistance teams that are supported by the Kansas Prevention Collaborative. The CCB supports KDADS coalition grantees and contractors in online documentation of their work, including their efforts to develop, implement, and or provide support for prevention strategies and activities, including capacity-building activities. Lists of accomplishments, graphs, success stories, and characterization of community and system changes are available on demand for all those doing and supporting the work; and

print capabilities help make the work of reporting easier and more rewarding (https://ctb.ku.edu/en/community-check-box-evaluation-system).

e. *Kansas Behavioral Health Indicators Dashboard*
The purpose of the Kansas Behavioral Health Indicators Dashboard (KBHID) is to provide online behavioral health information for Kansas counties to use in the development of strategic prevention planning and to assess community behavioral health needs and disparities. This data system is a function of the work of the State Epidemiological Outcomes Workgroup (SEOW) and includes relevant data from numerous Kansas and National data sources. Data are updated on an ongoing basis as they become available through various agencies. Where county data are not available or not able to be published, Kansas data are compared to national comparison data (www.kbhid.org).

f. Kansas Behavioral and Mental Health Profile
As part of the State Epidemiological Outcomes Workgroup, the Kansas Behavioral and Mental Health Profile is designed to provide an in-depth, data-focused perspective on the extent of substance abuse consumption patterns and related consequences, with information presented that derives from state health agencies, treatment agencies, law enforcement and revenue agencies. The document's purpose is to illustrate the current state of behavioral and mental health which support a data-informed prioritization process as part of a comprehensive state and community level assessment. Data includes an array mental health treatment data, mental health and substance use disorder treatment data, problem gambling, and a set of risk and protective factor indicators associated with substance abuse and related problem among youth and adults. The profile can be found on the KDADS website here: https://www.kdads.ks.gov/docs/default-source/csp/bhs-documents/kansas-behavioral-health-profile-2018.pdf?sfvrsn=bf7407ee_0

6. <u>Statewide Coalitions</u>

a. Kansas Coalition on Problem Gambling
The Kansas Coalition on Problem Gambling (KCPG) is a community organization dedicated to solving the social issues of problem gambling. It is a statewide organization dedicated to solving the social issues of problem gambling. It also serves as a catalyst for collaboration with multiple state agencies, regional task

forces, concerned citizens, and stakeholders from across the state. The mission of the KCPG is to reduce the onset and progression of problem gambling.

b. *PreventionWorKS*

The PreventionWorKS Coalition is one of many ways that the Kansas Prevention Collaborative supports prevention efforts in communities across Kansas. The meetings are convened by the Kansas Prevention Collaborative and are driven by the same priorities. Event attendance alone will neither assist nor obstruct the state grant application process. Members represent their local community prevention efforts. The PreventionWorKS Design Team chooses members for a steering committee through an application process that optimizes diversity and strengths. PreventionWorKS was developed by a design team, led by KDADS, with five guiding principles. These were initially and remain:

i. i. Connections: Supportive mentoring and collaboration
   ii. Voice: PreventionWorKS will offer a place for a shared voice and access to key change agents
   iii. Synergy: The synergistic opportunities of statewide projects, pooling of resources, unifying voice & collaborative impact that will leverage other opportunities
   iv. Empowerment: Opportunities with strength in numbers, elevating successes, and sharing statewide and local data
   v. Integration: Integration of approaches related to behavioral health promotion and prevention across the continuum of care

SYSTEM GAPS

1. <u>Lack of Integration between Prevention and Treatment Resources</u>

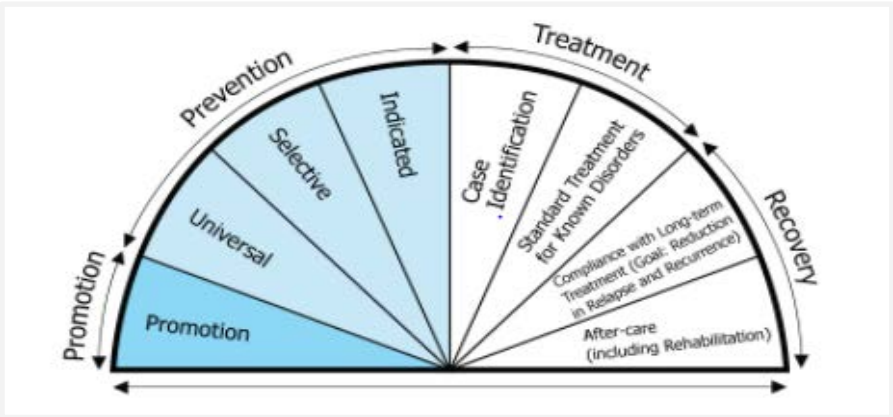
   Suicide is a rising public health problem which is best addressed in a variety of settings. In addition to prevention programming taking place in community and school settings, there are opportunities for bolstering prevention and intervention in mental health and treatment settings. Setting priorities for use of evidence-based screening for suicide risk (e.g. Columbia Suicide Severity Rating Scale) within treatment settings is one step towards creating greater safety from suicide. This is particularly important as some healthcare providers like primary care offices are more likely to encounter a person considering suicide than mental health professionals.

   It is important that professionals in these settings have the knowledge and tools to screen for suicide risk. Additionally, the Kansas Suicide Prevention Plan recommends a focus on “care linkages” which would improve treatment continuity for those at risk of suicide. The time between discharge from an inpatient substance use/mental health

facility and/or Emergency Departments and the first appointment with a mental health care provider is a time of increased risk for suicide. Robust systems for follow-up with the person at risk can create more safety from suicide.

There is also a disconnect between prevention, early intervention and treatment for substance use. SBIRT (Screening, Brief Intervention and Referral to Treatment focuses on prevention, early detection, risk assessment, brief counseling and referral for assessment that can be utilized in a variety of community settings. There are current licensing requirements that limit the pool of professionals who can conduct this early intervention. Setting priorities for evidence-based prevention and early intervention models begins to connect treatment and prevention professionals to provide a more comprehensive level of support and care for Kansans.

The Behavioral Health Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders. The model includes promotion, prevention, intervention, treatment and recovery. In Kansas, the components of this model operate in silos. Opportunities must be explored for providers to coordinate services for a seamless behavioral health care system. This includes integrating prevention efforts into all aspects throughout of the continuum of care.



2. <u>Promotion of Resources to Unfunded Coalitions and Communities With No Coalition</u>
   Coalitions without KDADS funding sometimes have a lack of knowledge about resources. This decreases their ability to communicate and collaborate with each other. KDADS offers many of the same services and resources which are available to funded coalitions and task forces to the general public and unfunded coalitions. However, there are some services and resources which are not available to the public that are offered to coalitions and task forces with current KDADS funding. These include in-person and virtual training events guiding use of the Strategic Prevention Framework (SPF) and the fidelity-monitoring, accountability, training, and technical assistance associated with contract deliverables. For example, a

coalition with KDADS funding for substance abuse prevention is expected to participate in a training series on steps of the SPF and required to submit deliverables related to Sustainability. This requires a community coalition to develop a sustainability action plan consistent with the training and technical assistance provided to the funded coalition to fulfill that expectation. Comparatively, a community coalition without KDADS funding would not have the expectation to complete or submit a sustainability action plan and would not have dedicated training and technical assistance for the coalition outside of what is offered to the general public in the form of online information and education opportunities, webinars (PreventionTalKS), or statewide coalition meetings (PreventionWorKS).

The Kansas Prevention Collaborative maintains a coalition registry of coalitions and task forces without current funding resources from KDADS, at no cost to the coalitions, and distributes informational messages and invitations to training events to the full coalition contact list electronically. This resource is located at www.kansaspreventioncollaborative.org. A gap in this service to the public is that there likely are prevention coalitions in the state which are not included on the coalition registry, and their contact information may not be available or current. The KPC does not know who it does not know, and while attempts are made to regularly update the contact list for the KPC Coalition registry, it is likely this is not fully successful at identifying all coalitions and keeping communication current and consistent with all.

Anyone in the public can subscribe to the KPC electronic mailing list, as a member of a community coalition or not, but messages about how to subscribe to this list have been offered through the website, social media, and word of mouth. It is likely that there are many in the general public who do not know about the KPC website or the advantages using this site may offer.

3. <u>Lack of Coordination Between State Agencies and Planning Council Sub-Committees</u>
   Each State Agency has policies and procedures specific to their role. Sometimes those policies vary, and may be contrary to each other. Increased communication and coordination between agencies should be encouraged. Likewise, coordination between the Governor's Behavioral Health Services Planning Council (GBHSPC) Sub-committees should increase. The Prevention Sub-committee has received overviews from and created contacts with the other Sub-committees, as we believe that prevention crosses all areas. We would support on-going collaboration of the Sub-committees.

4. Limited or Lacking Behavioral Health Services
   There are limited numbers of State Mental Health Hospital beds at Larned and Osawatomie State Hospitals, which at time creates waiting lists for services. Local hospitals may not have mental health treatment units, and those that do provide acute treatment rather than longer treatment episodes. Funding for community mental health centers has been reduced drastically over the years and has led to a reduction in community-based services, especially in rural and frontier areas. Reinstatement of that funding should be supported by the legislature.

5. Lack of Coordination Between Prevention Efforts and Judicial System
   There is a disconnect between prevention efforts at the county, city and state levels with regards to diversion and addressing substance use cases. Judicial entities do not consistently request evaluation and treatment for alcohol and substance use disorders when they are present in cases for other crimes like theft, assault and battery, domestic violence, etc.

6. Evidence-Based Practices for Marijuana Prevention
   Kansas is surrounded by states that have recently legalized some form of marijuana (medical and/or recreational). Because of national trends, we have seen perception of risk of harm from marijuana use steadily decrease among youth in our state. We do not have a coordinated plan in place to develop, promote or share effective marijuana prevention strategies in our communities.

7. Evidence-Based Practices for Opioids
   The opioid epidemic has had significant impacts in many states. Because this epidemic has come on rapidly, there is limited research on evidence-based practices to address best practices in opioid prevention efforts. Given the unique geographic nature of Kansas, we must identify practices that will be effective in urban, rural and frontier communities.

8. Strategies to Targeted 18-25-year-olds in college
   Kansas has extensive history utilizing the Kansas Communities That Care Student Survey for needs assessments related to substance abuse. This survey is intended for youth in grades 6, 8, 10, and 12. There has been no consistent statewide data available for young adults, ages 18-25 years old. Progress was made with the initiation of the 2017 Kansas Young Adult Survey and data collected in future years among this population could be beneficial to prevention efforts supportive of young adults in Kansas. Knowledge of resources available for rural and frontier community colleges pertaining to addiction, recovery and other self-help focused are insufficient. There is not a referral system in place for providing rural and

frontier college level educational institutions information when their students voice a desire to establish recovery groups.

9. Communities Utilizing Local Resources in Strategic Manner
   Kansas statutes include the "Local alcoholic liquor fund" and describe the distribution of moneys (Statute 79-41a04). Revenue generated from local liquor taxes is to be expended only for operation of domestic violence programs, park and recreation costs, or alcohol and drug programs funded by the county treasury. Knowledge of these funds and their usage varies from one city or county to another and there is not currently a known mechanism for tracking the alcohol and drug strategies supported in each community at a State level. An opportunity exists for increased education of community coalitions about these local resources and for coordinating funded strategies in a strategic manner.

10. Prevention Workforce Development
    Internal reviews of federal site visits have affirmed the need for the Kansas prevention infrastructure to continue to improve prevention workforce development for the state. KDADS Prevention and Promotion Team and the Kansas Prevention Collaborative partner agencies have been involved in ongoing discussions about strategies for strengthening this system.

11. Resources and Funding for Suicide Prevention
    Kansas has been without dedicated funding for suicide prevention efforts since the expiration of the Kansas Youth Suicide Prevention (KYSP) grant in 2015. While the KYSP was funded a network of local suicide prevention coalitions were provided with funding for local efforts and additional coalitions were started. Several training initiatives were funded to increase the availability of programming in Kansas. Since this funding was not continued after the expiration of the federal cooperative agreement, the network of suicide prevention resources has atrophied. Some sustainability efforts have been made such as the inclusion of suicide prevention as an area of focus for the Kansas Prevention Collaborative.

    The Kansas State Suicide Prevention Plan identified increasing suicide prevention, intervention and management training to behavioral health, school, and primary care providers. The Prevention Sub-Committee recognizes that many of these professionals may not be aware of the training available or provided. While there is some capacity within the state for professionals to access this training, more attention and resources are needed. There is a lack of readily available training for the management of suicide risk in behavioral

health settings. Information and training for primary care providers is also an area for growth in resources.

While not specifically targeted, the Prevention Sub-Committee acknowledges the challenges and barriers in access to public and behavioral health services in rural and frontier communities. Rural communities particularly experience a health disparity around suicide death. In addition to lack of access to resources, financial problems related to the agricultural industry, high isolation, high levels of access to lethal means (e.g. firearms and pesticides), high occupational suicide rates for the farming industry and stigma around seeking mental health treatment contribute to these rates (KHI, 2018).

Section 8 - Funding Breakdown Specific to Prevention

County, State and Federal dollars

1. The Substance Abuse Block Grant funds are dispersed throughout the state through a Request for Proposals (RFP) process. This initiative called the Kansas Prevention Community Coalition Initiative (KPCCI), funds approximately four planning grantees and seven implementation grantees. The process will continue each year to gain new planning grantees and promote those from planning to implementation. This initiative will address underage drinking, youth marijuana use, and shared risk and protective factors.

2. The Partnership For Success (PFS) grant focuses on efforts to prevent and reduce underage drinking, both past-30-day alcohol use, binge drinking among youth and young adults aged 12-20, and to prevent and reduce the incidence and prevalence of prescription drug abuse and misuse among individuals aged 18-25 in high-risk, high need, sub-recipient communities and pilot areas across the state.

3. The State Targeted Response to Opioids grant (STR) addresses the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose-related deaths through provision of prevention, treatment, and recovery activities for opioid use disorder (OUD), including prescription opioids as well as illicit drugs such as heroin. Four regional sub-awardees use data to demonstrate critical gaps in availability of treatment for OUDs in geographic, demographic, and service-level terms; address the critical gaps in availability of treatment for OUDs in geographic, demographic, and service-level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly address the gaps in their systems of care; deliver evidence-based treatment intervention, including medication and psychosocial interventions; and

report progress toward increasing availability of treatment for OUD and reducing opioid-related overdose deaths.

4. The Garrett Lee Smith Campus Suicide Prevention Grants have historically been available each year through SAMHSA grant opportunities. This grant provides a three-year funding cycle for colleges and universities to build infrastructure and programming for suicide prevention and mental health awareness. More recently, SAMHSA has announced availability of grant funding for the Zero Suicide Initiative. The grant announcements page provides information on the upcoming availability of these and other funding opportunities (https://www.samhsa.gov/grants/grant-announcements-2018).

5. Local Alcoholic Liquor Fund Tax Dollars
   As referenced above as a gap, Kansas statutes include legislation governing the collection and use of local alcoholic liquor tax funds and the distribution of these funds. Statute 79-41a04 outlines how all moneys credited to the local alcoholic liquor fund shall be allocated to cities and counties of the state. These local liquor tax funds are available, in statute, for citizens to use by meeting the local criteria, application, and implementation practices and policies of their local community governing bodies responsible for the funds. Historically, community coalitions in Kansas have found opportunities to support in part or full strategies selected for implementation through planning processes.

6. Public and Private Funding Options
   In Kansas, we are fortunate to have many public and private foundations that have identified health goals as priorities. Behavioral health prevention efforts have been supported by organizations such as the Kansas Health Foundation

7. Problem Gambling Prevention Efforts
   Funding for problem gambling prevention comes from the 2% Problem Gambling and Other Addictions fund. The Kansas Department for Aging & Disability Services (KDADS) serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system, including addiction prevention and treatment services. Funding for addiction services has historically relied on Federal Block Grants and Kansas General Fund Matching Dollars. The Block Grant strategic plan describes the usage of the additional source of addiction service funding, the Problem Gambling and Other Addictions Fund.

   During the development of the 2007 Kansas Expanded Lottery Act, concerns were raised about the negative impact expanded gambling may have on the incidence of problem

gambling and other addictive disorders within Kansas. Due to these concerns, a provision was included in the act that created a Problem Gambling and Other Addictions Fund (PGAF) by earmarking 2% of net revenues created by State-owned casino gaming to be directed toward services to address problem gambling and the treatment of alcohol and other drug addictions.[2]

Section 9 - Populations Served

In July 2017, the State of Kansas had an estimated population of 2.9 million people residing in 105 counties.[3] Of these 105 counties, 36 are considered frontier (less than six persons per square mile); 32 are considered rural (6 to 19.9 persons per square mile); 21 are considered densely-settled rural (20.00-39.9 persons per square mile); 10 are considered semi-urban (40-149.9 persons per square mile); and 6 are considered urban (150+ persons per square mile). Geographic location can impact how Kansans access behavioral health prevention services and the workforce qualified to provide those services (according to the University of Kansas's Institute for Policy & Social Research: www.ipsr.ku.edu/ksdata/ksah/population/popden2.pdf).

National Outcome Measures for the Kansas Prevention Block Grant focus on primary prevention strategies for youth and young adults. The Block Grant requires states to report the numbers of individual and populations served through prevention programs, policies, and practices broken down by the following demographic categories:

- Age: 0-4; 5-11; 12-14; 15-17; 18-20; 21-24; 25-44; 45-64; 65 and over; (age unknown).
- Gender: Male; Female
- Race: White; Black or African American; Native Hawaiian/Other Pacific Islander; Asian; American Indian/Alaska Native; More than one race; Race not know or Other
- Ethnicity: Hispanic or Latino; Non-Hispanic or Latino

In addition to identifying priority indicators that universally impact all Kansans (suicide death rates and opioid prescribing rates), the Prevention Sub-Committee also identified specific indicators for youth age 12-18 (see Section 5, Prevention Sub-Committee Priorities for data measures and sources). These included:

- Major depressive episodes
- Self-reported Depression
- Past month alcohol use
- Perceived great risk of harm from regular marijuana use
- Favorable attitudes toward marijuana use

[2] Problem Gambling & Other Addictions Fund Strategic Plan Fiscal Years 2014 – 2017; a project developed through a contract by the Kansas Department for Aging & Disability Services (KDADS), Behavioral Health Services (BHS) with Kansas Family Partnership and Problem Gambling Solutions, Inc)

[3] https://www.census.gov/quickfacts/KS

The Kansas Prevention Collaborative Block Grant also used data to prioritize indicators focused on youth age 12-17 and one indicator of young adults (age 18-25) methamphetamine use (see Section 5, Block Grant Priorities for data measures and sources). These included:

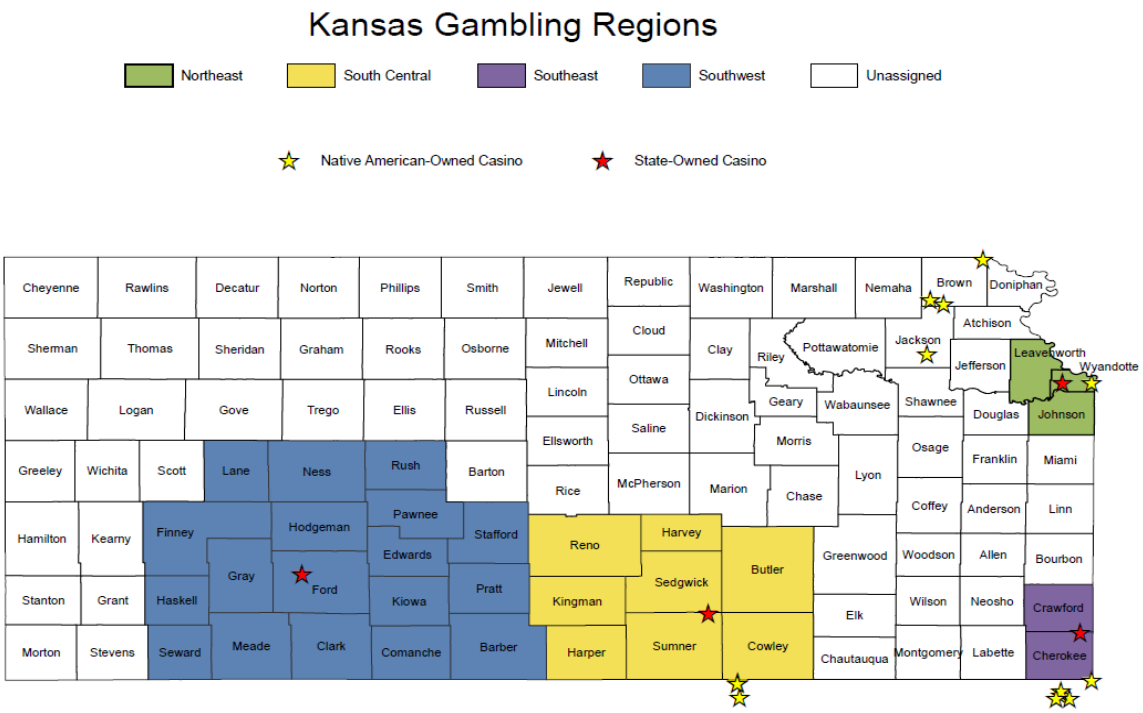
- Past month alcohol use
- Past month marijuana use
- Past month Methamphetamine use (age 18-25)

Problem Gambling Prevention Efforts

Casino Market Regions are a targeted population for problem gambling prevention and awareness interventions. The market regions include the following counties –

- Northeast: Johnson, Leavenworth and Wyandotte
- Southwest: Barber, Clark, Comanche, Edwards, Finney, Ford, Gray, Haskell, Hodgeman, Kiowa, Lane, Meade, Ness, Pawnee, Pratt, Rush, Seward and Stafford
- South-Central: Butler, Cowley, Harper, Harvey, Kingman, Reno, Sedgwick and Sumner
- Southeast: Cherokee, Crawford, Bourbon, Allen, Neosho, Labette, Woodson, Wilson and Montgomery

The market regions are not determined by statute but include the gaming zones and surrounding counties that will be impacted both positively and negatively by proximity to a casino. The gaming zones were determined by statute in 2007. They are the county or counties that house the state-owned casino and are legislatively intended to receive 2% of the casino revenue. The lottery regions were determined by statute as well. They are six designated regions in the state for the Kansas Lottery revenue, marketing, compliance, etc.



SECTION 10: Agencies and Councils Engaged in Prevention Work

There are many state agencies in Kansas that value and engage in prevention work. We recognize that preventative measures reduce the need for intervention and treatment services. The following agencies have designated prevention programs that impact behavioral health –

1. <u>Kansas Department for Aging and Disability Services (KDADS)</u>
   KDADS prevention initiatives are supported through the Substance Abuse Prevention and Treatment block grant allocation and discretionary funds initiated through Substance Abuse and Mental Health Services Administration (SAMHSA).

   a. *Kansas Prevention Collaborative Community Initiatives* – This initiative funds approximately four planning grantees and seven implementation grantees. The process will continue each year to gain new planning grantees and promote those from planning to implementation. This initiative will address underage drinking, youth marijuana use, and shared risk and protective factors.

   b. *Partnerships for Success 2015* – This initiative focuses on efforts to prevent and reduce underage drinking, both past-30-day alcohol use, binge drinking among youth and young adults aged 12-20, and to prevent and reduce the incidence and prevalence of prescription drug abuse and misuse among individuals aged 18-25 in high-risk, high need, sub-recipient communities and pilot areas across the state.

c. *State Targeted Response to Opioids* – This initiative addresses the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose-related deaths through provision of prevention, treatment, and recovery activities for opioid use disorder (OUD), including prescription opioids as well as illicit drugs such as heroin.

2. Kansas Department of Health and Environment (KDHE)

KDHE offers a variety of prevention programs that focus on physical and environmental health. Many of these programs include substance abuse prevention goals and for those without specific goals to reduce use or misuse the programs and their delivery methods can impact stigma-reduction efforts, reduction of adverse childhood experiences (ACEs), and effect risk and protective factors with research-demonstrated influence on substance use patterns. Programs that focus on behavioral health prevention include –

a. *Prescription Drug Overdose/Misuse Prevention* - This program is supported through the Kansas Prescription Drug Overdose: Data-Driven Prevention Initiative funded by the Centers for Disease Control. This project is facilitated in collaboration with the Partnerships for Success prescription drug initiative supported by KDADS.

b. *Kansas Tobacco Use Prevention Program* – This program provides resources and assistance to state and local partners for development, enhancement and evaluation of initiatives to prevent death and disease from tobacco use and secondhand smoke exposure.

The program focuses on four priority areas: 1) Preventing the initiation of tobacco use among young people, 2) Promoting quitting among tobacco users of all ages, 3) Eliminating nonsmokers' exposure to secondhand smoke, and 4) Identifying and eliminating disparities related to tobacco use and its effects among different population groups.

c. *STI/HIV Prevention* – This prevention program supports HIV prevention activities in the following program areas: STI/HIV Testing, Prevention with Positives, Condom Distribution, Policy Initiatives, Jurisdictional HIV Planning, Technical Assistance and Capacity Building, and Monitoring and Evaluation.

d. *Sexual Violence Prevention and Education* – This program funds local community agencies to design, implement and evaluate sexual violence primary prevention community change strategies such as community mobilization, environmental, policy

and social norms change strategies. Funded agencies have active community-based coalitions guiding their work, complete a community needs assessment every five years that takes a shared risk and protective factor approach and develop an action plan based on the results of their needs assessment. The link to the state plan for this program is - http://www.kdheks.gov/rpe/download/State_Plan.pdf

3. Kansas Department of Corrections (KDOC)
   KDOC prevention programs focus on recidivism of juveniles in custody. While this is not primary prevention, there is value in recognizing efforts to prevent future interactions with corrections. This FY17 report https://www.doc.ks.gov/publications/Reports/2016 outlines several programs to prevent recidivism in the juvenile court system including mentoring and parenting programs.

4. Kansas Department of Transportation (KDOT)
   The KDOT Bureau of Traffic Safety strives to improve the quality of life for the travelling public by reducing the number of motor vehicle fatalities, injuries, and crashes. They influence human behavior by identifying problems and implementing effective educational and enforcement programs focusing on prevention. The Kansas Traffic Safety Resource Office is the education link of the bureau. A portion of their work focuses on teen safety, including underage drinking prevention. More information about this initiative can be found here - https://www.ktsro.org/teen.

5. Kansas Commission on Veterans Affairs Office
   According to their website (www.kcva.ks.gov) the Kansas Commission on Veterans' Affairs Office's (KCVA) mission is to provide Kansas veterans, their relatives, and other eligible dependents with information, advice, direction, and assistance through the coordination of programs and services. The KCVA provides updates on recognition, employment opportunities, benefits, news and events, and support of the veteran's crisis line. Veterans in emotional crisis in need of help can call the toll-free number (1-800-273-8255; press 1) 24/7 for confidential support.

6. Kansas Army National Guard
   The Kansas Army National Guard participates in the National Guard Counterdrug Program, whose mission is to support the detection, interdiction, disruption, and curtailment of drug trafficking activities and use through the application of military-unique skills and resources.

7. NAMI

NAMI Kansas and their affiliates provide programs of education, support, and advocacy for people living with mental illness, their families and friends through the following (and some additional) methods:

a. We advocate for improved community-based care for people with mental illness, such as improved access to medication, housing, and supported employment.
b. We work to improve institutions and organizations in Kansas that serve people with mental illness.
c. We help show the importance of funding research on mental illness.
d. We provide free education programs to the community regarding mental illness and its treatment.
e. We advocate to eliminate discrimination and stigma against people with mental illness.
f. Most NAMI activities are free of charge. You do not need to be a member to participate. But your membership and your contributions make NAMI stronger and better able to accomplish our important mission.

8. Keys for Networking

With the Kansas Prevention Collaborative, Keys for Networking provides:

a. Outreach and information to families via Facebook. Please share this page with family members and friends whose children/adolescents have severe mental health and/or substance abuse issues, educational needs as a result of these issues and/or suicide ideation. Through Facebook, Keys also offers private groups where parents whose children have same or different issues may share strategies to negotiate with providers, manage youth in their home, make school work. Contact the page above to get involved and to receive information daily.
b. One to one parent information, support and advocacy via phone, email, Skype, chat lines to:
    i. Assist parents with educational problems such as seclusion and restraint, suspension and expulsion, transitioning youth from residential treatment programs to home schools, securing Section 504 and IDEA plans to help children with severe emotional behavioral programs succeed;
    ii. Assist parents with securing helpful mental health and substance abuse services, including paying for them;
    iii. Assist parents to participate with providers and managed care organizations to make sure their interests are heard and protected, that the priorities for care are safety and children close to home/at home.

c. One to one and small group training and problem-solving sessions via internet, telephone, chat rooms on negotiating with providers, securing school supports, and managing children/adolescents who are difficult to raise through a series of Keys developed modules, "Kids for Keep," available 24/7 in print and/or online to clients.
d. Represent interests of Kansas parents to state policy groups: the Governor's Behavioral Health Services Planning Council (GBHSPC), the GBHSPC Children's Committee, the Kansas Mental Health Coalition, the Kansas State Department of Education Task Force on School Seclusion and Restraint, KanCare Consumer Advisory Council, the national Federation of Families for Children's Mental Health, and the national Family-Run Executive Director Leadership Association. Kansas Juvenile Justice Reform Planning Committee, and others.

9. Headquarters, Inc.

Headquarters, Inc., is the suicide prevention leader in Kansas providing counseling, education, and resources for all to improve public health. They operate the National Suicide Prevention Lifeline in Kansas and work to support suicide prevention efforts throughout the state of Kansas. They have been credentialed by the American Association of Suicidology since 2001 and were honored with the AAS Crisis Center Excellence Award in 2013.

In 2018, ContactUSA accredited them for Online Emotional Support for their crisis chat program and hotline services. Services provided by Headquarters include:

- Operation of 24/7, confidential crisis lines (785-841-2345 or 800-273-8255)
- Operates the National Suicide Prevention Lifeline for all 105 counties in Kansas
- Short-term therapy clinic
- Community suicide awareness and training programs
- Suicide intervention training for behavioral health, law enforcement, educational and other professionals
- Consultation available for strategies to reduce suicide rates in communities around the state

Section 11 - Call to Action

The Prevention Sub-Committee has identified the following recommendations and calls to action based on identified gaps in services and data priority areas.

This document is our call to action. We ask our policy makers, state and local leaders, and all those who have a vested interested in prevention in the behavioral health efforts to

acknowledge the identified gaps in services and seek to promote the well-being of every person and community in Kansas.

The work put into the Kansas Behavioral Health Prevention Plan is meant to help guide behavioral health prevention efforts in Kansas. This document outlines our process for developing the plan, highlights data points relevant to prevention work, outlines current prevention efforts, and highlights strengths and gaps within those efforts. There are also a set of recommendations based on system gaps that the Prevention Sub-Committee will continue to work with key stakeholders to systematically improve.

We have recognized this work cannot be completed by any one entity. It takes the collaborative effort of a multitude of agencies to identify the at-risk populations being sought to protect. We ask for your support in promoting this behavioral health prevention plan.

1. Improve Shared Access to Data Resources Among State Agencies and Planning Council Sub-committees
   a. Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.
   b. Integrate and utilize the guidance of a State Epidemiological Workgroup (SEOW).
   c. Enhance data collection procedures: Change legislation regarding public behavioral/health youth state surveys (e.g. the Kansas Communities That Care (KCTC) Student Survey and the Youth Risk Behavior Surveillance System (YRBSS) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection and availability of data for decision making.

2. Better Coordinate Efforts and Care Transitions of Behavioral Health Services
   a. Increase healthcare linkages and identify care transition best practices for mental health, substance abuse, and emergency departments across the state. Periods following discharge from these settings are times of particularly high risk for suicide. A model for follow-up with clients during this period should be implemented in Kansas.
   b. Modify the KDADS requirements to become approved to provide SBIRT (Screening, Brief Intervention, and Referral to Treatment) services to Medicaid-eligible clients.
   c. Encourage State Departments, Agencies, the Judicial System, and Planning Council sub-committees to develop policies and practices improving their ability to work collaboratively on similar priorities and to address shared goals.
3. Form an Evidence-Based Practices Workgroup (EBW) for Behavioral Health Promotion

a. An EBW could promote more use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services.
b. Priority areas for initial EBW focus include marijuana, opioids, and strategies to help those age 18-25.

4. Allocate Resources to Prioritized Areas of Need Through Data-driven Decision Making
   a. Increase access and availability of behavioral health services by restoring funding for community mental health centers and supporting efforts to recruit students to enter the behavioral health services community.
   b. Dedicate resources and funding for suicide prevention.
   c. Support the KPC in serving coalitions without KDADS funding and communities without coalitions.
   d. Support the KPC in addressing areas of focus and capacity-building for prevention coalitions and task forces (substance abuse, problem gambling, and suicide) prioritized based on needs assessment data.

Section 12 - Sustainability and Cultural Competence

The Prevention Sub-Committee recognizes the need for accessible and sustainable data sources for Kansas. Prevention has a wide variety of data resources; however, there is a gap in accessible data for behavioral health treatment data. As we move towards a more integrated approach to treatment, having timely access to a wide variety of data resources is key to sustaining prevention efforts and showcasing outcomes.

The Prevention Sub-committee supports any efforts to increase cultural competence of providers in the state in accordance with the Strategic Prevention Framework's identification of cultural competence as a foundational principle. These include cultural education on any population in our community, be that ethnic, racial, military, and local/regional cultural norms. We are committed to developing an environment that promotes respect and understanding of diverse cultures in our State. We strive for an environment where all individuals can fully participate in prevention efforts regardless of their location, gender, age, or other contextual factor.

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Appendix 1: Acronyms

AA - Alcoholics Anonymous
AAMFT - American Association for Marriage and Family Therapy
AAS - American Association of Suicidology
ABC - Alcohol Brief Counseling
ABCD - Asset Based Community Development
ABH - Advanced Behavioral Health
ACA - American Council on Alcoholism
ACEs - Adverse Childhood Experiences
ACMHCK - Association of Community Mental Health Centers of Kansas
ACoA - Adult Children of Alcoholics
ADAPT - Alcohol and Drug Abuse Prevention and Treatment
ADC - Alcohol and Drug Counselor
ADFM - Active Duty Family Member
ADPC - Alcohol and Drug Policy Council
ADT - Active Duty Training
AHA - American Hospital Association
AIC - American Incarceration Center
ALA - American Lung Association
AMA - American Medical Association
AMSR - Assessing and Managing Suicide Risk
AOD - Alcohol and Other Drugs
APA - American Psychiatric Association
APA - American Psychological Association
ARRC - Adult Risk Reduction Center
APIS - Alcohol Policy Information System
ASAM-PPC - American Society of Addiction Medicine, Patient Placement Criteria
ASPIRE - Assessment of Prevention Indicators & Resources
ATOD - Alcohol, Tobacco, and Other Drugs
ATR - Access to Recovery
AU - Advocacy Unlimited
BAC - Blood Alcohol Content
BAL - Blood Alcohol Level
BHP - Behavioral Health Partnership
BHS - Behavioral Health Services
BHTTA - Behavioral Health Training and Technical Assistance
BRC - Blue Ribbon Commission (on Mental Health)
BRFSS - Behavioral Risk Factors Surveillance Survey
CADCA - Community Anti-Drug Coalitions of America

CASA - Center on Addiction and Substance Abuse
CAPT - Center for the Application of Prevention Technologies
CBT - Cognitive Behavioral Therapy
CCB - Community Check Box
CCMHO - Council of Community Mental Health Organizations
CCP - Crisis Counseling Assistance and Training Program
CDC - Centers for Disease Control and Prevention
CEDARR - Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation
CINC - Child in Need of Care
CIS - Children's Intensive Services
CMAP - Community Medication Assistance Program
CMHC - Community Mental Health Center
CMHS - Community Mental Health Services
CMS - Centers for Medicare and Medicaid Services
COA - Children of Alcoholics
COA - Council on Accreditation
CPA - Child Placing Agency
CPP - Certified Prevention Professional
CRM - Capacity, Readiness, and Mobilization
CRO - Consumer Run Organization
CSAP - Center for Substance Abuse Prevention
CSAT - Center for Substance Abuse Treatment
CUP - Conditional Use Permit
DARC - Drug and Alcohol Rehabilitation Counselor
DARE - Drug Abuse Resistance Education
DAS - Department of Administrative Services
DATA - Data and Alcohol Treatment Association
DBT - Dialectical Behavioral Therapy
DCF - Department for Children and Families
DD - Developmental Disabilities
DDS - Department of Developmental Services
DDRP - Drug Demand Reduction Program
DEA - Federal Drug Enforcement Administration
DFAF - Drug Free America Foundation
DFC - Drug Free Community
DFSCA - Drug-Free Schools and Communities Act
DHHS - Department of Health and Human Services
DOC - Department of Corrections
DOE - Department of Education
DOT - Department of Transportation
DPT - Division of Pharmacologic Therapy
DSS - Decision Support System
DUI - Driving Under the Influence
DUR - Drug Utilization Review
DWI - Driving While Intoxicated
EAP - Employee Assistance Program
EBP - Evidence Based Program (or Practice)
EBS - Evidence Based Strategies
EC - Emotional Competency
EPSDT - Early, Periodic Screening and Diagnosis Testing
ERG - Educational Reference Group
FT - Family Therapy
GA - Gamblers Anonymous
GLSMA - Garrett Lee Smith Memorial Act
HIDTA - High Intensity Drug Trafficking Area
HRD - Human Resource Development
HUD - Housing and Urban Development
I/DD - Intellectual and Developmental Disabilities
ICAA - International Council on Alcohol and Addictions
ICCPUD - Interagency Coordinating Committee on the Prevention of Underage Drinking
IC&RC - International Certification and Reciprocity Consortium
ICR - Institute for Community Research
HIS - Indian Health Services
IIAA - International Institute for Alcohol Awareness
IOM - Institute of Medicine
IOP - Intensive Outpatient
ISPN - Interagency Suicide Prevention Network
JCAHO - Joint Commission on Accreditation of Healthcare Organizations
KAMFT - Kansas Association of Marriage and Family Therapists
KASW - Kansas Association of Social Workers
KBHID - Kansas Behavioral Health Indicators Dashboard
KCTC - Kansas Communities That Care
KDADS - Kansas Department of Aging and Disability Services
KDHE - Kansas Department of Health and Environment
KPC - Kansas Prevention Collaborative
KPCCI - Kansas Prevention Collaborative Community Initiative
KRGC - Kansas Racing and Gaming Commission
K-TRACS - Kansas Tracking and Reporting of Controlled Substances
LAC - Licensed Addiction Counselor
MADD - Mothers Against Drunk Driving
MAT - Medication Assisted Treatment
MCO - Managed Care Organization
MDS - Minimum Data Set

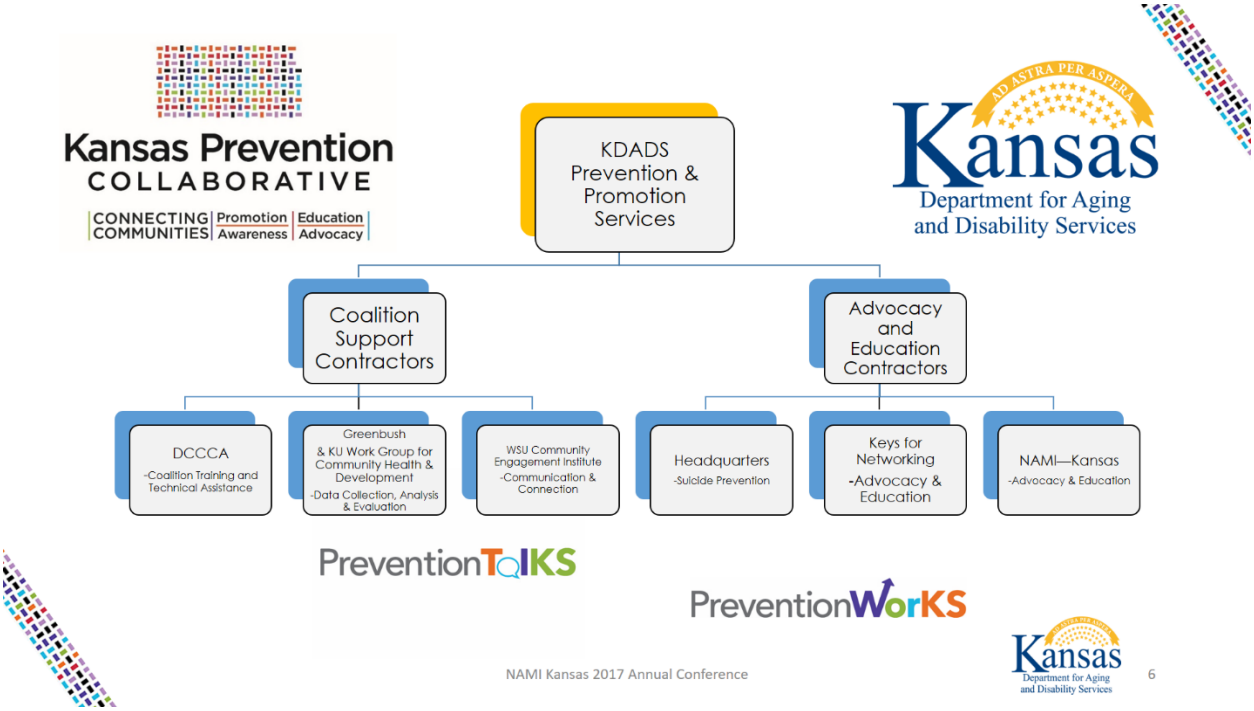
MHA - Mental Health Association
MI - Motivational Interviewing
MOA - Memorandum of Agreement
MOU - Memorandum of Understanding
MST - Multi-Systemic Therapy
MSTBSF - Multi-Systemic Therapy – Building Stronger Families
NA - Narcotics Anonymous
NAADAC - National Association of Alcoholism and Drug Abuse Counselors
NAC - National AIDS Clearinghouse
NACoA - National Association of Children of Alcoholics
NAMI - National Alliance on Mental Illness
NASADAD - National Association of State Alcohol and Drug Abuse Directors
NASMHPD - National Association of State Mental Health Program Directors
NASW - National Association of Social Workers
NCADI - National Clearinghouse for Alcohol and Drug Information
NCAP - National Center for the Advancement of Prevention
NECAPT - Northeast Centers for the Application of Prevention Technologies
NHTSA - National Highway Traffic Safety Administration
NIAAA - National Institute of Alcohol Abuse and Alcoholism
NIDA - National Institute of Drug Abuse
NIMH - National Institute of Mental Health
NPN - National Prevention Network
NPS - National Prevention System
NREPP - National Registry of Evidence-based Programs and Practices
NSSP - National Strategy for Suicide Prevention
OJJDP - Office of Juvenile Justice and Delinquency Prevention
OMH - Office of Minority Health
ONDCP - Office of National Drug Control Policy
PBPS - Performance Based Prevention System
PCP - Primary Care Provider
PFS - Partnership for Success
PG - Problem Gambling
PGCI - Problem Gambling Community Initiative
POE - Principles of Effectiveness
PRISM - Partnership Resource and Infrastructure Support Monies
PSA - Public Service Announcement
PSA - Personal Service Agreement
QMHP - Qualified Mental Health Professional
RADAR - Regional Alcohol and Drug Awareness Resources Centers
RESPECT - Recovery-Oriented, Empathic Services Proactively Empowering Consumers in Treatment
RFA - Request for Application
RFP - Request for Proposal
RSS - Recovery Support Services
RSVP - Retired Senior Volunteer Program
RYASAP - Regional youth/Adult Substance Abuse Project
SADD - Students Against Destructive Decisions
SAMHSA - Substance Abuse and Mental Health Services Administration
SAP - Student Assistance Program
SAS - Substance Abuse Services (Treatment/Prevention)
SAT - Student Assistance Team (or School Assistance Team)
SBI - Screening and Brief Interventions
SBIRT - Screening, Brief Intervention, and Referral to Treatment
SDFSC - Safe and Drug-Free Schools and Communities
SED - Serious Emotional Disturbance
SEOW - State Epidemiological Outcomes Workgroup
SIG - State Incentive Grant
SMI - Serious Mental Illness
SODA - State Opioid Treatment Authority
SPDC - Suicide Prevention Data Center
SPF - Strategic Prevention Framework
SPMI - Serious and Persistent Mental Illness
SSA - Single State Agency
SSI - Supplemental Security Income
SUD - Substance Use Disorder
Synar - Not an acronym, but refers to Amendment and Program to reduce retail access to minors
TA - Technical Assistance
TPCP - Transition from Prison to Community Program
TRAC - Transformation Accountability System
VEP - Voluntary Exclusion Program
WIT - Women in Transition
YAR - Youth as Resources
YRBS - Youth Risk Behavior Survey
YSAB - Youth Suicide Advisory Board
YSB - Youth Service Bureau

APPENDIX 2: Kansas Prevention Collaborative

In June of 2015, five contractors were selected to provide services as part of the collaborative. Since its inception, the Kansas Prevention Collaborative formed new partnerships and contracted with additional entities for providing the best support service to Kansas coalitions. The KPC has refined subcontracts with the University of Kansas Center for Community Health and Development (CCHD) and a contract with Headquarters, Inc. The Kansas Prevention Collaborative contractors and their role summaries are included in the table and the graphic below.

Contractor	Purpose
DCCCA, Inc.	Provision of statewide training and technical assistance to community coalitions, community initiatives, and KDADS projects that may be focused on one or more behavioral health concerns (substance abuse prevention, problem gambling awareness and prevention, suicide prevention, mental health promotion)
The Center for Learning Tree Institute, Greenbush	Provision of statewide, regional, and local-level behavioral health data collection, analysis and evaluation, including the Administration of the Kansas Communities that Care Student Survey
Wichita State University-Center for Community Support and Research	Provision of statewide behavioral health education, resource and information dissemination, consumer outreach and advocacy including the development of a communication's hub and the development and facilitation of a statewide prevention coalition (Since the origin of the KPC, this partner has been renamed Wichita State University's Community Engagement Institute.)
Keys for Networking	Provision of behavioral health education, resource and information dissemination, consumer outreach and advocacy with a specific focus on creating and maintaining adequate capacity to support families and individuals in crisis and providing guidance to families and individuals in accessing appropriate services within communities, educational entities, and home environments

NAMI, Kansas	Provision of behavioral health education, resource and information dissemination, consumer outreach and advocacy with a specific focus on creating and maintaining adequate capacity to support families and individuals in crisis and providing guidance to families and individuals in accessing appropriate services within communities, educational entities, and home environments
University of Kansas Center for Community Health and Development (CCHD)	The CCHD brings capacity-development tools and evaluation expertise through their workforce, the Community Check Box, and their management of the KPC WorkStation.
Headquarters, Inc.	Suicide prevention expertise and suicide prevention efforts throughout the state of Kansas. Headquarters, Inc. also provides counseling, education, and resources to improve public health and generate awareness.



APPENDIX 3: Topic Specific Statewide Plans

The following components have been pulled from statewide plans relevant to behavioral health prevention. Plan recommendations and content were not developed by the Governor's Behavioral Health Services Planning Committee but are included to provide a more comprehensive picture of prevention efforts in Kansas.

Kansas Suicide Prevention Plan

The Kansas Suicide Prevention Plan, revised 2014, identified five primary goals –

- Integration of prevention efforts across the lifespan with attention to co-morbidity of other illnesses and disorders
- Increasing suicide related training to a variety of audiences involved in suicide prevention
- Increasing the continuity of care and linkages in healthcare systems for those at risk of suicide
- Use of data-drive approaches
- Utilize evaluation to determine successes and future directions

The Prevention Subcommittee continues to acknowledge the strong link between risk for suicide death and other behavioral health concerns including experiences with mental illness, substance use disorders and problem-gambling. Some progress has been made on the state Suicide Prevention Plan, however, more work is left to do to make an impact the suicide death rate in Kansas. One step would be for the creation of an Annual Action Plan centered on the goals of the state plan. State agencies and their partners should identify steps which can reasonably be accomplished in one year's time. Examples include:

- Centralized trainer registry for all suicide prevention programs available in the state (e.g. ASIST, Yellow Ribbon)
- Conduct a statewide workforce survey of the sectors identified for training to collect baseline information on how prepared Kansas is to support and treat those at risk of suicide.

The Kansas Suicide Prevention Plan can be found at –
https://www.sprc.org/sites/default/files/KS%20Suicide%20Prevention%20Plan-Revised%202014.pdf

Prescription Drug and Opioid Prevention Plan

Prevent the misuse of prescription drugs and use of illicit opioids among Kansas residents.

Prevention Sub-Committee Strategies

1. Develop a collaborative, Kansas-specific website as an informational hub to increase public awareness and facilitate a coordinated response to prescription drug, and prescription/illicit opioid misuse, abuse, dependence, and overdose.

2. Implement coordinated statewide media campaigns to raise awareness of OUD, opioid overdose, and alternative therapies for pain management

3. Develop and disseminate educational materials for both professional and non-professional audiences on the issues of prescription drug and opioid misuse, substance use disorder, overdose, and mitigation strategies.
    a. Health care professionals
    b. Public

4. Promote safe use, storage, and disposal of prescription medications, including opioids, to prevent misuse, and illicit acquisition and distribution at the state and community level.

5. Collect, analyze, use, and disseminate surveillance data to inform prevention efforts and monitor trends in at-risk populations.

Increase the number of healthcare professionals educated on opioid prescribing, pain management, patient education, and addiction to increase use of best practices associated with prescribing, pain management and preventing opioid misuse in Kansas.

Provider Education Sub-Committee Strategies:

1. Offer and raise awareness of educational opportunities (virtual and in person) on evidence-based practices associated with pain management, prescribing, alternative therapies, addiction, and treatment.

2. Develop and disseminate a comprehensive resource toolkit for health care providers on best practices associated with opioid prescribing, pain management, addiction, and patient education.

3. Recommend additional education requirements on MAT, Addiction, and Opioid prescribing to better equip healthcare professionals with the necessary tools to implement evidence-based practices

4. Develop and implement opioid prescribing policies and prior authorizations for Medicaid beneficiaries, managed care, and FFS

5. Develop a joint committee on opioid misuse to engage subject matter experts to review and synthesize new and emerging research regarding opioid addiction and best

practices associated with safe and effective chronic pain management and disseminate findings.

6. Increase use of K-TRACS for surveillance and intervention

7. Increase access and use of SBIRT across provider disciplines

A link to the Kansas Prescription Drug and Opioid Misuse and Overdose Strategic Plan can be found at www.preventoverdoseks.org.

Plan to Prevent Sexual and Domestic Violence

The comprehensive state plan to prevent sexual and domestic violence in Kansas 2011-2018 identified 4 goals:

1. Decrease social norms that support male superiority and sexual entitlement
2. Increase gender equity for women and girls in Kansas
3. Increasing the capacity to monitor, evaluate and improve primary prevention programming in a data-driven and evidence-based manner
4. Increase the quantity and quality of primary prevention programming intended to prevent first-time perpetration of sexual and domestic violence.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Kansas law designates CMHCs as the gatekeepers for admission to state mental health hospitals. Under contract, CMHCs also carry out similar functions for nursing facilities for mental health, psychiatric residential treatment facilities and Medicaid-funded community hospital psychiatric services.

Community mental health centers (CMHCs) provide a variety of services in order to enable individuals with mental illness and co-occurring disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Many substance use disorder providers are dually licensed as CMHCs enabling them to coordinate both mental health and substance use disorder care for those with co-occurring diagnoses.

In the CMHCs contract with KDADS, there are specific services for the uninsured/underinsured (which is funded by Block Grant and State funds) that must be given first priority for use with individuals who meet SPMI or SED criteria: 1) Intensive Case Management (CPST) 2) Attendant Care, 3) Peer Support, 4) 24-hour crisis response, triage, stabilization and treatment services, 5) Psychiatric services, and 6) Psychosocial Rehabilitation Services. These services are prioritized as they have been identified as particularly critical in assisting individuals in maximizing their independence and capabilities.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational Services	(●) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

In 2017, thirteen of the Kansas CMHC's were licensed to provide M/SAT. Kansas identified a growing need for co-occurring mental health and substance use services. As of 2019, there are currently nineteen CMHC's licensed to provide M/SAT.

3. Describe your state's case management services

CMHC case managers provide Community Psychiatric Support and Treatment (CPST). CPST provides goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the consumer's individualized treatment plan. CPST is a face-to-face intervention with the consumer present; however, family or other collaterals may also be

involved. The majority of CPST contacts must occur in community locations where the consumer lives, works, attends school, and/or socializes. CPST may include the following components: assist the consumer and family members or other collaterals to identify strategies or treatment options associated with the consumer's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the consumer's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration; individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the consumer, with the goal of assisting the consumer to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living; participation in and use of strengths-based planning and treatments, which include assisting the consumer and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; to use personal strengths, resources, and natural supports to address functional deficits associated with the consumer's mental illness; and, assist the consumer with effectively responding to or avoiding identified precursors or triggers that would risk the consumer remaining in a natural community location, including assisting the consumer and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or as appropriate, to seek other supports to restore stability and functioning.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Kansas Department for Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waivers. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use disorder services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. Addressing Social Determinants of Health and Independence are key themes in the current waiver application.

KDADS contracts with 25 CMHC's to provide six services that must be given first priority for use with individuals who meet the Severe and Persistent Mental Illness (SPMI) or Severely Emotionally Disturbed (SED) criteria. Those six services are particularly critical to consumers in maintaining their independence and maximizing their capabilities, they are as follows: 1) Intensive Case Management (CPST) 2) Attendant Care 3) Peer Support 4) 24-hour crisis response, triage, stabilization and treatment services 5) Psychiatric services and 6) Psychosocial Rehabilitation Services. Within these contracts KDADS also identifies goals which focused monitoring for reduction of hospitalities and hospital stay.

KDADS also funds several Crisis Centers across the state with impressive early outcomes. These centers with detox beds and beds for stabilizing people in mental health crises give police officers and medical teams a place to take people where they can stay up to 23 hours instead of housing them in jails or emergency rooms. For example, the Sedgwick County Community Crisis Center (a joint endeavor between a Community Mental Health Center and a Regional Alcohol Drug Assessment Center) is estimated by the Wichita State University Public Policy and Management Center to have resulted in community cost avoidance to hospitals, EMS, and law enforcement of between $13.2 and $21.6 million in its first three years of operation.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	4.8%	0.6%
2.Children with SED	6.3%	1.6%

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Automated Information Management System (AIMS) is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Using the 2017 Census population estimates and KDADS database, Automated Information Management System (AIMS), the prevalence and incidence rates were identified by taking the past five-year accruals and by finding the average percentage increase or decrease and applying it to get the estimated totals. The rate was then identified by taking the estimated totals divided by the census population estimate for Kansas.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(●) Yes ( ) No
b)	Educational services, including services provided under IDE	(●) Yes ( ) No
c)	Juvenile justice services	(●) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(●) Yes ( ) No
e)	Health and mental health services	(●) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(●) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

There are several subcommittees of the GBHSPC in Kansas including a Rural and Frontier subcommittee. Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

The Subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as the Secretaries of relevant state agencies.

The GBHSPC's annual subcommittee's charter, bylaws and reports can be found on the KDADS website at this link: https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc.

Rural and Frontier Subcommittee
The Rural & Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, [the committee] assures accessibility/availability of mental health services in frontier/rural Kansas counties. In the Committee's 2018 annual report, FY2018 goals and recommendations include: statewide adoption of KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order, strengthening continuum of care in rural/frontier areas, and continuing to diversify subcommittee membership to ensure that needs and resources are considered both within and alongside the behavioral health system.

SAMHSA was onsite in May 2018 for a 10-year comprehensive onsite review. The SAMHSA Lead on the Review indicated onsite that Kansas has one of the best Planning councils in the country.

b. Describe your state's targeted services to the homeless population.

The Housing and Homelessness subcommittee (HHS) is another subcommittee of the GBHSPC. Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

Housing and Homelessness subcommittee (HHS)
The Housing and Homelessness Subcommittee (HHS) focuses on helping adults experiencing severe and persistent mental illness and children diagnosed with severe emotional disturbance and their families obtain and maintain safe, decent, affordable, and permanent housing. The HHS acts as the body in Kansas who offers guidance and recommendations to the Governor's Behavioral Health Services Planning Council and to KDADS, so they can effectively exercise leadership in this arena. The subcommittee recommendations for FY19 are that the subcommittee will work with KDADS to coordinate the Subcommittee's goals and strategies with the Kansas Interagency Council on Homelessness, the subcommittee will explore options for a centralized data system within the housing and homelessness field that other State and local entities have access to for finding housing and services for our shared customers, and the subcommittee will ask the three Managed Care Organizations to recommend someone from their respective organizations to serve on the subcommittee with the intent to explore Evidence-Based Practices and/or Promising Practices that support the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders.

The Kansas Department for Aging and Disability Services currently offers multiple programs to assist individuals that are homeless or at risk of homelessness and experiencing an SMI:

Supportive Housing Recovery Supports
In 2016 through the support of the Cooperative Agreement to Benefit Homeless Individuals (CABHI), the State of Kansas BHS Commission partnered with Sam Tsemberis to bring the Housing First Model to Kansas. Kansas continues to work on our internal statewide infrastructure to bring this training to scale across the State. In January of 2019, Sam Tsemberis came to Kansas to provide an Introduction to Housing First to members of the Governors Behavioral Health Policy Council and other community stakeholders, peers and families. Sam will be returning in September of 2019 to provide a statewide Housing First training to our Mental Health and SUD provider networks. In 2017 through the CABHI agreement the BHS Commission began to partner with the HUD Continuum's of Care (COC's) and KDADS currently is partnered with the Kansas Statewide Homeless Coalition the Balance of State COC to provide information, education and HUD Housing related trainings to our Behavioral Health Services Provider Networks across Kansas. In July of 2019 in partnership with Kansas Department of Health and Environment the state added a per-diem CPST Medicaid code to ensure that Medicaid eligible consumers exiting institutions ie., state hospitals, state and county correctional facilities, nursing homes for mental health and ER's have immediate access to Housing Supportive Services to either sustain or obtain client housing using the Housing First Model. This Operation Community Integration Program per diem code is an integrative code that both SUD and MH providers can use to ensure that consumers have the Housing Supportive Services necessary to sustain independent living in the community and support the consumers through the transition process to full community integration. All consumers that are participants in this program must be connected to a Federal HUD Access Point to ensure that BHS consumers who are HUD eligible will have access to HUD Access Points, and Coordinated Entry. Consumers participating in this Medicaid code will have the ability to select recovery support services that they feel will help them be successful in community integration. Programs/Supportive Services included in the (OCI) Recovery Support Services Array include; SAMHSA's Cognitive Behavioral therapy Intervention work book, Medication Assisted Treatment, Housing First Support Services, IPS Supported Employment, SOAR/Entitlement Benefits Counseling (referral to a C-WICK), Mobile Crisis Response, CIT Interventions.

IPS Supported Employment (Enhancing Supported Employment in Kansas-ESEK) and the Employment First Act
Kansas was one of the first states in the United States to sign into law the Employment First Act. In 2014 the State was awarded a Federal Cooperative Agreement from SAMHSA to expand our state infrastructure for IPS Supported Employment. Over 5 years through two-evaluation sites, Kansas is strengthening and enhancing services and supports to promote employment as a part of recovery and towards economic self-sufficiency for employment age youth and adults with mental health needs. The ESEK Federal Award was essential to our state and will allow us to strengthen, enhance and sustain an evidence based participant guided and empowering approach for addressing the employment needs and desires for youth and adults with SMI. More than 3,000 youth and adults will have been impacted and introduced to IPS Supported Employment. Through a Technical Assistance award funded by SAMHSA under the ESEK Cooperative Agreement the State of Kansas has contacted with the National Council for Behavioral Health to look at developing a statewide Center for Excellence and a State of Kansas Resource Center for Evidence Based Practices to ensure that our provider networks have access to the most recent evidenced based and promising practice programs that will assist our consumers down their individual path of recovery. Our first consulting meeting took place in July of 2019 and we will meet on a monthly basis until September 20th, 2019. The Governors Behavioral Health Policy Council has given permission for KDADS to create a sub-committee group specific to Evidence Based Practices, to ensure that consumers, families, stakeholders and our providers all have input into the selection of EBP programming within the State of Kansas. In 2019 as part of an 1115 demonstration waiver for KANCARE 2.0, the State of Kansas will be introducing an Employment Program for consumers with Behavioral Health diagnosis, consumers on the HCBS waivers and consumers who would like to return and/or enter the workforce.

Projects for Assistance in Transitioning from Homelessness (PATH)
PATH is a SAMHSA-funded program designated to support the delivery of eligible services to persons who have an SMI and may also have a co-occurring disorder and are homeless or at risk of becoming homeless. Through outreach services provided by CMHCs, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive services.

Interim Housing (IH)
IH projects is a state-funded program that involves short-term (up to six months) project-based housing that provides immediate community-based housing for persons who meet HUD's definition of homeless; who are homeless and being discharged from inpatient or residential mental health or substance use treatment facility (e.g., a state psychiatric hospital (SPH), nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program). There are currently six CMHCs that have Interim Housing Projects. In addition, the state requires CMHCs to have Housing Specialists, who are responsible for increasing the array of housing options available to consumers. The CMHC Housing Specialists assist persons with behavioral health issues, including co-occurring mental health and substance use disorders, to access safe and affordable housing of their choice and to provide the necessary supports and services that ensure the person lives a safe, healthy, self-determined life in their own homes. CMHC Housing Specialists actively participate in and assist with local, regional, and/or statewide efforts to decrease homelessness and to address situations where individuals are precariously housed. KDADS' Behavioral Health Services Commission and the Commission on Aging are jointly responsible for programming and funding statewide. In addition, while all CMHCs serve individuals regardless of age, multiple CMHCs provide services that target older adults.

Social Security Outreach Access and Recovery
Consumers exiting state hospital and state correctional facilities now have access to a SOAR/Benefits Specialist to assist them with

transition into the community. In 2017, the State of Kansas KDADS partnered with the State Medicaid Agency KDHE to ensure that federally disabled consumers who had become dis-connected from their benefit could be re-connected to both SSA and Medicaid with assistance from a SOAR staff. State of Kansas Hospital Staff are also participating in the Social Security Administrations TI Benefit Program to ensure that consumers who are hospitalized because of an illness and may be at risk of homelessness can work with the Social Security Administration, under the TI program, to request that SSA benefits remain active to avoid homelessness, evictions etc. which we believe will decrease some of our housing issues in Kansas. Consumers who participate in this program can now have their Medicaid placed into suspension status, instead of being shut off, when they enter the State Hospitals allowing consumers to access medications and services on the day of discharge. The Kansas Department of Corrections and Kansas Department for Aging and Disability Services have MOU's with the Social Security Administration to ensure that consumers exiting institutions can be re-connected to benefits to ensure that federally disabled consumers have access to services on the day of discharge/release. The State of Kansas continues to grow our SOAR program within our provider networks and HUD Continuum of Care locations in Kansas. We have increased the number of SOAR Certified Staff within the state and in fiscal year 2018-2019 we doubled our SOAR staff across the State. We have partnered with Kansas Statewide Homeless Coalition and 2019 is a year of cross over training with our COC's and BH provider systems. We anticipate a SOAR point of contact at each provider agency or within each HUD COC so that our Homeless or At Risk of Homelessness population have an advocate across the Social Security Systems and can have access to recovery oriented programs such as Ticket To Work, PACE, and the SSA Trial Work Period.

c. Describe your state's targeted services to the older adult population.

Kansas Department for Aging and Disability Services
Kansas recently elected a new governor. Governor Laura Kelly became the 48th governor of the State of Kansas in January of 2019. Under Governor Kelly, Laura Howard was appointed the new Secretary for the Kansas Department for Children and Families (DCF) and the Kansas Department for Aging and Disability Services (KDADS). Janis DeBoer was appointed the Deputy Secretary of the Kansas Department for Aging and Disability Services.

Under Secretary Howard, KDADS was reorganized into five commissions: Financial and Information Services Commission, Aging and Disability Community Services and Programs Commission, State Hospital Commission, the Survey, Certification and Credentialing (SCC) Commission, and the Behavioral Health Services (BHS) Commission.

Aging & Disability Community Services and Programs Commission (A&D CSP)
Amy Penrod was appointed the Commissioner of the Aging & Disability Community Services and Programs Commission. The Aging & Disability Community Services and Programs (A&D CSP) Commission manages a system of community-based supports and services for persons with disabilities, which are delivered through the Medicaid Managed Care system (KanCare) in partnership with organized networks. These services include programs for those with physical disabilities, intellectual/developmental disabilities, frail elderly and children with autism. It is responsible for coordinating intra-agency KDADS activity around KanCare. The Commission works with each KDADS Commission to ensure that client services are monitored appropriately. The Commission coordinates with all three KanCare Managed Care Organizations (MCOs) regarding KDADS-specific program areas (home and community-based service waivers and behavioral health).

A&D CSP also administers a variety of community-based programs for the aging population through contracts and grants of state and federal funds. The programs administered include Older Americans Act, congregate and home-delivered meals, caregiver programs, in-home services, Senior Care Act services, and Client Assessment, Referral and Evaluation (CARE) program, as well as quality assurance programs for the Older Americans Act and Senior Care Act. In addition, it is responsible for the Aging and Disability Resource Center, or ADRC, the single-entry point for older adults and persons with disabilities to connect with local experts who can help them choose a long-term care option. The Commission oversees and implements grants that assist individuals who are aging or have a disability under Senior Health Insurance Counseling for Kansas (SHICK), Senior Medicare Patrol (SMP), Lifespan Respite and Community Transition Opportunities. The SHICK program assists individuals with questions related to Medicare. The SMP program educates the community about reporting Medicare/Medicaid and health-care fraud and abuse and how to identify and report scams. The Commission's Community Transitions Opportunities program works with nursing facilities to identify residents who wish return to living in a community setting.

Governor's Behavioral Health Services Planning Council Subcommittees
There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Supportive Employment and Vocational Services and 8) Veterans. In addition, the GBHSPC has approved forming three new subcommittees: Problem Gambling, Aging, and Evidence-Based Practices.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

To ensure that emergency health staff and first responders are able to train others in their arenas of work, KDADS staff attended Youth Mental Health First Aid training of facilitators. KDADS staff then facilitated several trainings. Community Mental Health Centers (CMHCs) also offer Adult Mental Health First Aid training within their communities for educators, families, clergy, health care professionals and other stakeholders. Each CMHC also participates in disaster planning and training at both the local and state levels. KDADS has taken a comprehensive approach to train law enforcement, first responders, and other personnel in the area of mental health issues throughout the state. They have provided grant funding to enable emergency health responders including law enforcement, mental health providers, those who work with Veterans, and others, to receive Crisis Intervention Training (CIT). CIT training programs include instruction, classroom materials, and student room and board. Law enforcement officers trained will earn continuing education hours through the Kansas Law Enforcement Training Center (KLETC). KLETC will also produce an online training video and testing instrument for use by law enforcement agencies that are unable to send staff to the training center. More than 1,000 first responders have been trained to date. There are plans to provide a series of six one-day mental health awareness training sessions throughout the state, which will lay the ground work for more specialized behavioral health training in the future. Regional training events will target smaller, rural law enforcement agencies that do not have the local mental health resources to provide such training.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	◉ Yes ○ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/social)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Services for special populations:

Targeted services for veterans?	◉ Yes ○ No
Adolescents?	◉ Yes ○ No
Other Adults?	◉ Yes ○ No
Medication-Assisted Treatment (MAT)?	◉ Yes ○ No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (•) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (•) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (•) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (•) Yes ( ) No

5 Has your state identified a need for any of the following:

- **a)** Open assessment and intake scheduling (•) Yes ( ) No
- **b)** Establishment of an electronic system to identify available treatment slots (•) Yes ( ) No
- **c)** Expanded community network for supportive services and healthcare (•) Yes ( ) No
- **d)** Inclusion of recovery support services (•) Yes ( ) No
- **e)** Health navigators to assist clients with community linkages (•) Yes ( ) No
- **f)** Expanded capability for family services, relationship restoration, and custody issues? (•) Yes ( ) No
- **g)** Providing employment assistance (•) Yes ( ) No
- **h)** Providing transportation to and from services (•) Yes ( ) No
- **i)** Educational assistance (•) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Kansas Department for Aging and Disability Services (KDADS) licenses behavioral health providers in Kansas. Licensing standards identify expectations and guidelines for the development and operation of substance use disorder (SUD) treatment programs licensed/certified by the State of Kansas. When new providers apply for a license and during regular site visits, KDADS staff verify compliance with these standards. The standards are rigorous and cover a range of areas, including but not limited to, client rights, confidentiality, client record review, incident reports, member accessibility, program environment and safety, assessment, treatment planning, updates, and discharge planning/follow-up.

In Kansas, there are five Designated Women's Facilities (DWFs) located across the state in nine locations. DWFs undergo the same rigorous licensing requirements as described above. Kansas is in the process of developing a new substance use disorder data system to enhance the monitoring and tracking of Block Grant data collection and monitoring elements related to DWFs and other Block Grant facilities. Block Grant monitoring processes are being reviewed and enhanced electronic Block Grant data collection and monitoring elements is being considered for the new system.

Kansas contracts with three Managed Care Organizations for Medicaid and an Administrative Services Organization (ASO) for Block Grant substance use disorder treatment services. KDADS monitors the Medicaid plans and the ASO that oversee, authorize and reimburse for SUD treatment services. The ASO and the Medicaid plans contract with Substance Use Disorder providers, including the previously referenced Designated Women's Facilities, to provide a full continuum of services for pregnant women and women with dependent children.

The ASO for the Block Grant substance use disorder system also provides an expansive array of reports to the state on substance use disorder services utilization including Designated Women's specific-reporting for additional monitoring. Contract language with the plans and in the provider agreements include compliance related activities including corrective action up to and including provider suspension and termination from their network. The ASO maintains and manages the State's substance use disorder hotline and waitlist for residential treatment. Pregnant women are rarely on the waitlist, but if there is one waiting, the ASO ensures pregnant women and other priority populations are given priority in accessing care.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs — ( ) Yes (●) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — ( ) Yes (●) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — (●) Yes ( ) No
- **c)** Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Kansas Department for Aging and Disability Services (KDADS) license both behavioral health providers and methadone clinics in Kansas. Licensing standards identify expectations and guidelines for the development and operation of substance use disorder (SUD) treatment programs and methadone clinics licensed/certified by the State of Kansas. The standards are rigorous and cover a range of areas. There are a set of standards specific to methadone clinics which includes onsite reviews of policies, procedures, and client records.

Kansas is in the process of developing a new substance use disorder data system. Block Grant monitoring processes are being reviewed and enhanced electronic Block Grant data collection and monitoring elements are being considered for the new system.

Kansas contracts with three Managed Care Organizations (Medicaid) and an Administrative Services Organization (ASO) for the Block Grant substance use disorder treatment services. KDADS monitors the the Medicaid plans and the ASO that oversee, authorize and reimburse for SUD treatment services for the providers in their network. The ASO and the Medicaid plans contract with Substance Use Disorder providers to provide a full continuum of services for those who inject drugs. The ASO maintains and manages the State's substance use disorder hotline and waitlist for residential treatment. The ASO ensures those who inject drugs and other priority populations are given priority in accessing care. Contract language with the plans and in provider agreements include compliance related activities including corrective action up to and including provider suspension and termination from their network.

The majority of the methadone clinics in Kansas are located primarily in urban areas and are self-pay. Medicaid plans are highly encouraged to contract with Methadone clinics. Currently, there are three of the nine methadone clinics that are Medicaid providers. There is one methadone clinic in the ASO network under the Block Grant program.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — (●) Yes ( ) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — (●) Yes ( ) No
- **c)** Established co-located SUD professionals within FQHCs — (●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and

corrective actions required to address identified problems.

In Kansas, there is a Kansas Tuberculosis Control Program within the Kansas Department of Health and Environment. State laws and regulations require that cases of tuberculosis be reported to the local or state health department, The Kansas Tuberculosis Control Program provides, free-of-charge, anti-tuberculosis medications to local health departments for the treatment of TB disease. Additionally, preventative medications for individuals with TB infection are provided at no cost to local health departments or other medical providers. In order to receive medications for a person afflicted with TB infection, the health care provider or local health department must provide the state program information about the diagnostic screening of the patient (skin test and chest x-ray results). For individuals with active TB disease, the local health department must provide information about the diagnostic screening of the patient along with information about the patient's treatment, potential contacts to the patient, and other detailed information as requested on an ongoing basis.

For substance use disorder Block Grant treatment services, KDADS maintains a policy on our website specifically related to Tuberculosis to ensure compliance with the federal regulation to facilitate the provision of TB services and to create the necessary linkages between substance use disorder providers and local health care providers. Contractual agreements with the ASO and in the ASO's provider agreement with providers also include language about TB referrals. Contract language with the plans and in provider agreements include compliance related activities including corrective action up to and including provider suspension and termination from their network. In addition, the previous substance use disorder data system included a TB Risk assessment along with other TB related data elements for monitoring and tracking.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No
- **b)** Establishment or expansion of tele-health and social media support services ○ Yes ○ No
- **c)** Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ◉ Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ◉ Yes ○ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ◉ Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ◉ Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ○ Yes ◉ No
- **f)** Explore expansion of services for:
  - **i)** MAT — ◉ Yes ○ No
  - **ii)** Tele-Health — ◉ Yes ○ No
  - **iii)** Social Media Outreach — ◉ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ◉ Yes ○ No
- **b)** Establish a program to provide trauma-informed care — ◉ Yes ○ No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ◉ Yes ○ No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ◉ Yes ○ No
- **b)** An organized referral system to identify alternative providers? — ◉ Yes ○ No
- **c)** A system to maintain a list of referrals made by religious organizations? — ○ Yes ◉ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No
- **c)** Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ( ) Yes (●) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Independent Peer Review was one of the areas reviewed during Kansas's 10-year comprehensive site visit with CSAT in May 2018. It was noted in one of the communications from SAMHSA that "States may satisfy the independent peer review requirement by demonstrating that at least 5 percent of their entities providing services obtained accreditation, during their fiscal year, from a private accreditation body such as the Joint Commission on the Accreditation of Healthcare Organizations, the Commission on the Accreditation of Rehabilitation Facilities, or a similar organization." Our Block Grant Coordinator position was vacant during the review. In follow-up, KDADS researched provider accreditation. It was found that the SABG provider network does meet the required 5% accreditation. Of the 44 SABG providers, there are nine providers with accreditation or 20.5% (Council on Accreditation (COA), Commission on the Accreditation of Rehabilitation Facilities (CARF), Joint Commission). KDADS has notified SAMHSA of the follow-up and findings and is awaiting CSAT approval.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) [ ] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ( ) Yes (●) No
- **b)** Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

- **a)** Recent trends in substance use disorders in the state (●) Yes ( ) No
- **b)** Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No
- **c)** Preformance-based accountability ( ) Yes (●) No
- **d)** Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No
- **b)** Addition of training sessions designed to increase employee understanding of recovery support services ( ) Yes (●) No
- **c)** Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ( ) Yes (●) No
- **d)** State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

- **a)** Prevention TTC? (●) Yes ( ) No
- **b)** Mental Health TTC? ( ) Yes (●) No
- **c)** Addiction TTC? (●) Yes ( ) No
- **d)** State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

- **a)** Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

- **a)** Tuberculosis ( ) Yes (●) No
- **b)** Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

- **a)** Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No
- **b)** Professional Development ( ) Yes (●) No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.kdads.ks.gov/commissions/survey-certification-and-credentialing-commission

Footnotes:

Criterion 4, 5 and 6: 1.c) Kansas is not a Medicaid expansion state. Service needs have exceeded allotted funding consistently for many years.

Kansas is not a HIV Designated State.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No

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

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

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? — (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? — (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? — (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? — (●) Yes ( ) No

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

Crisis Intervention Training (CIT)/Veterans Services
The current KDADS state coordinator for the Crisis Intervention Training (CIT)/Veterans services position has nine years of senior ranking active duty military service and civilian law enforcement experience. KDADS has taken a comprehensive and proactive approach to train law enforcement, first responders and other professionals around the state in the areas of mental health and crisis intervention. The Behavioral Health Services Commission and the Governor's Behavioral Health Services Planning Council have provided grant funding to CIT and veteran's programs. This funding created a new employment position and the ability to train hundreds of law enforcement professionals in the state of Kansas on Crisis Intervention and Veteran Programs Training. Through this grant, KDADS has partnered with the Kansas Law Enforcement Training Center (KLETC) located in Hutchison, KS. KLETC provides the curriculum and classroom presenters, student room and board, snacks and finally a 40-hour certificate and CIT pin for their uniform. In FY19, we have trained over180 personnel stretching over 19 counties with a focus on the rural and frontier areas with little resources.

Crisis Intervention Teams (CIT) is a police training program created in 1988 in Memphis, TN. It was originally a partnership between

NAMI and the Memphis Police Dept after a shooting of a mentally ill person. CIT is a program that utilizes community partnerships to provide consumers access to treatment systems and mental health advocates in the time of a crisis. Long term, CIT has led to additional options for inpatient treatment, including sub-acute care facilities and increased long term beds. These upgrades to the mental health system are the result of advocacy by NAMI and other agencies and can directly be attributed to the law enforcement officers of Kansas. The goals of the training are to give officers and mental health professionals the knowledge of the major diagnoses they would encounter on the street or in the jail and also to be able to identify these diagnoses in a crisis and how to best communicate with consumers at that time. Additionally, Officers are trained in de-escalation techniques for calming a crisis and choosing the best placement for the consumer within the proper system.

The Kansas Department for Aging and Disability Services (KDADS) Commissioner and the state CIT/Veterans Coordinator are leading a SAMHSA sponsored event called the Governor's Challenge in the state of Kansas. Kansas is one of seven states in the United States selected to receive technical assistance and resources to reduce Service Member, Veteran and Family Member suicide. We also participate in the SAMHSA sponsored event called the Mayors Challenge in the capitol city of Topeka. Goals are the same in reducing Service Member, Veteran and Family Member suicide. The CIT/Veterans Coordinator is currently working on a Governors Proclamation for Veterans and an informational video with our Governor.

Justice Involved Youth and Adult Subcommittee
The Governor's Behavioral Health Services Planning Council's Justice Involved Youth and Adult Subcommittee is a subcommittee of the State's Planning Council. The subcommittee is comprised of a group of stakeholders and forensic professionals charged with examining pertinent issues in Kansas as they pertain to the justice involved population. The Justice Involved Youth and Adult Subcommittee prioritizes its goals and activities around transforming mental health policies, programs, and funding that address jail diversion, access to timely and appropriate services while incarcerated, and reentry. The subcommittee recommendations for 2017 include engaging community partners and related to creating an adult continuum of care subcommittee.

State Agency Collaborations
• Kansas Department of Corrections (KDOC) Juvenile Services Division is currently using the Youth Level of Services/Case Management Inventory Screen, which is a researched based screen designed to reduce risk surrounding recidivism and target consumers individuals needs so that parole planning can be based on consumers level of risk. Parole officers within the Juvenile Services Division work closely with the consumer to ensure that Evidence-Based Principals of the Risk, Need and Responsivity Model for Juveniles are followed.

• Kansas Department for Aging and Disability Services (KDADS) and KDOC are currently participating in Agency-to-Agency Collaborative Staffing's on high risk cases discharging from State Corrections, County Jails and our State Psychiatric Hospitals to avoid homeless discharges, duplication of services/effort and increase community safety.

• KDADS through our Community Mental Health Centers (CMHCs) and KDOC certified SSI/SSDI Outreach, Access, and Recovery (SOAR) staff also collaborate with the Department for Children and Families (DCF) to ensure that consumers who were in Juvenile Corrections custody on the day of their 18th birthday have access to DCF's Independent Living Program. This program is designed to provide services and supports to Transitioned-Aged Youth for a successful transition to self-sufficiency and to detour them from further correctional involvement.

• Transitioning youth can also participate in DCF's Education and Training Voucher program for a total of five years as they are exiting Juvenile Correctional facilities. This program assists our juvenile consumers who are exiting Correctional Facilities to build skills and access training and post-secondary education and certified training programs that are essential in the re-entry process and also recognized as a best practice by the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

• State Hospital staff and administration have begun coordinated discharge planning with KDOC parole staff and administration to ensure a smooth community transition using CMS discharge planning guidance as the core to discharge planning for both institutions. Each agency and the consumer share the Risk, Needs of the consumer. These needs and risks become part of the consumers discharge planning and community transition plan.

• KDOC has a certified SOAR worker at each State Correctional Facility to assist with discharge planning. This process includes connecting consumers to necessary documents to ensure that the consumer can obtain benefits at the time of discharge i.e. Driver's license, birth certificate etc. KDOC currently has a Memorandum of Understanding (MOU) with the Social Security Administration to process SOAR cases 90 days before release.

• KDADS 2019 Mental Health contract ensures that each Community Mental Health Center has a Certified SOAR worker on staff to assist with obtaining identification and documentation necessary to connect a consumer back to SSA and Medicaid benefits.

• The Kansas Department of Health and Environment (KDHE), the State Medicaid Authority, is creating a program to ensure that SSA entitled consumers who are serving a sentence in either a County and/or State Corrections with time (90 days or less) maintain active Medicaid status in a suspended state instead of shutting down. This program will allow consumers to access services on the day of discharge.

• As part of the KanCare 2.0 Medicaid Managed Care contract, KDHE has urged the Managed Care Organizations (MCOs) to focus

on improving access to services for all Medicaid consumers exiting institutions.

• KDADS partners with Kansas Housing Resources Corporation who serves as the primary administrator of federal housing programs for the State of Kansas. This partnership has allowed our Behavioral Health (Mental Health and Substance Use Disorder) providers to be exposed to U.S. Department of Housing and Urban Development (HUD) and the federal programs that HUD may have available to assist with community tranisition for the disabled population. Our BHS providers will be participating in a Housing First Training with Sam Tsemberis in September of 2019. Consumers who meet HUD's definition of disabled persons are now accessing Federal HUD programming through our BHS provider systems (many of those systems are current HUD Access Points for the Coordinated Entry Programs). Sam Tsemberis continues to provide consultation work with our KDADS BHS division staff to develop a statewide infrastructure for the Housing First Model as recommended by HUD.

• In 2019 KDADS in collaboration with KDHE opened up a per diem Medicaid code for a program called Operation Community Integration. This program is designed to provide supportive housing services for consumers exiting institutions. The program model uses the Evidence Based Practice of Housing First and allows consumers to self-direct care as it pertains to supportive housing sevice needs. Consumers exiting the institution are part of the eligible population to be served under this Medicaid billing code.

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

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Footnotes:

Kansas Department on Aging and Disability Services is including County Jail Liaison in our agreements with our community mental health centers for the state fiscal year 2021 which begin July 1, 2020 and ends June 30, 2021.

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** [x] Methadone
- **b)** [ ] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [ ] Naltrexone (oral, IM)
- **f)** [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

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

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☐ Crisis Intervention Team/Law Enforcement
- **e)** ☐ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ Peer Support/Peer Bridgers
- **b)** ☐ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

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

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

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	◉ Yes ○ No
b)	Required peer accreditation or certification?	◉ Yes ○ No
c)	Block grant funding of recovery support services.	◉ Yes ○ No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	◉ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ◉ Yes ○ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Consumer-Run Organizations (CROs)
Kansas has built an infrastructure of Consumer-Run Organizations (CROs) to promote recovery through peer recovery supports to adult consumers or former consumers of mental health services, especially people with severe and persistent mental illness (SPMI). CROs are legally incorporated non-profit consumer governed and operated organizations using a peer recovery model built on self-direction, empowerment, peer support and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. Typically, a CRO provides an array of services to its' members that include leadership, education, training and research opportunities; one-on-one peer support, peer support groups, self-help groups, employment and housing support, life skills training, and health and wellness activities. CROs seek to provide a safe, healing and trauma-free environment, which enhances wellness and promotes resiliency. CROs act as bridge supports from state institutions to life in the community; and education about Medicaid and other community resources to connect members to services. Recovery oriented services typically include self-help groups, activities and resources to empower members to work, volunteer, attend school or further enrich their lives as members work towards recovery.

Three of the CROs are regional centers for CRO leadership and administration purposes. They are called Regional Recovery Resource CRO (RRRC). These RRRCs are dedicated Peer Support Specialists that offer resources, technical assistance and support development of recovery supports and peer support programs in communities and populations statewide. The RRRC provides support to build capacity within the other CROs in their Kansas regions as well as recovery supports in communities not having established a CRO or peer support group. The RRRC connects with Community Mental Health Centers for crisis prevention and intervention, the State Mental Health Hospitals to bridge supports prior to the consumer discharge, Homeless shelters to assist with a referral process, Police Departments to expand the CIT program, and Nursing Facility for Mental Health (NFMHs) to bring hope and recovery resources to the people they serve. KDADS funds 10 Consumer-Run Organizations (CROs) to provide nontraditional peer supports to consumers or former consumers of mental health services to support recovery and improve quality of life, such as helping people achieve employment, housing and greater social connectedness.

Supportive Housing Recovery Supports
In 2016 through the support of the Cooperative Agreement to Benefit Homeless Individuals (CABHI), the State of Kansas BHS Commission partnered with Sam Tsemberis to bring the Housing First Model to Kansas. Kansas continues to work on our internal statewide infrastructure to bring this training to scale across the State. In January of 2019, Sam Tsemberis came to Kansas to introduce Housing First to members of the Governor's Behavioral Health Policy Council and other community stakeholders, peers and families. Sam will be returning in September of 2019 to provide a statewide Housing First training to our Mental Health and SUD provider networks. In 2017 through the CABHI agreement, the BHS Commission began to partner with the HUD Continuum's of Care (COC's) and KDADS currently is partnered with the Kansas Statewide Homeless Coalition the Balance of State COC to provide information, education and HUD Housing related trainings to our Behavioral Health Services Provider Networks across Kansas.

In July of 2019, in partnership with Kansas Department of Health and Environment (KDHE), Kansas added a per-diem CPST Medicaid code to ensure that Medicaid-eligible consumers exiting institutions i.e., state hospitals, state and county correctional facilities, nursing facilities for mental health (NFMH) and ER's have immediate access to Housing Supportive Services to either sustain or obtain client housing using the Housing First Model. This Operation Community Integration Program per diem code is an integrative code that both SUD and MH providers can use to ensure that consumers have the Housing Supportive Services necessary to sustain independent living in the community and support the consumers through the transition process to full community integration. All consumers that are participants in this program must be connected to a Federal U.S. Department of Housing and Urban Development (HUD) Access Point to ensure that BHS consumers who are HUD eligible will have access to HUD Access Points, and Coordinated Entry. Consumers participating in this Medicaid code will have the ability to select recovery support services that they feel will help them be successful in community integration. Programs/Supportive Services included in the (OCI) Recovery Support Services array include; SAMHSA's Cognitive Behavioral therapy Intervention work book, Medication-Assisted Treatment (MAT), Housing First Support Services, IPS Supported Employment, SOAR/Entitlement Benefits Counseling (referral to a C-WICK), Mobile Crisis Response, CIT Interventions.

IPS Supported Employment (Enhancing Supported Employment in Kansas-ESEK) and the Employment First Act
Kansas was one of the first states in the United States to sign into law the Employment First Act. In 2014 the State was awarded a Federal Cooperative Agreement from SAMHSA to expand our state infrastructure for IPS Supported Employment. Over 5 years through two-evaluation sites, Kansas is strengthening and enhancing services and supports to promote employment as a part of

recovery and towards economic self-sufficiency for employment age youth and adults with mental health needs. The ESEK Federal Award was essential to our state and will allow us to strengthen, enhance and sustain an evidence-based participant guided and empowering approach for addressing the employment needs and desires for youth and adults with SMI. More than 3,000 youth and adults will have been impacted and introduced to IPS Supported Employment. Through a Technical Assistance award funded by SAMHSA under the ESEK Cooperative Agreement, the State of Kansas has contacted with the National Council for Behavioral Health to look at developing a statewide Center for Excellence and a State of Kansas Resource Center for Evidence Based Practices to ensure that our provider networks have access to the most recent evidenced-based and promising practice programs that will assist our consumers down their individual path of recovery. Our first consulting meeting took place in July of 2019 and we will meet on a monthly basis until September 20th, 2019. The Governors Behavioral Health Policy Council has given permission for KDADS to create a sub-committee group specific to Evidence-Based Practices, to ensure that consumers, families, stakeholders and our providers all have input into the selection of EBP programming within the State of Kansas. In 2019 as part of an 1115 demonstration waiver for KANCARE 2.0, the State of Kansas will be introducing an Employment Program for consumers with Behavioral Health diagnosis, consumers on the HCBS waivers and consumers who would like to return and/or enter the workforce.

Social Security Outreach Access and Recovery (SOAR)
Consumers exiting state hospital and state correctional facilities now have access to a SOAR/Benefits Specialist to assist them with transition into the community. In 2017, the Kansas Department for Aging and Disability Services (KDADS) partnered with the State Medicaid Agency (KDHE) to ensure that federally disabled consumers who had become disconnected from their benefit could be reconnected to both the Social Security Administration (SSA) and Medicaid with assistance from a SOAR staff. State of Kansas Hospital Staff are also participating in the Social Security Administrations TI Benefit Program to ensure that consumers who are hospitalized because of an illness who may be at risk of homelessness can work with the Social Security Administration under the TI program to request that SSA benefits remain active to avoid homelessness, evictions etc. which we believe will decrease some of our housing issues in Kansas. Consumers who participate in this program can now have their Medicaid placed into suspension status instead of being shut off when they enter the State Hospitals allowing consumers to access medications and services on the day of discharge. The Kansas Department of Corrections and Kansas Department for Aging and Disability Services have memorandums of understanding (MOU's) with the Social Security Administration to ensure that consumers exiting institutions can be reconnected to benefits to ensure that federally disabled consumers have access to services on the day of discharge/release.

The State of Kansas continues to grow our SOAR program within our provider networks and HUD Continuum of Care locations in Kansas. We have increased the number of SOAR Certified Staff within the state and in fiscal year 2018-2019 we doubled our SOAR staff across the State. We have partnered with Kansas Statewide Homeless Coalition and 2019 will be a year of crossover training with our COC's and BH provider systems. We hope to have a SOAR point of contact at each provider agency or within each HUD COC so that our Homeless or At-Risk of Homelessness population have an advocate across the Social Security Systems and can have access to recovery-oriented programs such as Ticket to Work, PACE, and the SSA Trial Work Period.

System of Care (SOC)

The SAMHSA Center for Substance Abuse Treatment and Mental Health Services awarded KDADS the Cooperative Agreement for the Kansas' Systems of Care for Mental Health Services to Children and Their Families (Kansas SOC) to create, expand, and sustain a trauma-informed, family-driven and youth-guided approach for addressing the needs of children and youth with SEDs and their families annually. Kansas' SOC is a partnership including: KDADS, Wichita State University, and four local jurisdictions/Community Mental Health Centers including: Compass Behavioral Health, South Central Mental Health Counseling, Center, Inc., Sumner County Mental Health Center and Wyandot Center for Community Behavioral Health. Kansas SOC's CMHCs will provide quality, best practice oriented, trauma informed, mental health services with cultural and linguistic competence. Services are provided within the family's community recognizing that youth and families do better when they're in a familiar, supportive environment. The partners involved in each child's plan of care provide services that are wrapped around the youth for success in the community and home. Juvenile justice, education, primary care, substance use, mental health and child placement agencies are consulted as part of the treatment team for the youth, thereby ensuring that the youth are served by the systems they are part of, and the key service of care coordination gives the youth the best avenue of success in the community.

Kansas SOC supports the wide scale operation, expansion and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (CMHI). This will build upon progress made in developing comprehensive SOC across the county by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure and the development and implementation of evidence-based and evidence-informed services and supports. Other activities supported will include the implementation of systemic changes, training and workforce development, and cultural and linguistic competencies.

Since being awarded the Kansas SOC the centers identified have been very creative in their approaches to the needs of the SOC for their geographical areas. There have been many memos of understanding (MOU) establish with other child serving agencies within the state, local agencies including Juvenile Justice, Department for Children and Families (DCF), local courts, academic centers and other entities. Kansas continues to identify areas of improvement and in doing so has implemented and/or enhanced establishing new coordination and cooperation in providing services throughout the state.

As part of the expansion efforts in 2019 the System of Care partners held a summit which included: MCO, CMHCs, parents,

children and other state stakeholders within the System of Care. The focus of the summit was to bring about changes within the system that provides services to children with SED. The primary focus was on how to expand the System of Care and make it a universal system across all of Kansas. In addition, the diversified Kansas SOC Advisory Council will work on State level programmatic and financial policy changes as needed.

KanCare
KDHE, a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waivers. Mental health and substance use services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. The KanCare 2.0 goals include helping Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health, in addition to, traditional Medicaid benefits.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The SAMHSA definition of recovery is commonly accepted in practice by KDADS and those who received Mental Health Services (MHS) and/or Substance Abuse Treatment (SAT) Block Grant funding. Peer Mentoring services are provided as both MHS and SAT services. Persons who are self-identified as having lived experience and who have established recovery may complete a state approved training process and apply for certification. Additionally, our state recognizes that a large number of our peer mentors have, at some point in time, come in contact with our state correctional system. In response to this correlation, we are currently working with the Kansas Department of Corrections (KDOC) to increase learning opportunities for our mentors that focus on criminal thinking. Kansas is fortunate to have 126 Oxford Houses that operate under the “Oxford House Model”, a community-based approach to addiction treatment, which provides an independent, supportive, and sober living environment.

5. Does the state have any activities that it would like to highlight?

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

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes	○ No
Home and community based services.	○ Yes	○ No
Peer support services.	○ Yes	○ No
Employment services.	○ Yes	○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes (●) No

b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes (●) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The SAMHSA Center for Substance Abuse Treatment and Mental Health Services awarded KDADS the Cooperative Agreement for the Kansas' Systems of Care for Mental Health Services to Children and Their Families (Kansas SOC) to create, expand, and sustain a trauma-informed, family-driven and youth-guided approach for addressing the needs of children and youth with SEDs and their families annually. Kansas' SOC is a partnership including: KDADS, Wichita State University, and four local jurisdictions/Community Mental Health Centers including: Compass Behavioral Health, South Central Mental Health Counseling, Center, Inc., Sumner County Mental Health Center and Wyandot Center for Community Behavioral Health. Kansas SOC's CMHCs will provide quality, best practice oriented, trauma informed, mental health services with cultural and linguistic competence. Services are provided within the family's community recognizing that youth and families do better when they're in a familiar, supportive environment. The partners involved in each child's plan of care provide services that are wrapped around the youth for success in the community and home. Juvenile justice, education, primary care, substance use, mental health and child placement agencies are consulted as part of the treatment team for the youth, thereby ensuring that the youth are served by the systems they are part of, and the key service of care coordination gives the youth the best avenue of success in the community.

Since being awarded the Kansas SOC the centers identified have been very creative in their approaches to the needs of the SOC for their geographical areas. There have been many memos of understanding (MOU) establish with other child serving agencies within the state, local agencies including Juvenile Justice, Department for Children and Families (DCF), local courts, academic

centers and other entities. Kansas continues to identify areas of improvement and in doing so has implemented and/or enhanced establishing new coordination and cooperation in providing services throughout the state.

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

The Governor's Behavioral Health Planning Council and the Children's Subcommittee provide oversight and guidance to the child serving agencies to ensure that improvements are being evaluated and implemented as they are recommended.

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

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

Kansas has made progress toward a more statewide collaborative approach to suicide prevention efforts by partnering with other state agencies such as the Kansas Attorney General's Office, Kansas Dept. of Education and Kansas Dept. for Health & Environment. In collaboration with these agencies and other professionals, KDADS has initiated steps to revise and update the state suicide plan. Many Kansas communities have formal initiatives toward suicide prevention awareness and education such as media campaigns, educational opportunities and training events. Kansas has been involved in the SAMHSA and VA Suicide Prevention Governor's Challenge and Mayor's Challenge for service members, veterans, and families. Kansas professionals, researchers, advocates and consumers continue to improve the understanding of suicide prevention in Kansas. KDADS has increased communication to and with local level suicide prevention coalitions, enhanced partnerships, and enhanced data collection by adding depression and suicide questions to our youth survey which is given annually. These important changes will lead to a more coordinated approach to suicide prevention in the future.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

While no formal statewide strategies have been implemented, Kansas has placed a greater emphasis on suicide prevention with focusing on collaboration among state agencies, raising awareness and increasing resources to rural counties in our state. Significant progress has been made by collaborating with Kansas Dept of Health & Environment, Kansas Dept for Education, Kansas Dept for Children and Families, Kansas Attorney General's Office, and the Kansas Suicide Prevention Resource Center on suicide prevention efforts with the creation of the Empowering Youth & Preventing Suicide Workgroup. Kansas recently collaborated with our state crisis call center on a State Capacity Building Grant that will support increasing our call answer rate and enhance long-term state support for the call center.

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

It would be helpful to have technical assistance in how to integrate suicide prevention and mental health with substance use on the community level.

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

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Regarding Question #1 above, the State did begin partnering with the Kansas Law Enforcement Training Center (KLETC) for Crisis Intervention Training (CIT). The Behavioral Health Services Commission and the Governor's Behavioral Health Services Planning Council have provided grant funding to CIT and veteran's programs. This funding created a new employment position and the ability to train hundreds of law enforcement professionals in the state of Kansas on Crisis Intervention and Veteran Programs Training. Through this grant, KDADS has partnered with the Kansas Law Enforcement Training Center (KLETC) located in Hutchison, KS. KLETC provides the curriculum and classroom presenters, student room and board, snacks and finally a 40-hour certificate and CIT pin for their uniform. In FY19, we have trained over180 personnel stretching over 19 counties with a focus on the rural and frontier areas with little resources.

Regarding question #2, the last Behavioral Health workforce study in Kansas is dated. Therefore, KDADS in partnership with Wichita State University, will be conducting another study in FY2019. Based upon the results of the study, new partnerships may need to be formed.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

Governor's Behavioral Health Services Planning Council
In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private

citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Supportive Employment and Vocational Services and 8) Veterans.

Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. State staff on the Council and in the subcommittees represent a variety of state agencies such as the Kansas Department of Corrections, Kansas Department for Children and Families, Kansas Department of Health and Environment, Kansas State Hospitals, and Kansas Rehabilitation Services. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

Children's Subcommittee
The Children's Subcommittee is dedicated to maintaining the community-based family-driven values of the Kansas children's public mental health system of care. The subcommittee makes recommendations to improve the Kansas public mental health system and ensure the needs of children and families are met. In the subcommittee's 2017 – 2018 annual report, there are four goals with recommendations related to identifying a process for the Children's subcommittee to link/communicate well with other subcommittees, making recommendations regarding caregiver, parent, and family engagement in navigating behavioral health systems, defining/describing the Kansas children's continuum of care, and identifying and describing the data elements that the children's subcommittee wants in an integrated data system.

KDADS Contracts
KDADS contracts to provide services for children to ensure they are able to access appropriate educational resources such as special education and related services. These partners provide guidance to families and individuals in accessing appropriate services for mental health and treatment in the community, home and education environments. In addition, parents and youth are offered information education and training with multi-media operations (print, electronic transfer, phone) to learn how to better navigate the education system. These services are offered for both grade school and college level youth. They provide training to educators as well on mental health, substance use prevention and other behavioral health supports and services that may assist in the education process.

State Agency Collaboration
Kansas recently elected a new governor. Governor Laura Kelly became the 48th governor of the State of Kansas in January of 2019. Under our new governor, Laura Howard was appointed the new Secretary for the Kansas Department for Children and Families (DCF) and the Kansas Department for Aging and Disability Services (KDADS). KDADS partners with DCF on initiatives such as the Families First legislation which will allow the Kansas Department for Children and Families to fund evidence-based programs that develop parenting skills or treat mental illness or substance abuse.

KDHE, a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waiver programs: Autism, Frail Elderly, Intellectual/Developmentally Disabled (I/DD), Physical Disability, Serious Emotional Disturbance, Technology Assisted, and Brain Injury. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance use disorder, as well as, operates the state hospitals and institutions.

Health Homes
The Health Homes program for Kansas (called "OneCare Kansas") stems from a Legislative Proviso to reinstate Health Home services in Kansas. OneCare Kansas will provide coordination of physical and behavioral health care with long term services and supports for people in KanCare with chronic conditions. OneCare Kansas is intended for people with certain chronic conditions, like diabetes, asthma, or mental illness. They can be members who also receive Medicare along with Medicaid. One Care will be an opt -in program. The target populations are being determined. KDADS staff are part of the OneCare planning council and project team to develop the OneCare program. The project team will jointly consult with SAMHSA in development of the program.

KDADS also has several partnerships and agreements with other state agencies. An example is an agreement with the Kansas Department of Revenue/Alcoholic Beverage Control in efforts to reduce tobacco use by youth and maintain compliance rates for Synar. Other examples include partnering with the Kansas Department of Corrections on several projects to address the behavioral health needs in corrections services.

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

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council
The Prevention Subcommittee serves as a subcommittee of the Governor's Behavioral Health Services Planning Council. According to the Prevention Subcommittee's Charter, the Prevention Sub-Committee was established in an effort to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes, and to increase the effectiveness of State and local efforts to address prevention issues. The Prevention Sub-Committee will serve as the Advisory Council for Kansas Behavioral Health Prevention Initiatives.

This group will serve as a broad, representative voice for behavioral health as it relates to prevention of a range of health and behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder prevention. The Strategic Prevention Framework (SFP) will be used as a guiding mechanism for the work associated with this charter. The SPF is comprised of five distinct phases: assessment, capacity building, planning, implementation, and evaluation. A primary mandate for the Subcommittee is to provide feedback and guidance to the Governor's Behavioral Health Services Planning Council related to KDADS BHS prevention initiatives.

Kansas Citizen's Committee on Alcohol and Other Drugs (KCC)
The Kansas Citizen's Committee on Alcohol and Other Drugs (KCC) is an advisory committee to the Secretary of the Kansas Department for Aging and Disability Services (KDADS) and also serves as a subcommittee of the Governor's Behavioral Health Services Planning Council. The KCC has been in existence for many years and is statutorily required. K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A's 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

The values of the GBHSPC is prevention, treatment, and recovery services:
• Allow people to direct their care and treatment;
• Are respectful and empowering;
• Are effective and influenced by evidence-based practices that lead to a personal process of recovery and resilience; and
• Are integrated, flexible, and accessible.

There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Supportive Employment and Vocational Services and 8) Veterans.

Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees. The Subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as the Secretaries of relevant state agencies. The subcommittees reviewed draft sections of the FFY 2020-2021 Behavioral Health Assessment and Plan and provided written feedback to the State.

The GBHSPC has approved forming three new subcommittees for Problem Gambling, Aging, and Evidence-Based Practices.

Subcommittee Reports and Recommendations
The GBHSPC's annual subcommittee's charter, bylaws and reports can be found on the KDADS website at this link: https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc. For more information, please click on the embedded subcommittee links to expand.

Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC)
The Kansas Citizen's Committee on Alcohol and Other Drugs has been in existence for many years and is statutorily required. K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A's 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas. The Kansas Citizen's Committee Subcommittee Report for 2018 highlights several specific recommendations and action steps related to Increased Funding, Improved Access and Service Integration, the Workforce Crisis, and Prevention.

Children's subcommittee
The Children's Subcommittee is dedicated to maintaining the community-based family driven values of the Kansas children's public mental health system of care. The subcommittee makes recommendations to improve the Kansas public mental health system and ensure the needs of children and families are met. In the subcommittee's 2017 – 2018 annual report, there are four goals with recommendations related to identifying a process for the Children's subcommittee to link/communicate well with other subcommittees, making recommendations regarding caregiver, parent, and family engagement in navigating behavioral health systems, defining/describing the Kansas children's continuum of care, and identifying and describing the data elements that the children's subcommittee wants in an integrated data system.

Housing and Homelessness subcommittee (HHS)
The Housing and Homelessness Subcommittee (HHS) focuses on helping adults experiencing severe and persistent mental illness and children diagnosed with severe emotional disturbance and their families obtain and maintain safe, decent, affordable, and permanent housing. The HHS acts as the body in Kansas who offers guidance and recommendations to the Governor's Behavioral Health Services Planning Council and to KDADS, so they can effectively exercise leadership in this arena. The subcommittee recommendations for FY19 are that the subcommittee will work with KDADS to coordinate the Subcommittee's goals and strategies with the Kansas Interagency Council on Homelessness, the subcommittee will explore options for a centralized data system within the housing and homelessness field that other State and local entities have access to for finding housing and services for our shared customers, and the subcommittee will ask the three Managed Care Organizations to recommend someone

from their respective organizations to serve on the subcommittee with the intent to explore Evidence-Based Practices and/or Promising Practices that support the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders.

Justice Involved Youth and Adult subcommittee
The Governor's Behavioral Health Services Planning Council's Justice Involved Youth and Adult Subcommittee is a group of stakeholders and forensic professionals charged with examining pertinent issues in Kansas as they pertain to the justice involved population. The Justice Involved Youth and Adult Subcommittee prioritizes its goals and activities around transforming mental health policies, programs, and funding that address jail diversion, access to timely and appropriate services while incarcerated, and reentry. The subcommittee recommendations for 2017 include engaging community partners and related to creating an adult continuum of care subcommittee.

Supportive Employment and Vocational Services subcommittee
The Vocational Subcommittee evaluates outcomes to discover areas in which the system is doing well and where it can improve. It also makes recommendations on where to focus funding for vocational programs. In the subcommittee's 2017 report, subcommittee recommendations relate to the following goals for 2017 and 2018: recommend that the State use their KanCare 2.0 renewal application to implement a 1915(i)-"like" waiver to provide employment supports and other services for individuals with behavioral health issues; Mental Health Centers will use available resources to support getting consumers to work; the IPS Supported Employment model is the model of choice for the Kansas mental health system and should be made available at every Community Mental Health Center; Training and collaboration opportunities will be available across the state, to address areas of consistency of services and proper mental health and vocational rehabilitation training for all providers of supported employment services, and Increase engagement of stakeholders, consumers, families and employers.

Rural and Frontier Subcommittee
The Rural & Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, [the committee] assures accessibility/availability of mental health services in frontier/rural Kansas counties. The vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in mental health services. Rural issues are often misunderstood, minimized and not considered when forming mental health policy. In the Committee's 2018 annual report, FY2018 goals and recommendations include: statewide adoption of KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order, strengthening continuum of care in rural/frontier areas, and continuing to diversify subcommittee membership to ensure that needs and resources are considered both within and alongside the behavioral health system.

Veterans subcommittee
The Veterans subcommittee's mission is to ensure that veterans, service members and their families are involved in developing recommendations to improve access to behavioral health services which are relevant to military culture in collaboration with key provider organizations and other stakeholders.

According to the history section of the 2018 Veteran's subcommittee annual report, this subcommittee reactivated in June of 2017. The state was divided into five regions with a designated mental health facility as the lead in that region. The plan of the subcommittee was to identify members in those five regions to help accomplish their goals. Many of the subcommittee members received training from SAMSHA technical assistance program for strategic planning in September 2017. From that training the committee established goals to identify quality resources for veterans, their families and children across the state. this subcommittee was comprised of the chair, co-chair and 16 members from across the state. Goals for 2018 include: Identifying quality resources for veterans and their families; initiating digital outreach for veteran and family services using Facebook, Twitter, etc.; engaging veteran service organizations across the state such as VFW posts and American Legions; identifying current available courses that train providers in military culture; expanding the three-day crisis intervention training across the state for police/first responders concerning veterans in a mental health crisis, and communicating/partnering with the State of Kansas Department of Veterans Affairs.

SAMHSA technical assistance personnel came to Topeka for the Mayor's Challenge Site visit on August 30th and 31st [2018] to provide attendees training to identify other key players, set goals and objectives, implement strategies, identify other agencies to partner with etc. The training had representatives from the Topeka Police Department, Valeo, VA Eastern Kansas, State of Kansas, City of Topeka HR and Municipal Court and the Shawnee County Suicide Prevention Coalition. Once the Topeka Coalition is established the goal will be to expand this prevention/education effort to other cities in the state.

Prevention subcommittee
According to the Prevention Subcommittee's Charter, the Prevention Sub-Committee was established in an effort to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes, and to increase the effectiveness of State and local efforts to address prevention issues. The Prevention Sub-Committee will serve as the Advisory Council for Kansas Behavioral Health Prevention Initiatives.

This group will serve as a broad, representative voice for behavioral health as it relates to prevention of a range of health and

behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder prevention. The Strategic Prevention Framework (SFP) will be used as a guiding mechanism for the work associated with this charter. The SPF is comprised of five distinct phases: assessment, capacity building, planning, implementation, and evaluation.

With a primary mandate to provide feedback and guidance to the Governor's Behavioral Health Services Planning Council related to KDADS BHS prevention initiatives, this workgroup also is responsible for the following key roles and responsibilities:
• Develop a statewide plan to address behavioral health prevention
• Guidance, research and recommendations relating to prevention across the lifespan
• Feedback on Substance Abuse Prevention and Treatment (SAPT) Block Grant prevention initiatives
• Feedback on Kansas behavioral health prevention initiatives including suicide prevention, problem gambling prevention and substance abuse prevention
Feedback related to strategic initiatives at the State level to infuse prevention efforts across the Institute of Medicine (IOM) continuum of care, integrating lifespan and developmentally-appropriate strategies into current prevention processes and supports.
• Guidance and feedback related to behavioral/mental health promotion and shared risk and protective factors. This could include Adverse Childhood Experiences (ACE's), evidence-based strategies, needs identified through assessment, outcomes of recent strategies, and relevant research.
FY18 recommendations include: improve shared access to data resources among state agencies and planning council subcommittees, better coordinating efforts and care transitions of behavioral health services, forming an evidence-based practices workgroup (EBW) for behavioral health promotion, and allocating resources to prioritized areas of need through data-driven decision making. The Suicide Prevention Subcommittee became a workgroup of the Prevention subcommittee in 2017.

SAMHSA was onsite in May 2018 for a 10-year comprehensive onsite review. The SAMHSA Lead on the Review indicated onsite that Kansas has one of the best Planning councils in the country.

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

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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

Footnotes:

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404

Kansas
Governor's Behavioral Health Services Planning Council

www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Ric Dalke, Vice Chairperson

Laura Kelly, Governor

August 20, 2019

To Whom It May Concern,

The Kansas Governor's Behavioral Health Service Planning Council (GBHSPC) has continued to focus on ensuring that Behavioral Health Services are integrated and meet the needs of Kansas children, adults, and their families who are experiencing mental health, addictions, and co-occurring disorders. The Council is made up of a cross section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens.

GBHSPC members continue to participate in subcommittees and task forces. Currently, the GBHSPC has eight active subcommittees. The subcommittees are: Housing and Homelessness, Justice Involved Youth and Adults, Supportive Employment and Vocational Services, Prevention, Children's, Rural and Frontier, Veterans, and the Kansas Citizen's Committee on Alcohol and Drugs (KCC). The KCC is a unique subcommittee in that it is established under its own Kansas statute with the purpose to review the substance use disorders service system in Kansas and advise the Secretary on issues and needs for services.

The Council recently has also approved forming additional subcommittees for Aging, Problem Gambling and Evidence-Based Practices (EBPs). The new EBPs subcommittee will provide a much-needed role to the Kansas Behavioral Health infrastructure in leveraging the content experts from the all the subcommittees on making recommendations for selected EBPs. The EBP subcommittee will advise the Secretary on funding and training recommendations, as well as, guidance on fidelity measures.

The GBHSPC continues to serve the Secretary and the Governor by organizing and participating in special task forces and has been active in participation in the Governor's current taskforce on mental health services.

This letter is confirmation that the Kansas FY2020-2021 Behavioral Health Assessment and Plan has been drafted collaboratively with the GBHSPC and subcommittees. The Behavioral Health Assessment and Plan has been reviewed and approved by the Kansas Governor's Behavioral Health Service Planning Council (GBHSPC).

Sincerely,

Sherman Wes Cole
Chair, Governor's Behavioral Health Services Planning Council

Governor's Behavioral Health Services Planning Council
Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC)
Annual Report, 2018

Presented to:
Wes Cole, Chairperson, Governor's Behavioral Health Services Planning Council
Tim Keck, Secretary, Kansas Department of Aging and Disability Services
Sam Brownback, Governor

Purpose: K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A's 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas.

Vision: Kansas is a community where people are free from the adverse effects of substance use disorders, mental illness, and other behavioral health disorders.

Mission: To empower healthy change in people's lives through quality services that address the treatment, prevention and recovery from substance use disorders, problem gambling, mental illness, and other behavioral health disorders.

Current Membership:

Member	Representing
Krista Machado, Chair Elect	Prevention
Mollie Thompson	Prevention
Dana Schwartz	Prevention
Daniel Warren	Treatment
Shane Hudson, Past Chair	Treatment
Sara Jackson	Treatment
Jennifer Foster	Citizens
Al Dorsey	Citizens
Nancy Jo Kepple, Recorder	Citizens
Christopher Lund	Citizens
Toni Ragland	Citizens
Lane Mangels	Law Enforcement
Fan Xioin	Public Health
Victor Fitz	GBHSPC Liaison
Kayla Waters, Chair	Higher Education
Bill Persinger	Mental Health
Maren Turner	Aging
Tina Abney	Child Protective Services
Peggy Cecil	Discretionary
Diana Marsh	KDADS/KCC Support Staff

As an advisory council on addiction prevention and treatment in Kansas, we urge you to recognize the benefits, both humanitarian and pragmatic, of effective statewide addiction counseling services:

- Effective prevention and treatment saves lives, and allows for improved quality of lives for individuals, families, and communities.
- Effective prevention and treatment is financially responsible in that it offsets higher costs associated with associated family trauma, policing, incarceration, lost productivity, morbidity, and mortality.
- Effective prevention and treatment services the public safety of Kansans, by reducing rates of assaults, accidents, abuse, crime, and suicide.

As in previous years, the most critical needs of the Addiction Counseling field relate to funding, service accessibility and integration, workforce crisis, and prevention.

Increased funding is necessary to support effective addiction services**.** Kansas has well-established prevention, treatment, and professional training programs. With recent improvements in professionalization and program monitoring, the field of addiction counseling in Kansas is adopting more effective, evidence-supported practices that effectively reduce the harm and costs of addiction. These programs need financial support to fully implement their effective practices. We recommend:

- **Facilitate Pursuit of Grant Funding:** There are various opportunities to procure national funds to address substance use disorders; for example the national spotlight on opioid use problems is generating grant opportunities, and other opioid use problems. We recommend creating a new state-level grant-support position to work directly with agencies to help *secure and maintain* these opioid-related funds as well as other addictions prevention and treatment grants. At present, agencies are not in a position to fully take advantage of national grant opportunities. The workforce crisis means that they are already struggling to keep up with the standard workload. Furthermore, many agencies simply won't have staff with the skillset necessary to pursue and monitor large grants. A state-level coordinator could provide the grant-specific expertise, allowing agency directors and staff to focus on their own professional strengths in service provision. This coordinator should be charged with promoting collaboration across agencies and professions in to develop initiatives that align with various federal funding opportunities.
- We are pleased that a portion of the Problem Gambling and Other Addictions Fund is being devoted to treatment. We recommend that the state continues to incrementally increase the proportion of this money that is applied to treatment over the next several years until the full fund is being applied as intended.

Improved Access and Service Integration will reduce the cost and strain associated with waiting until problems are more severe (or more severely impact medical health, legal status, and family wellness) before beginning treatment:

- Currently, Addictions Counseling agencies are not allowed to provide mental health treatment for clients with co-occurring disorders *even when* they have the professional capacity to do so (e.g. professional staff with the appropriate license to treat co-occurring issues). This results in wasteful, redundant, piecemeal services for clients. We recommend allowing Addiction

Counseling agencies to become approved providers **for co-occurring issues** providing they have the appropriate resources to do so. This expansion of services should *only* apply to addiction counseling clients with co-occurring issues, not to general mental health clientele.

- Support Medicaid expansion for substance use disorder and mental health services, and ensure that existing and future health plans include coverage for behavioral health services.
- Support a global payment model that would allow providers to determine appropriate care and use the full contingent of trained addiction services providers for each patient within per-member-per-month funds
- Support telehealth initiatives to improve access for all Kansans to quality services. Building this infrastructure now will pay off as the population ages and faces physical limitations in accessing standard treatment.
- Update Senate Bill 123 practices to include current evidence based practices into existing programs.
- Continue the Institution for Mental Disease (IMD) exclusion waiver for residential Substance Use Disorder treatment facilities in Kansas. This waiver allows for more than 16 treatment beds for Medicaid patients aged 21-64. Many residential Substance Use Disorder treatment facilities in Kansas currently have more than 16 beds and are often at capacity.
- Adopt coding practices that allow for the integration of CMHC, Primary Care, and Behavioral Health services to reduce the waste and gaps in service.

The **Workforce Crisis** in Kansas and across the nation, insufficient staffing is resulting in poorer services, increased professional burnout, and administrative strain. Kansas agencies are using effective approaches to prevention and treatment, but doing so requires adequately trained staff with manageable workloads:

- Support initiatives that provide tuition reimbursement for addictions counselors equal to that provided to other behavioral health professionals.
- As recommended above, support better funding for agencies so that they may provide compensation and benefits sufficient to encourage prospective professionals to seek training and licensure.

Prevention is ultimately the most humanitarian and practical approach to addiction problems.

- Work to publicize the availability of prevention tools that may be used by community groups, schools, and families at www.kansaspreventioncollaborative.org.

- Barrier: Even when agency staff are available for procuring grants, they do not have access to the data that national funding agencies require on grant applications. Two specific policies make Kansas uniquely deficient in this regard.
    - Recommendation: Address the following policies so that agencies may make better, data-based decisions and compete for national resources:
        - Reverse the Active Consent policy that currently requires active parent consent on the Kansas Communities that Care Student Survey. At this point the sample of student responses is so skewed that the data are not able to be used for meaningful decision making.

- Review the KDADS policy that does not allow Beacon Health Options to give county specific data to providers. Explore options to report county data about substance use, treatment access, and outcomes to agencies in order to aid in strategizing local and state response to addiction.

In **conclusion,** we appreciate your commitment to Kansas and we hope you find this report useful.

Governor's Behavioral Health Services Planning Council

Subcommittee on Housing and Homelessness

2018 Annual Report

September 2018

Presented to:
Wes Cole, Chairperson, Governor's Behavioral Health Services Planning Council
Secretary Tim Keck, Kansas Department for Aging and Disability Services
Jeff Colyer, Governor of Kansas

Mission

Our mission is to promote the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders. We will fulfill our mission through assertive and strategic partnerships with local communities, housing developers, lenders and Federal and State agencies.

Vision

Our vision is that all Kansans experiencing a severe and persistent mental illness, Serious emotional disturbance and/or co-occurring disorders have access to safe, decent, affordable, and permanent housing.

Introduction

The Governor's Behavioral Health Services Planning Council (GBHSPC) formed the Subcommittee on Housing and Homelessness (SHH) in 2001 as a result of advocacy efforts of homeless service providers and consumers who experience mental illness. The Subcommittee is charged with researching and offering recommendations to the GBHSPC regarding housing and homelessness issues experienced by adults diagnosed with severe and persistent mental illness, and by children diagnosed with severe emotional disturbance and their families.

Membership

MEMBER	AGENCY/AFFILIATION	AREA REPRESENTED	POPULATION DENSITY*
Al Dorsey	Kansas Housing Resources Corporation	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Amber Giron	United Health Care	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Brianna Frits	Veteran Administration	Northeastern Kansas	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Christy McMurphy Chair	Kim Wilson Housing, Inc., Wyandot Inc.	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Doug Wallace	Kansas Housing Resources Corporation	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Elizabeth Worth Vice-Chair	Johnson County Mental Health Center	Johnson County	Urban
Jason Hess	Heartland Regional Alcohol Drug Assessment Center (HRADAC)	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Maggie Flanders	COMCARE of Sedgwick County	Sedgwick County	Urban
Nate Miller	Southwest Guidance Center	Seward, Stevens, Meade, and Haskell Counties	Semi-Urban, Densely-Settled Rural, Rural, Frontier
Sarah Barnhart	Kansas Department of Corrections	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Stephanie Cline	South Central Kansas Mental Health Association	Sedgwick County	Urban
Theresa Douthart	Valeo Behavioral Health Care	Shawnee County	Urban
Victor Fitz	Substance Abuse Center of Kansas	Sedgwick County	Urban
Melissa Bogart-Starkey	Kansas Department for Aging & Disability Services, Behavioral Health Services Subcommittee Staff Support		

***Defined by Kansas Department of Health & Environment**

List of Outstanding Accomplishments/Milestones Achieved During FY 2018

1. Several members of the GBHSPC's Subcommittee on Housing and Homelessness participated in Kansas Department for Aging and Disability Services workgroup to develop a pilot project that would accomplish these objectives: 1. coordinate with existing housing programs and subsidies through HUD's Continua of Care; 2. offer evidence-based interventions that will provide the right care at the right time; 3. use the Housing First Model in which participants are connected to housing and housing supports immediately, regardless of their current stage of recovery. The workgroup began working early January 2018 and presented its final recommendations to the Secretary of KDADS on March 16th.

2. Continuum of Care (CoC) communities of Johnson County, Wichita/Sedgwick County, Topeka/Shawnee County and the Balance of State (100 counties) were awarded $7,835,720 in FY2018. Wyandotte County/Kansas City (part of the Greater Kansas City CoC) was awarded $1,212,087 in FY2018. The Continua of Care committees cover the entire state and are focused on increasing the number of housing and service options for our most vulnerable citizens who are homeless. Sixty-nine percent of the Subcommittee on Housing and Homelessness members are actively involved in at least one Continuum of Care community. The Subcommittee's statewide representatives are also involved in either a supporting and/or funding role.

3. SSI/SSDI Outreach, Access and Recovery (SOAR) is a SAMHSA endorsed best practice that was originally created to increase access to SSI/SSDI for eligible adults experiencing homelessness. Since 2009, SOAR has been adopted and implemented by many CMHCS and other community partners across Kansas. In 2016, Kansas was ranked as one of the "Top 10" SOAR states by the National SOAR Technical Assistance Center. The Subcommittee applauds KDADS' efforts to expand SOAR to more agencies across Kansas, especially those in rural communities. Additionally, through the work of KDADS, SOAR trained workers are now helping people in both State Mental Health Hospitals and the correction system apply for SSI / SSDI. In Kansas the highest number of submissions is for initial or new SSI cases. Many of these new SSI cases are for people who lost their SSI benefits due to being placed in an institution. KDADS and KDHE have collaborated to ensure people discharging from these institutions are connected or reconnected to benefits.

   As new communities and new providers have implemented SOAR, the cumulative approval rate for SOAR cases has declined over the last couple of years; however, Kansas' approval rate continues to be well above the national average. According to the 2017 SOAR Outcome Data, Kansas SOAR workers received 1,218 decisions on initial

applications with 864 approvals or an approval rate of 71%. Nationally, the average cumulative approval rate on initial applications is 64%. The Kansas SOAR Program continues to demonstrate effectiveness with helping eligible adults experiencing homelessness gain financial stability.

4. Kansas Interagency Council on Homelessness (KICH) was reorganized and reconvened in 2016 and upon KDADS' direction is now a sub-workgroup of the GBHSPC's Homelessness and Housing Subcommittee. The group is charged with reviewing and updating the State of Kansas' strategic plan to prevent and end homelessness. KDADS and Kansas Housing Resources Corporation plans to develop a long-term leadership

5. The Cooperative Agreement to Benefit Homeless Individuals (CABHI) Kansas is completing the final year of implementation and will end in September 2018. The CABHI-Kansas Project introduced an integrated team approach to serving eligible consumers. The integrated services offered at the CABHI sites include case management, substance use disorder assessment and referral services, supported employment and housing assistance. The CABHI teams utilized evidence-based practices, such as IPS Supported Employment and housing assistance following the Housing First Model, to deliver services proven to be effective. The lessons learned from the three-year CABHI project will be used as a model for other KDADS programs. Two specific strategies that will be recommended to other programs is the integrated service approach for serving disabled adults and the Housing First Model with housing. In 2017, KDADS brought in Sam Tsemberis to provide a Housing First Training to several staff from the community mental health centers, including staff working with the PATH, CABHI, and Supported Employment projects. A representative from the Community Action network was also invited to attend the training. KHRC and KDADS collaborated to remove housing barriers for one CABHI site. Sam Tsemberis is scheduled to return to Kansas in October 2018 to provide a second training on the Housing First Model. Building on the success of the integrated CABHI teams, KDADS plans to invite all SUD service providers to this second training. During the three-year CABHI Project, KDADS worked with community partners to enhance the infrastructure in Kansas to make safe and affordable housing available. Results of these efforts can be seen in the coordination of the Kansas Interagency Council on Homelessness and the expansion of SOAR in the state mental health hospitals.

6. Developing a training curriculum for Housing Specialists has become an ongoing topic for the members of the Kansas Interagency Council on Homelessness (KICH) and the members of the Subcommittee on Housing and Homelessness during their respective meetings. Through these ongoing discussions, the general concept of a training curriculum is being further defined to include topics for training, modalities for the training and the agencies responsible for coordinating the training. A set of training topics is being developed as the core knowledge needed for a housing specialist, regardless of agency or special population served by the housing specialist. More specialized training will be created as advanced trainings for the housing specialists. The

training curriculum has been expanded from targeting behavioral health housing specialists to all housing specialists, including behavioral health housing specialists and those providing housing services in corrections, health, homeless programs, and substance use services. As a result of input from subcommittee members, Kansas Housing Resources Corporation has a greater understanding of the training needs of housing specialists and other non-profit providers. Beginning in 2018, KHRC has removed any restrictions for attending training classes at the Kansas Housing Conference. Attendees can attend any of the classes offered at the Kansas Housing Conference, including those that were previously restricted to specific groups. KHRC has allocated funding to the Kansas Statewide Homeless Coalition to offset the registration cost of the conference for members of the coalition. These registration scholarships are used to reduce the registration cost for members of the coalition to create more opportunities for individuals to attend the conference. In 2017, scholarships were awarded to a variety of agencies, including small nonprofits and staff from two homeless shelters.

7. The Housing and Homelessness Subcommittee added seven new members this year. The new members are: Doug Wallace, CSBG Program Manager at Kansas Housing Resources Corporation; Jason Hess, Executive Director at Regional Alcohol & Drug Assessment Center; Maggie Flanders, Homeless Plan Specialist at COMCARE of Sedgwick County; Nate Miller, Facility Manager/Housing Coordinator at Southwest Guidance Center; Stephanie Cline, Clinical Director, Residential Care at South Central Kansas Mental Health Association; Theresa Douthart, Housing Resource Specialist at Valeo Behavioral Health Care; and, Victor Fritz, Clinical Care Manager at Substance Abuse Center of Kansas.

8. In March 2018, a representative from the Subcommittee on Housing and Homelessness met with the Prevention Subcommittee to discuss opportunities for coordination between the two subcommittees. After reviewing the Subcommittee on Housing and Homelessness' accomplishments and goals, a general discussion ensued regarding the potential for crossover between the two subcommittees. The chairpersons for both subcommittees will continue to explore ways the two subcommittees could collaborate on common goals.

Recommendations for KDADS for FY 2019

1. **Recommendation: KDADS Housing Pilot Program**

Members of the GBHSPC's Subcommittee on Housing and Homelessness commend the Kansas Department for Aging and Disability Services for convening a workgroup to develop a pilot project that provides housing options to individuals experiencing homelessness and disabling conditions. While the pilot proposal was not fully implemented as proposed, KDADS was able to fund four pre-pilot programs, named the "Bridge Housing Program" to test out the strategies proposed by the workgroup. The Subcommittee recommends that KDADS track the outcomes of the four pre-pilot Bridge Housing programs and if they are successful, present a budget enhancement to KDADS budget to fully implement the program statewide.

Rationale:
Homelessness is a costly issue. The national cost of not addressing homelessness is $56,000 per year per person, which is $153.00 per person per day (National Alliance to End Homelessness). Using the national figure of $153.00 per person per day and the 2017 Kansas PIT count of 2,098 individuals experiencing homelessness, Kansas spends an estimated $321,000 per day in public services just for these individuals to maintain homelessness. Congruent with a large and growing body of national research, local data supports that it continues to be significantly more cost-effective to invest in Housing First solutions for individuals and families who are experiencing homeless - such as rapid rehousing and permanent supportive housing – versus the alternatives of institutionalization, crisis care, or doing nothing at all.

2. **Recommendation: Housing Specialist Certification and ongoing Education**

The GBHSPC's Subcommittee on Housing and Homelessness (Subcommittee) recommends that KDADS-BHS in cooperation with Kansas Housing Resources Corporation (KHRC) and other partners continue to develop the training curriculum for Housing Specialists. Specifically, the subcommittee recommends:

1) KDADS in cooperation with the Subcommittee, KHRC and other partners will continue to identify the core knowledge that is needed for housing specialists, regardless of programs or special populations served by the housing specialist.
2) KDADS and KHRC will collaborate to develop or arrange for specialized training based on national models such as Housing First and/or specialized training targeted to providing housing services to specific populations or programs.
3) KDADS, KHRC and other state partners will continue to clearly identify roles and responsibilities for the implementation of the housing specialist training curriculum.

4) KHRC in collaboration with KDADS and community partners will continue to seek a better understanding of the training needs for housing specialists

5) KDADS and KHRC should encourage their providers to develop the Housing First approach in their programs.

Rationale: Through the development of the Housing First approach and through HUD's program Rapid Re-housing (RRH), the role of the housing staff has been defined as a person who specializes in working with landlords and helping people find appropriate housing. Housing First and RRH programs that have housing staff working in conjunction with case managers, have extremely high success rates in helping families obtain and maintain permanent housing.

3. Recommendation: Continue the Supported Housing Program

The GBHSPC Subcommittee on Housing and Homelessness recommends that KDADS-BHS continue to support the funding of Supported Housing Funds to assist those with Severe and Persistent Mental Illness (SPMI) and persons with Serious Mental Illness (SMI) in obtaining or maintaining housing in the community as they are integral to the work being done by the housing specialists.

Rational:
Supported Housing Fund program provides affordable housing linked to services for low-income, disabled and formerly homeless or potentially homeless people with Severe Persistent Mental Illness (SPMI) and persons with Serious Mental Illness that fit KDADS' criteria. The goal is to provide persons the help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives. The SHF program supports eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is achieved by providing temporary funds to meet the cost of their housing needs. The total amount of Supported Housing Funds for FY2018 was $535,000 and there were 1,022 requests submitted for reimbursement. Due to high need, the funds were depleted by late June 2018, two months before the end of the grant term.

4. Recommendation: Expand and Enhance SOAR Services

The GBHSPC's Subcommittee on Housing and Homelessness applauds KDADS-BHS efforts to advance the provision of SOAR (SSI/SSDI Outreach, Access, and Recovery Program) statewide. SOAR is a federal program that helps states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and have a mental illness or other co-occurring disorders. In order to continue to grow the SOAR program in the state and to ensure that all of those eligible for Social Security disability benefits are receiving them, the GBHSPC's Subcommittee on Housing and Homelessness recommends that KDADS:

1. Create and maintain a full-time position in KDADS – BHS dedicated to SOAR. This position would be the SOAR State Lead and would be responsible for coordinating SOAR activities and training across Kansas.
2. The Subcommittee would like to collaborate with KDADS to explore opportunities to expand SOAR to rural communities across Kansas.
3. The Subcommittee would like to collaborate with KDADS to explore resources to support the provision of SOAR in smaller communities, including resources to help fund SOAR activities.

Rationale:
For people with behavioral health disorders, receiving SSI/SSDI can be a critical step toward recovery. SSI/SSDI benefits can provide access to housing, health insurance, treatment and other resources. Obtaining these benefits can be an important step toward ending homelessness.

5. **Recommendation:** Coordinate goals and strategies between the GBHSPC Subcommittee on Housing and Homelessness and the Kansas Interagency Council on Homelessness

Upon direction of KDADS and through continued support from Kansas Housing Resources Corporation, the Kansas Interagency Council on Homelessness is now a "Sub workgroup" of the GBHSPC's Subcommittee on Homelessness and Housing. The Sub workgroup is charged with reviewing and updating the State of Kansas' Plan to Prevent and End Homelessness.

Rationale:

Due to membership expertise for the different groups, researching certain topics and strategies may be better suited for one group over the other.

Subcommittee on Housing and Homelessness FY 19 Goals

1. The subcommittee will work with KDADS to coordinate the Subcommittee's goals and strategies with the Kansas Interagency Council on Homelessness.
2. The subcommittee will explore options for a centralized data system within the housing and homelessness field that other State and local entities have access to for finding housing and services for our shared customers.
3. The subcommittee will ask the three Managed Care Organizations to recommend someone from their respective organizations to serve on the subcommittee with the intent to explore Evidence-Based Practices and/or Promising Practices that support the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders.

Summary

The Subcommittee on Housing and Homelessness has researched best practice housing models used by other states and based on this research made recommendations tailored to the Kansas Behavioral Health System for the past several years.

There is strong evidence from other states that have invested in safe, decent, affordable housing coupled with supportive services that there is a significant reduction in the use of costly medical services like state hospitals, jails and prisons. In Kansas, the State Psychiatric Hospital system is chronically over census. Kansas needs to maintain current resources to guarantee KDADS housing programs continue to serve all Kansans with behavioral health disorders. This includes access to safe, decent, affordable and permanent housing. The continuation of this investment results in fewer hospital admissions and incarcerations. All Kansans ultimately benefit with the outcome of an improved quality of life for consumers and cost savings for taxpayers.

The Subcommittee challenges KDADS and other state and local stakeholders to work together to enhance the current infrastructure of housing experts to facilitate the expansion of housing options and resources such as SOAR and Behavioral Health Service Providers housing staff.

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GOVERNOR'S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL
CHILDREN'S SUBCOMMITTEE

PRESENTED TO:

Wes Cole, Chair
Governor's Behavioral Health Services Planning Council

Tim Keck, Secretary
Kansas Department for Aging and Disability Services

Jeff Colyer, Governor
State of Kansas

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INTRODUCTION:

You only need to listen to or read the news to be aware of the immediate need for attention to children' mental health issues. The recent school shootings and the rise in adolescent suicide alone are indicators that we are at a critical juncture in making sure that mental health prevention and intervention are one of our highest priorities. According to the Center for Disease Control, 1 in 5 high school students report being bullied on school property in the last year. Youth violence is the leading cause of death for young people and results in more than 500,000 nonfatal injuries each year. (1) For instance, the homicide rate among adolescents and young adults is higher than any other age group. Young people can be harmed by violence when they are the perpetrator, the victim, or a witness. Some forms of youth violence—such as bullying, slapping, or hitting—can cause more emotional harm than physical harm. Others, such as robbery and assault (with or without weapons), can lead to serious injury or even death. (2)

Exposure to this kind of violence not only causes physical damage, it also erodes the mental and social lives of its victims. Suicide is the second leading cause of death in adolescents aged 12 to 17, according to the Center for Disease Control. It is estimated that 6.8% of the total population of children aged 3 to 17 are diagnosed with ADHD, 3.5% with behavioral or conduct problems, 3% with anxiety, and 2.1% with depression. (3) In a study conducted by Cambridge University, those children who experience multiple Adverse Childhood Experiences (ACES) were more likely to develop a lifetime of mental and substance use disorders in adulthood, as well as physical health issues. (4) In Kansas, parents report that 23% of children 2 to 17 years of age have been diagnosed by their doctor as having Autism, developmental delays, depression and/or anxiety, Attention Deficit Hyperactivity Disorder (ADHD), or behavioral/conduct disorders. (5) The mental health rate per 1,000 children aged 0 to 17, who are identified as discharging from a hospital with a mental health diagnosis, has increased from 2.8 in 2011 to 5.1 in 2016.(6)

It is essential that all stakeholders look for solutions to address these statistics and enhance behavioral health services for the children and youth of Kansas and their families.

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SUMMARY OF RECOMMENDATIONS:

Below each of the four goals outlined below is a summary of the recommendations from the Children's Subcommittee. More detail for each of these recommendations can be found in the body of this report.

Goal #1: Identify a Process for the Children's Subcommittee to Link/Communicate Well with Other Subcommittees

1. Continue joint meetings convened by KDADS with all subcommittees quarterly or at least once every six months. This will help with networking, if subcommittees are working on the same issues or issues that overlap each other. The Children's Subcommittee anticipates an invitation or request from KDADS or the Council to participate in future joint meetings.
2. Instead of a newsletter, which was previously tried, the main council will designate a person to lead and organize all subcommittees and post minutes of their meetings to a central location on a shared drive for all other subcommittees to review. This lead person would coordinate with each subcommittee's designated person to have the minutes posted and hold each subcommittee's officers accountable.

Goal #2: Make Recommendations Regarding Caregiver, Parent, and Family Engagement in Navigating Behavioral Health Systems

1. State agencies will identify and remove barriers (i.e. policies, procedures, provider requirements) that hinder caregiver, parent, and family engagement.
2. State agencies will invest resources (funding) to support, encourage, and increase the direct training and support of parents in the care of their children.
3. State agencies will consistently and continually present and share information received from stakeholders in a clear and concise manner with families and providers.
4. State agencies will support, encourage, and incentivize programs and agencies that engage families effectively in the planning, governance, evaluation, and provision of behavioral health services.

Goal #3: Define/describe the Kansas Children's Continuum of Care

The Children's Subcommittee will continue to work closely with the COC committee to advance the development of solutions to address identified children's behavioral health issues.

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Goal #4: Identify and Describe the Data Elements that the Children's Subcommittee wants in an Integrated Data System.

1. KDADS will appoint an all-inclusive task force to develop the purpose of a statewide EMR/Behavioral Health database and a plan for its development.
2. The state will contract with an outside provider to develop this database. The Children's Subcommittee would recommend considering Dr. Teri Garstka at the University of Kansas to facilitate this process. Dr. Garstka provided a very interesting presentation to the Subcommittee, and its members liked the process utilized to guide agencies through determining the purpose of the database prior to its development.
3. Explore the possible replication of the MyRC data base model utilized by Johnson County Mental Health for statewide use in other counties/communities.
4. Replicate the already existing IRIS system, as a starting point, and then expand its use statewide. The IRIS system currently tracks a referral between programs for recipients of early childhood services and other program services that are a part of that system.
5. KDADS will complete a survey of state agencies and relevant stakeholders including KDOC, KSDE, DCF, KDHE and others, to determine what data elements are already being collected in their current systems and what information is needed by each agency.

2017-2018 GOALS AND ACCOMPLISHMENTS

The Governor's Subcommittee for Children's Behavioral Health has addressed the following four goals and accomplishments during the 2017 – 2018 year:

Goal #1 – Identify a Process for the Children's Subcommittee to Link/Communicate Well with Other Subcommittees

(1) Over the past year, individual Children's Subcommittee members reviewed previous reports from one of the other subcommittees, to identify areas of possible overlap, and presented a summary of the information to the other Children's Subcommittee members. The Subcommittee identified the following subcommittees may potentially have a connection or overlap with the work of the Children's Subcommittee:

- Veteran's Subcommittee will be doing some work over the next year, once they start meeting again, to look at services for veterans with children, especially supporting veterans upon returning home from service.
- Housing and Homeless Subcommittee probably has data and information related to children and families
- Justice Involved Youth and Adult Subcommittee
- Rural and Frontier Subcommittee
- Prevention (includes suicide prevention) Subcommittee
- Ks Citizen's Committee on Alcohol and Drug Abuse Subcommittee
- Vocational Subcommittee's work, as it relates to transitional age youth

(2) Jane Adams, Bobby Eklofe, and Erick Vaughn attended a joint meeting of all subcommittees, convened by KDADS. There was an agreement, at this meeting, that a future meeting would be organized. The Children's Subcommittee anticipates an invitation or request from KDADS or the Council to participate in future joint meetings.

(3) One month, the Children's Subcommittee contributed information to the subcommittee newsletter. However, the Children's Subcommittee did not see the result of that effort and has concerns whether the newsletter was or will be developed or shared.

(4) Erick Vaughn participated in a Prevention Subcommittee meeting and presented the Children's Subcommittee's recommendations and goals for this year. Erick provided some additional information to group members, because of questions and comments during the presentation.

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Goal #1 Recommendations:

1. Continue joint meetings convened by KDADS with all subcommittees quarterly or at least once every six months. This will help with networking, if subcommittees are working on the same issues or issues that overlap each other. The Children's Subcommittee anticipates an invitation or request from KDADS or the Council to participate in future joint meetings.
2. Instead of a newsletter, which was previously tried, the main council will designate a person to lead and organize all subcommittees and post minutes of their meetings to a central location on a shared drive for all other subcommittees to review. This lead person would coordinate with each subcommittee's designated person to have the minutes posted and hold each subcommittee's officers accountable.

Goal #2 – Make Recommendations Regarding Caregiver, Parent, and Family Engagement in Navigating Behavioral Health Systems

To learn more about the various perspectives of family engagement, during one of the Children's Subcommittee meetings, a panel presentation by representatives of agencies that work with parents was hosted, to hear their perspectives and concerns. Agencies represented were CASA, Families Together, and Johnson County Substance Abuse, and an Early Childhood Education representative also participated. The specific request was for each of the representatives to present feedback from parents regarding engagement in services and navigating behavioral health system(s). Below is a list summarizing the concerns that were shared:

Emotional Barriers

- Stigma
- Trust
- Fear of being blamed
- Feel "I should be able to handle this"
- Relationship with therapist
- Culture

Lack of resources

- Uninsured/Finances for payment of services
- Lack of early childhood education providers
- Transportation
- Limited number of foster homes for children/youth with challenging behaviors or special needs
- PRTF waiting lists

System Barriers

- Need wraparound and parent support for non-waiver eligible youth
- Parent education
- Train parents as advocates
- Lack of parent's participation in therapy if child is incarcerated or placed elsewhere
- Scheduling
- No one-stop for physical and behavioral health services and substance use treatment

As indicated by the list above, there are many factors that create challenges and barriers for families to engage in the behavioral health system and for providers to fully engage families and communities in all aspects of the behavioral health system.

Goal #2 Recommendations:

1. State agencies will identify and remove barriers (i.e. policies, procedures, provider requirements) that hinder caregiver, parent, and family engagement.
2. State agencies will invest resources (funding) to support, encourage, and increase the direct training and support of parents in the care of their children.
3. State agencies will consistently and continually present and share information received from stakeholders in a clear and concise manner with families and providers.
4. State agencies will support, encourage, and incentivize programs and agencies that engage families effectively in the planning, governance, evaluation, and provision of behavioral health services.

Goal #3 – Define/describe the Kansas Children's Continuum of Care

The Children's Subcommittee spent a great deal of time reviewing the charter for the Children's Continuum of Care Committee (COC) and discussing its purpose and role versus the role of the Children's Subcommittee. The Children's Subcommittee also had discussions with members of the COC Committee, as well as members of the Governor's Planning Council. The Children's Subcommittee concluded that there is some overlap between the two committees and the topics for which they are responsible. The Children's Subcommittee eventually came up with a working description that helped clarify the differences. The Children's Subcommittee's working definition is that the Children's Subcommittee has the task of identifying relevant topics of concern and offering suggestions for change. It is the task of the Children's Continuum of Care Committee to then take these identified issues and recommendations and move them forward with the Secretary and the Legislature.

Goal #3 Recommendation: The Children's Subcommittee will continue to work closely with the COC committee to advance the development of solutions to address identified children's mental health issues.

Goal #4 – Identify and Describe the Data Elements that the Children's Subcommittee wants in an Integrated Data System.

The Children's Subcommittee members believe that having a statewide database would be very valuable for several purposes:

(1) Identifying the issues that are the most urgent in the state,
(2) Monitoring the progress the Children's Subcommittee and others are making, and
(3) Sharing information to better serve children and families.

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The first thing the Children's Subcommittee did was explore and inform its members about existing databases in the state. The Children's Subcommittee reviewed the information available from the MCOs, Medicaid AIMS data, KSDE and other available systems. Johnson County Mental Health Adolescent Center for Treatment (ACT) is involved in a particularly interesting model called My RC (My Resource Connection). This system connects individuals who access it with many resources they might need, including housing, health care, counseling, transportation, etc., by providing contact information on a public website.

The Children's Subcommittee invited Teri A. Garstka, Ph.D, Associate Director for the Center for Public Partnerships and Research at the University of Kansas, to talk to its members about the DAISEY and IRIS systems that are already being utilized in some areas of the state Dr. Garstka presented a model for determining what an organization wants to get from a database that the Children's Subcommittee thought was very helpful.

We would also recommend the State look at the model created and utilized by Johnson County Mental Health called MyRC. They have already worked out many of the issues of HIPPA and information sharing that might be very helpful for the process.

Goal #4 Recommendations:

1. KDADS will appoint an all-inclusive task force to develop the purpose of a statewide EMR/Behavioral Health database and a plan for its development.
2. The state will contract with an outside provider to develop this database. The Children's Subcommittee would recommend considering Teri Garstka, Ph.D. at the University of Kansas to facilitate this process. Dr. Garstka provided a very interesting presentation to the Subcommittee, and its members liked the process utilized to guide agencies through determining the purpose of the database prior to its development.
3. Explore the possible replication of the MyRC data base model utilized by Johnson County Mental Health for statewide use in other counties/communities.
4. Replicate the already existing IRIS system, as a starting point, and then expand its use statewide. The IRIS system currently tracks a referral between programs for recipients of early childhood services and other program services that are a part of that system.
5. KDADS will complete a survey of state agencies and relevant stakeholders including KDOC, KSDE, DCF, KDHE and others, to determine what data elements are already being collected in their current systems and what information is needed by each agency.

2018-19 GOALS

At the end of each year, the Children's Subcommittee considers a large list of possible concerns and topics to prioritize goals for the following year. This year those topics included: Autism, Early Childhood Education/Services, Homelessness, Human Trafficking, Opioid and other related drug issues impacting children, Parent Engagement, Transition age youth aging out, and Trauma Informed Care. The Children's Subcommittee prioritized these issues. However, the Children's Subcommittee members felt it was frustrating to have questions regarding issues due to a lack of data and information to assist in prioritizing these topics and concerns.

Using the experience and knowledge of those serving on the Children's Subcommittee, the following goals were identified to pursue during the 2018-2019 year. The Children's Subcommittee acknowledges that, in pursuing these goals, a focus on resources for substance use services and treatment for parents must be maintained, as this has been missing from the Children's Subcommittee's previous work.

Goals:

1. Research resources available for parents with substance use disorders, specifically drug use that is affecting the care of their children. Consider making recommendations regarding how these resources can be increased in communities lacking resources, to improve outcomes for children.
2. Review existing recommendations regarding Transition Age Youth and prioritize those recommendations. Prioritize recommendations that focus on services after youth leave State of Kansas - DCF custody, including access to housing, employment and education.
3. Review and recommend Parent Engagement models across the continuum of care (schools, CMHCs, early childhood programs, etc.). The Children's Subcommittee's review will include parenting training of parents and training of direct service staff.

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GBHSPC
CHILDREN'S SUBCOMMITTEE
CHARTER

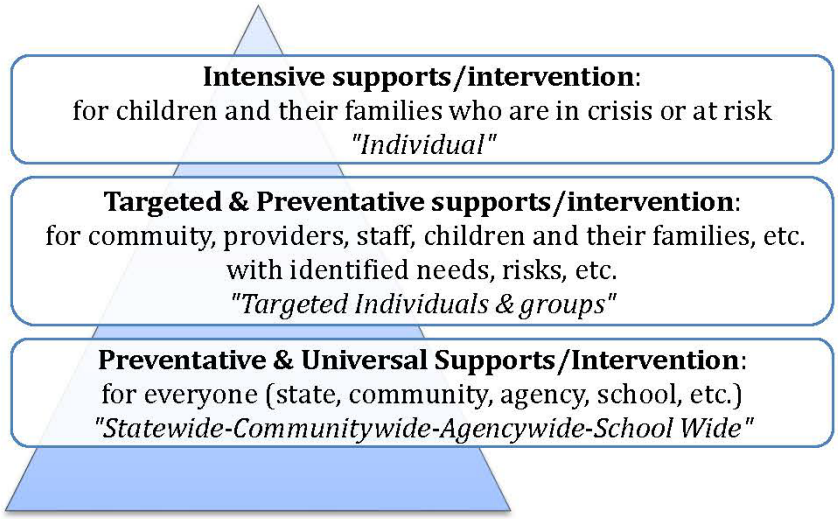
GBHSPC Subcommittee Charter	
Subcommittee Name:	Childrens Subcommittee
Context:	The Children's Subcommittee generates recommendations for the GBHSPC regarding the behavioral health system of Kansas as it relates to Kansas children and their families. The GBHSPC reviews not just this subcommittees recommendations but other existing subcommittees and presents all Behavioral Health recommendations to the Secretary of KDADS and the governor. It is acknowledged that although the priority focus of the GBHSPC are the SPMI and SED target populations (Federal law 102-321), the work of the subcommittee is to be conducted with the whole system and all Kansas citizens with behavioral health needs in mind.
Purpose:	The Children's Subcommittee is devoted to the behavioral health needs of children and their families. The subcommittee examines and makes recommendations to improve the array of behavioral health services offered to children and their families through Kansas Community Mental Health Centers (CMHC), substance use treatment providers other children's service systems and collaboration between systems of care such as Psychiatric Residential Treatment Facilities (PRTF), hospitals, juvenile justice services and schools. We: ▪ Identify strengths and needs. ▪ Make informed recommendations. ▪ Use subcommittee member networks to address identified needs and influence change.
Vision:	That all Kansas children and their families will have access to essential, high-quality behavioral health services that are strengths-based, developmentally appropriate, and culturally competent.
Mission:	To promote interconnected systems of care that provide an integrated continuum of person- and family-centered services, reflective of the Children's Subcommittee vision and values: ▪ *Interconnected Systems* *The integration of Positive Behavioral Interventions and Supports and School Mental Health within school systems to blend resources, training, systems, data, and practices in order to improve outcomes for all children and youth.*[i]

- *Systems of Care*
  A spectrum of effective, community-based services and supports that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses cultural and linguistic needs to enhance functioning at home, in school, in the community, and throughout life.[ii]

- *Integrated Services*
  Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.[iii]

- *Continuum of Care*
  - ✓ *Across the Lifespan – From birth to age 22.*
  - ✓ *Across Levels of Intensity – Preventative (Tier 1), targeted (Tier 2), intensive (Tier 3).*

- *Person & Family-Centered Planning*
  A collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person- and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.[iv]



Values:	The Children's Subcommittee will use the following values to guide their purpose: ▪ Use data from multiple sources to ensure an accurate picture of the target population ▪ Promote person and family-centered planning ▪ Ensure all recommendations are supported by evidence ▪ Maintain collaborative and inclusive networks ▪ Listen and respect the voices of those we serve

GBHSPC Approval	
Name	**Signature**
Click here to enter text.	
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Charter Effective Date: 05/08/2017

[i] http://www.midwestpbis.org/materials/interconnected-systems-framework-isf
[ii] https://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf
[iii] http://www.integration.samhsa.gov/about-us/what-is-integrated-care
[iv] https://www.samhsa.gov/section-223/care-coordination/person-family-centered

SUBCOMMITTEE MEMBERS

- Nancy Crago, LSCSW, *Chair, Director of Psychosocial Rehabilitation, Family Service and Guidance Center*
- Erick Vaughn, LMSW, *Vice Chair, Director of Strategic Initiatives, DCCCA, Inc.*
- Robert (Bobby) Eklofe, MHSA, *Secretary, Vice President of Behavioral Health Operations, KVC Hospitals, Inc.*
- Cherie Blanchat, LSCSW, *Past Chair Project Coordinator, TASN ATBS School Mental Health Initiative*
- Candace Moten, LMSW - *Family Preservation Services Program Manager, Kansas Department for Children and Families*
- Jeff Butrick, *Service Manager*, *Kansas Department of Corrections-Juvenile Services*
- Kevin Kufeldt, LCPC, *Program Manager, ACT Residential Treatment, Johnson County Mental Health*
- Cheryl Rathbun, *Chief Clinical Officer, Saint Francis Community Services*
- Chelle Kemper, *Secretary, Special Education Director*
- Jacob Box, *Parent Representative, Governor's Behavioral Health Services Planning Council Liaison*
- Gary Henault, *KDADS Liaison, Kansas Department for Aging and Disabilities Services, Children's Program Manager*
- Myron Melton, *Education Consultant, Special Education and Title Services Team, Kansas*
- Charlie Bartlett, *KDADS Liaison, Kansas Department for Aging and Disabilities Services, Special Projects*
- Julie Ward, LSCSW, *Topeka Public Schools, Department of School Social Work*
- Marci Ramsay, LSCSW, RPT, *Douglas County Child Development Association*
- Rich Harrison, *Behavior Consultant*, *Project Stay*
- Sherri Luthe, *Parent Representative*
- Vicki Vossler, *Special Education Administrator, Blue Valley Schools*

Governor's Behavioral Health Services Planning Council
Rural and Frontier Subcommittee

2018 Annual Report

Presented to:

Wes Cole, Chairperson & Gary Parker, Vice Chairperson
Governors' Behavioral Health Services Planning Council (GBHSPC)

Tim Keck, Secretary
Department for Aging and Disability Services (KDADS)

Jeff Colyer, Governor

Prepared by:
GBHSPC Rural and Frontier Subcommittee
Nicole Tice, Psy.D. – Fy2019 Chair
Tabitha Murski, LCP – Fy2019 Co-Chair
Renee Geyer, MMC – Fy2018 Chair

September 9, 2018

Introduction

Our VISION: Behavioral health equity for all Kansans. All residents of rural and frontier communities of Kansas will have access to essential, high quality behavioral health services.

Our MISSION: To collaborate through research to statistically understand and promote accessibility and availability of behavioral health services in rural and frontier Kansas counties.

Our HISTORY: Since more than 80% of Kansas is rural or frontier, this committee was originally developed under a state contract prior to becoming a part of the then Governor's Mental Health Services Planning Council (GMHSPC). Its original mission was to support the University of Kansas (KU) in forming a committee to represent the rural and frontier counties of Kansas that focused on the mental health needs of children in the child welfare system.

In July 2008, the task group was moved under the umbrella of the GMHSPC to become the Rural and Frontier (R/F) Subcommittee. This new collaboration increased partnerships with other sub-committees to serve as a planning and advisory council to the state, a requirement of federal Mental Health Block Grant funding. This affiliation, which is now inclusive of substance use disorders (SUD) and named the Governor's Behavioral Health Services Planning Council (GBHSPC), provides us with a formal process for making recommendations to the system and acknowledges the uniqueness of the behavioral health needs of rural and frontier areas. We are the only behavioral health subcommittee based upon geographic location.

We have learned… "Epidemiologic evidence suggests that the prevalence and incidence of adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) are similar between rural and urban populations (Kessler et al., 1994). However, access to mental healthcare, practitioners, and delivery systems to provide care, and attitudes and cultural issues influencing whether people seek and receive care differ profoundly between rural and urban areas." (*New Freedom Commission on Mental Health, Subcommittee on Rural Issues: Background Paper. DHHS Pub. No. SMA-04-3890. Rockville, MD: 2004. p. 2*)

We also know… "The vast majority of all Americans living in underserved, rural, and remote rural areas also experience disparities in mental health services. . . Rural issues are often misunderstood, minimized and not considered in forming national mental health policy." *(New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003, p. 50)*

One significant barrier to addressing this disparity is the lack of a consistent definition as to what constitutes frontier, rural, and urban areas in Kansas. This lack of consistency increases the risk of continued use of inaccurate information to make a wide range of policy and fiscal decisions that directly impacts the care and treatment available to Kansans who call rural and frontier areas home.

From the beginning the subcommittee has advocated for state-wide use of **KDHE's definition of the Frontier through Urban Continuum.** Defining the continuum ensures that limited resources intended to address critical rural issues in 84% of the State, are then transmitted

to meet those diverse needs in rural locations. Adoption of this definition will benefit the **entire state** in the development of further policy and decision making. Federal funding and State grant proposals will be strengthened by the adoption and use of this definition as well. To accomplish this, an executive order submitted in 2016 has been followed up by education and advocacy in 2018.

The Rural and Frontier Subcommittee continues to gather significant data based on this definition to highlight the unique behavioral health needs of those living in rural and frontier areas. Collectively, we believe these four behavioral health needs most need to be addressed:

1. **Lack of Urban/Semi-Urban Resources in 89 out of 105 Kansas counties**
2. **Higher percentage per capita of Hispanic residents**
3. **Rural Legacy of Depopulation**
4. **Behavioral Health Provider Shortage**

This Subcommittee also recognizes that innovation and creativity is necessary – and must be embraced! Organizations are now often designed to help meet diverse needs, and collaboration with other agencies and businesses are commonplace. Technology is one of the tools that are highly beneficial. For example, telemental health service provision and use of iPads in the field let us meet people where they are – any place – at any time. Addressing rural barriers with new and innovative ways of doing business often requires advocacy. We work hard to provide that advocacy supported by research data and information to promote behavioral health service accessibility!

Membership

Subcommittee members represent a variety of agencies and community partners who either reside in or serve residents of rural and frontier areas. Examples include, but are not limited to representation from Community Mental Health Centers, Veterans Services, Child Welfare Agencies, Private and State Psychiatric Hospitals,Managed Care Organizations (MCOs), University Partners, Law Enforcement, and adults and/or parents of children who are consumers of behavioral health services. A membership list with the Kansas counties they serve is provided in (Appendix A).

The subcommittee meets six times per year, usually during odd numbered months, on the fourth Thursday of the month. Members are able to participate in person at Compass Behavioral Health Outpatient office in Dodge City, as well as by phone conference or televideo.

FY2018 Objectives & Progress

- **#1 - Rural and frontier counties have smaller economies of scale and must provide services in more creative ways… or not at all. Because we believe it is the fundamental cornerstone necessary to build "Behavioral Health Equity for all Kansans", we continue to share the message about the importance of adopting KDHE's definition of the Frontier through Urban Continuum.**
    - Draft of Executive Order re: Frontier through Urban Definition, and KDHE Population Density Classifications in KS by County (Appendix B)

- **#2 - Strengthening the Continuum of Care in Rural and Frontier areas is the foundation upon which the Behavioral Health System operates.**

  A. "…technology itself is no longer the barrier to use. Perceptions of technology and related local and state legislation and organizational policy are now the more significant barrier." (R/F Subcommittee, Fy2016 Annual Report pg. 5, 2c)
  - Actively championing use of telemental health to address barriers to receiving behavioral health services – like workforce shortage and transportation.
  - Planning Telehealth Use Survey with KU Center for Telemedicine & Telehealth to explore telehealth as a tool for delivering an alternative service – especially for the elderly.
  - Presented on the need for telesupervision at the BSRB meeting on October 8, 2017.
  - Provided testimony on the need for telehealth parity in Kansas for House Bill 2674 on October 12, 2017. The bill was essential to meeting the mental health care needs of Kansans living in rural and frontier communities. (Appendix C)

  B. Increase funding for crisis beds for the non-insured &/or underinsured to fill the gap in rural and frontier areas of the state.
  - When the opportunity arises, the subcommittee will advocate for the next crisis center to be in Western Kansas west of Barton County. The subcommittee thinks of crisis resources beyond crisis beds. More community outreach is always needed.

  C. Advocate for adequate resources to meet consumer and provider behavioral health needs.
  - Efforts to conduct a R/F Telehealth Use Survey began in January of 2017 and are ongoing.
  - Hosted a Legislative Luncheon on October 12, 2017 in Dodge City, Kansas and presented on the Rural and Frontier subcommittees mission, values and goals.
  - Collaborated with Wichita State University on the type of behavioral health providers needed in R/F areas.
  - Advocating for social workers and other professionals to receive supervision via televideo to by approved the BSRB.

- **#3 - Continue to diversify membership to ensure that needs and resources are considered within and alongside the behavioral health system.**
  - Added five stakeholders to Subcommittee
  - Letter to BSRB re: use of telesupervision for QMHP's seeking behavioral health independent licensing. Upon request, provided links and documents supporting electronic efficacy to BSRB for their review.

Noteworthy Efforts pre Fy2018

- Presentation to GBHSPC re: R/F data and how use of televideo technology and protocol can meet behavioral health needs in R/F areas. 2016
- Developed implementation program for sharing resources related to the expansion of telemental health services in R/F areas. 2016
- Presentation at Larned State Hospital Mental Health Conference 2016
- Developed and implemented the Tele-mental Health Consumer Survey 2014 (Fy2015)
- Hosted Legislative Luncheon/January 26, 2012 with R/F presentation
- Hosted Legislative Reception/October 25, 2012 with R/F presentation
- Presented at state and national levels to advocate, educate and promote public awareness of behavioral health issues based on the KDHE continuum definition.

Fy2019 Goals

- In Fy2019, the R/F Subcommittee will continue focusing on finalizing the Executive Order for the Frontier through Urban Definition and strengthening the continuum of care in Rural and Frontier areas. The R/F subcommittee added a goal for 2019 to increase Suicide Prevention in Rural and Frontier areas. The subcommittee is looking to partner with the prevention subcommittee on this goal. Lastly, the group will look at partnering with the housing subcommittee to focus on homelessness in the Rural/Frontier Areas.

FY2018 Goals and Recommendations

Subcommittee members have collaborated in this formal process to provide data and make recommendations. Our literal "window of opportunity" is the window of advocacy. We appreciate and recognize the value of behavioral health equity for all Kansans, and will continue to work towards making access to essential, high quality behavioral health services for rural and frontier residents a reality!

The R/F Subcommittee recognizes the need for collaboration regarding identified goals and recommendations. As presented below, the weight of primary ability to affect change for each is more heavily weighted with the State at the top of the list and upon the R/F subcommittee toward the bottom. We acknowledge that in order to affect meaningful change across the state, both entities must partner creatively to implement tangible change.

1) Statewide adoption of KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order.

2) Strengthening continuum of care in R/F areas by:
   a) Championing use of telemental health to address barriers, advocating for BSRB approval of telehealth supervision, providing data regarding telemental health efficacy to promote its use and conducting a Telehealth Use Survey.
   b) Partner with other service organizations across state to increase access to services; continue to share information regarding rural and frontier strengths, needs, and unique issues; and advocate for solutions to address the behavioral health workforce shortage.

c) Advocate for crisis beds for the non-insured and/or underinsured to fill the gap in the western half of the state.

3) Continue to diversify subcommittee membership to ensure that needs and resources are considered both within and alongside the behavioral health system.

Summary

The behavioral health needs of Kansans in Rural and Frontier areas are unique and need to be taken into consideration regarding fiscal issues and related policy development. The adoption of a consistent definition of the Frontier through Urban Continuum (already utilized by KDHE) would help meet the behavioral health needs of all Kansans. In examining the continuum of care, the R/F Subcommittee has identified that telemental health has the ability to address multiple barriers, but local and state legislation related to it needs addressed. Lack of Urban/Semi-Urban resources, the rural legacy of depopulation, a higher percentage per capita of Hispanic residents, and a significant Behavioral Health Provider shortage all continue to be significant barriers to getting the quality behavioral health care Kansas residents in rural and frontier areas need and deserve. Therefore, the Rural and Frontier Subcommittee of the Governor's Behavioral Health Planning Council will continue to partner with a wide variety of individuals and organizations to identify ways to strengthen the continuum of care by using research and technology to advocate for, and meet the needs of, those who live in rural and frontier areas.

Appendix A: County Membership Representation

Appendix B: Draft of Executive Order: Frontier through Urban Definition, and KDHE Population Density Classifications in KS by County, 2016

Appendix C: House Bill 2674 Testimony

Governor's Behavioral Health Services Planning Council
Prevention Sub-Committee 2018

VISION
To ensure that key representatives and stakeholders are involved in the provision of reflection, feedback, and guidance relating to initiatives within Kansas Behavioral Health Prevention Initiatives to ensure enhanced collaboration, effectiveness, and impact on state and local level prevention and behavioral health outcomes.

MISSION
To provide feedback, guidance, advocacy, and engagement at the state level for related behavioral health prevention outcomes and identification of systems changes to address challenges, barriers, issues, and needs at the State, regional, or community level.

MEMBERSHIP
The Prevention Sub-Committee was established to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes and increase the effectiveness of state and local efforts to address prevention issues.

NAME	ORGANIZATION
Mende Barnett	Kansas Department for Aging and Disability Services
Bailey Blair, LMSW	American Foundation for Suicide Prevention – Kansas Chapter Board Member
Teresa Briggs	GBHSPC Prevention Liaison
Lisa Chaney	Learning Tree Institute at Greenbush
Chad Childs	WSU Community Engagement Institute
Steve Christenberry	Family Service and Guidance Center
Diane Garvey	Live Well Finney County
Kim Hefley	Sumner County Community Drug Action Team
Monica Kurz	Kansas Suicide Prevention Resource Center
Chrissy Mayer, Chair	DCCCA
Etienna Mertel	South Central Problem Gambling Task Force

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Joanna Mitchell	Prairie Band Pottawatomi Nation
Marissa Woodmansee	20th Judicial District Juvenile Services

FY18 FOCUS

The Prevention Sub-Committee had a strong focus on collaboration during FY18. The Sub-Committee believes that it is important to learn about the work of the other committees to make progress on behavioral health challenges in Kansas. Prevention can be woven into all sub-committee areas to reduce the incidence of substance abuse and provide supports for mental illness.

The other primary focus area of the committee was on continued development of the behavioral health prevention strategic plan. There are many entities working on behavioral health prevention in the state. The development of a strategic plan will allow for sustainable use of prevention resources in challenging times. The plan also will guide prevention planning at the state and community level, offering tangible calls to action to address behavioral health prevention needs.

GOALS

The Prevention Sub-Committee focused on refining our charter to clearly define roles and secure active participation and engagement in the work. The Sub-Committee continued to focus on our data collection and research goals and development of the statewide behavioral health prevention strategic plan. The committee identified four goal areas for FY18 –

<u>Data collection and research</u>

1) By June 30, 2018, the Prevention Sub-Committee will continue to identify and catalog behavioral health prevention efforts (funded and unfunded) that are occurring across the state.
2) By June 30, 2018, the Prevention Sub-Committee will identify the top five behavioral health prevention data priority areas as indicated by available state data resources.

<u>Develop framework for statewide prevention plan</u>

1) By June 30, 2018, the Prevention Sub-Committee will develop content for all identified sections of the statewide plan template.

<u>Develop a list of priorities/recommendations to present to the GBHSPC</u>

1) By May 30, 2018, the Prevention Sub-Committee will identify the top five prevention efforts that the committee would like to see continued or enhanced.
2) By May 30, 2018, the Prevention Sub-Committee will identify the top five behavioral health prevention needs as indicated by data and identify strategies for addressing the needs.

Develop opportunities for coordination with other GBHSPC sub-committees

1) By June 30, 2018, the Prevention Sub-Committee will gain greater understanding of the work of the other committees and identify at least one opportunity for collaboration with each sub-committee.

PROGRESS

The Prevention Sub-Committee met monthly over the course of the year to coordinate efforts to make connections and facilitate the development of the behavioral health prevention strategic plan. We focused on integration of the suicide Prevention Sub-Committee into the Prevention Sub-Committee and identified key stakeholders to engage in the Prevention Sub-Committee to maintain this priority.

As part of the integration work, the Prevention Sub-Committee reviewed the 2014 Kansas Suicide Prevention Plan to highlight key recommendations that are applicable for inclusion in the behavioral health prevention plan.

During this year, the Prevention Sub-Committee also received an overview of the block grant from KDADS staff which outlined the grant cycle and highlighted the importance of providing feedback on the block grant. At the inaugural FY18 meeting, the committee received a presentation from the University of Kansas Center for Community Health and Development and Greenbush to review data points for proposed block grant priorities. The four priority areas (reduce underage drinking in Kansas, reduce low perception of harm from marijuana use among youth in Kansas, reduce methamphetamine use among young adults, and behavioral health prevention and promotion) aligned well with the direction that the committee was moving toward. The committee was supportive of the identified priorities for the block grant application and will provide feedback as applications are renewed.

The Prevention Sub-Committee's work focused heavily on the development of the behavioral health prevention plan. We identified several key areas for alignment with the block grant requirements including –

- Prioritize needs assessment data for SABG funding
- Timelines
- Roles and Responsibilities
- Process Indicators
- Outcome Indicators
- Cultural Competence Component
- Sustainability Component

Additionally, we completed a data prioritization exercise utilizing data from the *2017 Kansas Behavioral and Mental Health Profile* to identify key components for the strategic plan. Data were categorized by –

- Health Disparities – differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions existing among specific populations
- Data Gaps – missing or incomplete pieces of data
- National Average Disparity – data points that Kansas for which significantly higher than the national average
- Significant Magnitude – data points impacting a large portion of the population
- Significant Trend – data points showed an upward trend

The Sub-Committee selected five priority areas. Each of these priorities was outlined in the strategic plan with appropriate data justification –

- Depression and Suicide
- Marijuana (specifically youth)
- Prescription Drug Misuse
- Alcohol (specifically youth)
- Problem Gambling

This data prioritization helped guide the formation of the strategic plan which continues to be refined to accurately portray the prevention landscape of Kansas and provide the direction needed to make positive changes at the state and community levels. The committee has had initial discussions about how to disseminate the document and will identify a final communication plan.

As the Prevention Sub-Committee came to the end of the state fiscal year, activities included organizational tasks including updating the charter, identifying new membership and strategies for recruitment, and identification of a new chairperson.

COORDINATION

The Prevention Sub-Committee continued our efforts to coordinate with all council sub-committees. At the end of FY17, we conducted an initial meeting with the Kansas Citizens Committee. The Sub-Committee's collaboration efforts with other sub-committees are outlined below. The Sub-Committee is pleased that we successfully met with all sub-committees to share the progress of our work, learn about their efforts, and identify areas of mutual interest.

Sub-Committee Name	Contact Person	Month	Areas of Shared Interest
Veterans	Ron Jeanneret	August	Data coordination, suicide prevention
Children's	Erick Vaughn	September	Data coordination, coordination of recommendations
Kansas Citizens Committee	Shane Hudson/Kim Reynolds	October and December	Coordination of prevention and treatment resources

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Rural and Frontier	Renee Geyer	January	Support for disparate populations and inclusion of rural Kansas needs in prevention planning
Justice Involved Youth and Adults	Bill Persinger	February	Data sharing and coordination
Housing and Homeless	Doug Wallace	March	Data mapping and options for coordinated training (MHFA)
Vocational	Matthew Angell	May	Data coordination, workforce prevention efforts

A common theme among all committees revolved around data access and availability. It also was indicated that some state-level data is unavailable or incomplete. Data collection and sharing is a tangible piece that all committees can collectively begin to address.

The Prevention Sub-Committee also met with representatives from the Prescription Drug and Opioid Advisory Committee. This committee is developing a plan to address opioid issues including treatment and recovery, provider education, prevention, law enforcement, and neonatal abstinence syndrome. We will coordinate with this committee to avoid a duplication of efforts in our prevention work.

RECOMMENDATIONS AND NEXT STEPS

The Prevention Sub-Committee will continue on course for the next year with continued focus on developing a sustainable comprehensive statewide behavioral health prevention plan. We will do this with significant focus in these prioritized areas and recommendations to the Council. This document is our call to action. We ask our policy makers, state and local leaders, and all those who have a vested interested in behavioral health promotion and prevention to acknowledge the identified gaps in services and seek to collaboratively improve the well-being of every person and community in Kansas.

The work put into this annual report and our Kansas Behavioral Health Prevention Plan is meant to be a guide for behavioral health prevention efforts in Kansas. There are many moving parts to the prevention infrastructure and the Prevention Sub-Committee continues to identify new partners and leverage resources to make an impact.

We recognize this work cannot be completed by any one entity. It takes the collaborative effort of a multitude of agencies, organizations, and citizens to identify the at-risk populations being sought to protect. We ask for your support in promoting our recommendations for next steps in this report and as described in more detail in the 2018 Kansas Behavioral Health Prevention Plan.

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The Prevention Sub-Committee is aware of a wealth of data resources that could be shared in more efficient and effective ways if barriers are removed. The Sub-Committee recommends the sharing of these data be done to develop a shared needs assessment for the Governor's Behavioral Health Services Planning Council. This Sub-Committee also recommends that this assessment be used to prioritize needs and guide capacity-building, planning, implementation, and evaluation of behavioral health services in Kansas.

FY18 Recommendations:

1. **Improve Shared Access to Data Resources Among State Agencies and Planning Council Sub-committees**
    a. Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.
    b. Integrate and utilize the guidance of a State Epidemiological Workgroup (SEOW).
    c. Enhance data collection procedures: Change legislation regarding public behavioral/health youth state surveys (e.g. the Kansas Communities That Care (KCTC) Student Survey and the Youth Risk Behavior Surveillance System (YRBSS) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection and availability of data for decision making.
2. **Better Coordinate Efforts and Care Transitions of Behavioral Health Services**
    a. Increase healthcare linkages and identify care transition best practices for mental health, substance abuse, and emergency departments across the state. Periods following discharge from these settings are times of particularly high risk for suicide. A model for follow-up with clients during this periods should be implemented in Kansas.
    b. Modify the KDADS requirements to become approved to provide SBIRT (Screening, Brief Intervention, and Referral to Treatment) services to Medicaid-eligible clients.
    c. Encourage State Departments, Agencies, the Judicial System, and Planning Council sub-committees to develop policies and practices improving their ability to work collaboratively on similar priorities and to address shared goals.
3. **Form an Evidence-Based Practices Workgroup (EBW) for Behavioral Health Promotion**
    a. An EBW could promote more use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services.
    b. Priority areas for initial EBW focus include marijuana, opioids, and strategies to help 18-25 year olds.

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4. **<u>Allocate Resources to Prioritized Areas of Need Through Data-driven Decision Making</u>**
    a. Increase access and availability of behavioral health services by restoring funding for community mental health centers and supporting efforts to recruit students to enter the behavioral health services community.
    b. Dedicate resources and funding for suicide prevention.
    c. Support the KPC in serving coalitions without KDADS funding and communities without coalitions.
    d. Support the KPC in addressing areas of focus and capacity-building for prevention coalitions and task forces (substance abuse, problem gambling, and suicide) prioritized based on needs assessment data.

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GOVERNOR'S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL UPDATE

JUSTICE INVOLVED YOUTH AND ADULTS – SUBCOMMITTEE REPORT

2017

Report presented to:
Governor's Behavioral Health Services Planning Council

Prepared by:

Lori Ammons, PsyD, Co- Chair
Rick Cagan, Co-Chair
Charles Bartlett, KDADS
Members of the Justice Involved Youth and Adults Subcommittee

INTRODUCTION

The interface between the mental health and criminal justice systems is substantial. The increased involvement of people with mental illness in the criminal justice system remains a difficulty for both state and local governments.

The JIYA Subcommittee convenes constituents at a policy level to carry out the vision and mission with the intent to promote actions for state level change through policy recommendations and planning.

JUSTICE INVOLVED YOUTH AND ADULTS SUBCOMMITTEE CHARTER

1. Develop a strategic plan to identify goals and objectives for state level change through policy and planning.
2. Formulate and prioritize strategies to achieve objectives of the strategic plan.
3. Implement strategies through workgroups, including timeline for completion.
5. Issue annual policy recommendations and planning to the Secretary from the Departments for Aging and Disability Services (KDADS), Children and Families (DCF), and Corrections (KDOC).

VISION AND MISSION

The vision and mission of the JIYA is as follows:

Vision

Justice involved Youth and Adults with behavioral health needs will achieve recovery.

Mission

To promote a recovery oriented system of care for individuals with behavioral health needs in or at risk for involvement in the justice system through policy recommendations and planning focused on prevention, diversion, treatment and reentry.

MEMBERSHIP

Randall Allen, *Kansas Association of Counties*

Lori Ammons, PsyD, *KU Medical Center, KDOC Behavioral Health Program Director*

Charles Bartlett, *Kansas Department of Aging and Disability Services*

Randy Bowman, *Director of Community Based Services, KDOC – Juvenile Services*

Mike Brouwer, *Douglas County Sheriff's Office*

Rick Cagan, *NAMI Kansas*

Bill Cochran, *Captain, Topeka Police Department*

Wes Cole, *GBHSPC Liaison*

Hope Cooper, *Deputy Secretary, KDOC*

Lesia Dipman, *Program Director, Larned State Security Program*

Jeffrey Easter, *Sedgwick County Sheriff's Office*

Nathan Eberline, *Kansas Association of Counties*

Letitia Ferwalt, *Johnson County DA's office*

Sally Frey, *KDOC, Southern Parole Region Director*

Jason Hess, *Executive Director, Heartland RADAC*

Sandy Horton, *Kansas Sheriff's Association*

Ted Jester, *Director, Johnson County Juvenile Detention Center*

Ed Klumpp, *Local law enforcement*

Dan Livingston, *Johnson County Mental Health*

Benet Magnuson, *Executive Director, Kansas Appleseed*

Marie McNeal, *KDOC Director Community Corrections*

Chris Mechler, *OJA*

Bill Persinger, *CEO, Valeo Behavioral Health*

Usha Reddi, *Manhattan City Commission*

Viola Riggin, *KU Medical Center, KDOC Director of Health Care*

Jennifer Roth, *Criminal Defense Attorney*

Dennis Tenpenny, *Community Support Services Director, Valeo Behavioral Health*

Jess Sholin, *Department of Children and Families*

Jennifer Truman, *Mirror, Inc.*

Susan Wallace, *Family Member*

SUBCOMMITTEE AND WORKGROUP SUMMARIES

Through FY 2016 – 2017, the Justice Involved Youth and Adults Subcommittee (JIYA) reviewed ongoing work and revised/realigned workgroups for the present year. The approach the Subcommittee used involved breaking current priority topics into two separate workgroups. Ad Hoc workgroups would be added as needed. The two overarching topic areas included Program/Best Practices and Systemic Issues.

Broad areas identified as topics to address for the Programs/Best Practice workgroup included the following:

- Crisis Intervention Training – Pre-Arrest
    - Co-Responders
    - Crisis Centers Expansion
- Training and Technical Assistance
- Mental Health Diversion – District Attorney
    - Mental Health Courts
- Assessment/Readiness for Counties
- Juvenile Services

Broad areas identified as topics to address for the Systemic Issues workgroup included the following:

- Funding/Policy
    - Formalizing Agency Relationships
- Kansas Offender Database / KEES (Ad Hoc)
- Data Sharing
- Standard of Care During Incarceration
- Competency
- Discharge Planning
    - Continuity/Care Coordination
    - Both Adults and Juveniles

The workgroups defined new goals and objectives for the year. This report will address each workgroup's recommendations as supported by the JIYA.

Best Practice Workgroup

Workgroup Goals and Objectives:

1. Identify and gather data on the prevalence of mental illness in our jails.
2. Identify what process and assessment to use to measure gaps in communities wanting to explore best practice programming for this population. Identify a pilot site.
3. Identify priorities for which we would like to have the CIT/VA Coordinator position advocate towards our goals.

4. Development of fact sheet for Drug Courts/Mental Health Courts to be placed on KDADS website.

Current Status:

1. Assessment in Jails
   A. This is step two of the six steps recommended by the Stepping Up Initiative to reduce the number of mentally ill people in jails.

   B. Asked Johnson County (large jail), Douglas County (medium jail) and Reno County (small jail) to participate in establishing a *Proposed Criteria for "Gold Standard" Screening and Assessment Process:*

      i. *Jail screening for mental illness is based on a definition of serious mental illness aligned with community/state definitions of mental illness*
      ii. *Jails use a valid screening process on all persons entering jails for mental illness, regardless of the day of the week, time of day, or reason for/pathway of admission*
      iii. *For those individuals staying 72 hours or longer, at least 80% of persons screened positive for mental illness are assessed by a licensed mental health professional*
      iv. *All persons assessed as having a serious mental illness are flagged or tracked in an administrative database*
      v. *The jail is able to query this data at any time to provide a daily, weekly, or monthly census of people with mental illnesses in jail.*
      vi. Serious Mental Illness Definition: "Psychotic, Bipolar, and Major Depressive Disorders and any other diagnosed mental disorder (excluding substance use disorders) associated with serious behavioral impairment as evidenced by examples of acute decompensation, self-injurious behaviors, multiple major rule infractions, and mental health emergencies that require an individualized treatment plan by a qualified mental health professional."

   C. Council for State Governments: Justice Center is the technical advisor for this project
      i. They have increased the frequency of webinars and started quarterly conference calls for counties based on size; small, medium, large.
      ii. Many counties in Kansas are doing significant work, but few have passed resolutions to join the Initiative. Goal should be to increase participating counties.
      iii. For counties considering initiatives related to reducing the number of people with mental illness in jail, this is an untapped resource.

   D. Intercept model – Shawnee County. Complex model.

E. Lead agency – Would like to identify some pilot communities. Discussed identifying a community that may have buy-in often requires a precipitating event to get the community leaders activated to solving a particular problem. Short list includes:
    a. Pittsburg – may also be a possible site
    b. Reno – highest crime rate, but may already have gone through the process.
    c. Manhattan – active discussion regarding the development of a crisis/stabilization center and peripherally CIT.
    d. Hays – may have had a precipitating event. Police shooting back in August.

2. Justice Assistance Grant to look at an "event"/funding to do some planning activity.

3. Jail Study – Consider combining with Stepping Up Initiative

RECOMMENDATIONS:

- Identify next steps on exploring the possibility of the Justice Assistance Grant having money earmarked for a community planning sight to do a pilot project for the assessment process.
- Continue to follow the Stepping Up Initiative, Step 2 with pilot communities to establish best practices in Screening and Assessment in jails.

Systemic Issues Workgroup

Workgroup Goals and Objectives:

1. Research the process of Competency in Kansas.
    a. Review the previous Competency Ad Hoc Workgroup's questions regarding Competency.
    b. Research current questions via presentation from the state hospital staff.

2. Establish an efficient model for Data Sharing:
    a. Determine which agencies are interested in sharing information.
    b. Establish how the information flows from each agency.
    c. Determine what information is needed from each agency.
    d. Review models from other agencies or states.
    e. Determine what kind of information is available electronically.
    f. Determine current obstacles for 3 agencies in sharing information. Make recommendations to solve such barriers.

Current Status:

I. Data Sharing
    a. Five broad areas were identified regarding data sharing, including:
        i. Which AGENCIES share necessary data / What is the flow?
        ii. What information is AVAILABLE among agencies
        iii. What information is USEFUL
        iv. What are the OBSTACLES in sharing the data/information?
        v. What is the MECHANISM for sharing the data/information?

b. AGENCIES:
    i. KDOC
    ii. Jails
    iii. Hospitals
    iv. Community Corrections / Parole
    v. CMHC's
    vi. DCF – children of incarcerated offenders
    vii. SUD Treatment
    viii. KDADS / MH Database
    ix. KS Jail Inventory Data System (live data)
c. FLOW of information / Continuity of care
    i. Community Corrections / Parole to CMHC's
    ii. Jail/KDOC to Probation
    iii. Probation to the Community, etc.
    iv. Resources where care was received previously
    v. Prescription history – Which medications worked the best for the individual offender? Consistency in formularies.
d. USEFUL Information:
    i. Jails
        1. Need prescription history / Similar formularies
        2. *Known medical problems; Medical history*
        3. *History of Medicare/Medicaid/Disability benefits and whether benefits were suspended.*
    ii. Parole/Community Corrections – particularly for Care Coordinators
        1. Those who are Seriously Mentally Ill
        2. Previous resources where offenders have received services – such as CMHC contacts
        3. History of psychiatric hospitalizations
    iii. DCF (to KDOC)
        1. Primarily for female offenders
        2. Is it realistic or healthy to connect/visit with the offender's children?
        3. Who has the offender's children?
    iv. KDOC – *From jails to KDOC; From Community BH Providers (CMHC's) to KDOC*
        1. Previous resources where offenders have received services – such as CMHC's/state hospitals
        2. Medical history
        3. Family contacts
        4. Prescription history
        5. History of benefits – SSI/SSDI; *(KDHE?).*
        6. Available resources for housing / discharge planning
    v. State Hospitals
        1. Available resources for housing / discharge planning

2. History of medical issues
3. Family contacts

vi. Need information from CMHC's, SUD providers, Hospital/Emergency departments, and the VA.

e. OBSTACLES:
   i. HIPAA – Legal obstacles; Special laws regarding behavioral health and SUD information. *There is a question regarding what information can be provided to law enforcement.*
   ii. Security of sharing the information
   iii. Accessibility of the information – electronic vs. hard chart. How to share information and in what format?
   iv. Political hurdles for entities to share what they own
   v. *Releases of Information- Agreements between agencies may alleviate obstacles of sharing information.*

f. MODELS from other agencies or states.
   i. Reviewed "The Criminal Justice Coordinating Council Network Mini-Guide Series: Three Approaches to Integrated Data Systems." February 2013 by the Justice Management Institute.
   ii. Reviewed the Johnson County Data System (Presentation by Robert Sullivan)
   iii. We know it can be accomplished. All systems reviewed served specific objectives of the involved agencies.

g. RECOMMENDATIONS
   i. **Engaging community partners**. The workgroup is moving forward with pinpointing 3 pilot communities. Involvement would initially involve KDOC, Parole, CMHC's, & Substance Use Disorders providers.
      1. We propose targeting three Community Mental Health Centers to begin the discussion where information sharing would be beneficial.
         a. We will possibly model after Shawnee County/Valeo partnership where a multi-disciplinary team meets regarding high acuity patients coming up for release with KDOC and possible jailed offenders.
         b. We also need to find ways to include those treating offenders with substance use.
      2. We propose targeting three of the following areas:
         a. Wyandotte County – There are increased KDOC re-entry services (K-SHOP) and Oxford houses available in this area.
         b. Sedgwick County (ComCare is an active re-entry partner)
         c. Ellis County (working with High Plains Mental Health),

d. Central Kansas Mental Health (including Saline County, Dickinson, Ellsworth, Lincoln, and Ottawa), and/or
e. Compass Community Mental Health Centers (Dodge City/Liberal - Finney, Ford, Grant, Gray, Greeley, Hamilton, Hodgeman, Kearny, Lane, Morton, Scott, Stanton, Wichita County).

ii. Adult Continuum of Care Subcommittee (GBHSPC)

1. We propose making a recommendation for the GBHSPC to endorse and focus on the issue of high behavioral health acuity releases from KDOC and any other jail entity.
2. Primary issues include:
   a. Integration of services from incarcerated status to community; Focus on high acuity need individuals who may be difficult to house with SPMI (ie: sexual offenders, offenders with poor impulse control); Offenders who have been screened for civil commitment/alternatives to commitment. Substance use treatment upon release.

II. Competency

a. The workgroup reviewed the previous Competency Ad Hoc Workgroup's questions regarding Competency. The Larned State Hospital provided a presentation to the workgroup and responded to questions regarding the process of Competency. No recommendations to the GBHSPC are ready to be presented at this time.

SUMMARY

In summary, the JIYA, through its diverse members of the subcommittee and workgroups, provides a unique avenue for members to come together to collaborate, analyze, and create recommendations for the GBHSPC. The Best Practices workgroup members will continue with their current goals of establishing a best practice in the screening and assessment of mentally ill offenders in jails, as well as review resources for funding, including grant opportunities. Additionally, the Systemic Issues workgroup members will engage communities interested in partnerships for data sharing opportunities and to establish a model to facilitate sharing of information among criminal justice entities, community mental health centers, substance use disorder providers, and any other interested agency/entity.

As a final note, Co-Chairs Rick Cagan and Lori Ammons jointly decided to solicit new Co-Chairs to lead the JIYA through the next year's activities. Both will continue to serve on the JIYA. Bill Persinger, CEO of Valeo Behavioral Health and Ted Jester, Director of Juvenile Services Center, Johnson County, agreed to serve as the new Co-Chairs for the upcoming year.

Governor's Behavioral Health Services Planning Council

Veterans Subcommittee Report 2018

2018 GBHSPC Veterans Subcommittee Membership

Chair: Steve Christenberry- FSGC (Retired)

Vice Chair: Steve Roth – Topeka Police Department (Lieutenant)

Members by Regional Recovery Center Areas

Kansas Department of Ageing and Disability Services		
Name	**Position**	**Contact**
Charles Bartlett	Project Coordinator	charles.bartlett@ks.gov
Ron Jeanneret	CIT/Vet Program Coordinator	ronald.a.jeanneret@ks.gov
Wes Cole	Volunteer	scole@micoks.net
Gary Henault	Children's Program Manager	gary.henault@ks.gov
Region 1 – Compass Behavioral Health (Garden Center)		
Name	**Agency**	**Contact**
Marilyn Roberts	Kansas Soldiers Home FT Dodge	marilyn.roberts@ksh.state.ks.us
Mike Morley	Midwest Energy/VFW Hays	mmorley@mwenergy.com
Larry Salmans	Kansas Senator (Retired)	senatorsalmans@yahoo.com
Region 2 – South Central Mental Health (Andover)		
Name	**Agency**	**Contact**
John Agnew	SAC Kansas – Wichita	john@sackansas.org
Pastor Dave Fulton	Saint Paul's Lutheran Church	pastordave.fulton@gmail.com
Region 3 – Wyandot Center (Kansas City)		
Name	**Agency**	**Contact**
Jason Hess	Director Heartland RADAC	jason@hradac.com (Lawrence, KS)
Randy Callstrom	President Wyandot Inc.	callstrom r@wmhci.org
Region 4 – Valeo Behavioral Health Care (Topeka)		
Name	**Agency**	**Contact**
Dr. Stephanie Davis	VA-Topeka	stephanie.davis12@va.gov
Carl Taylor	Manhattan/Junction City	ctaylor@therci.com
Region 5 – Four County Mental Health Center (Independence)		
Name	**Agency**	**Contact**
Doug Harlan	Iraq War Veteran	jtdug@att.net
Kathy Shepard	RSVP Program Four County	kshepard@fourcounty.com
Ryan York	Commissioner/Veteran	Ryan.york@hotmail.com

Veterans Subcommittee Charter October 2017

Governor's Behavioral Health Services Planning Council

Mission: To ensure that veterans, service members and their families are involved in improving access to behavioral health services which are relevant to military culture in collaboration with key provider organizations and other stakeholders.

Vision: There is an expanded and identifiable network of service providers and community supports to adequately meet the behavioral health care needs of veterans, service members, and their families which includes training provider staff about key elements of military culture and organization as well as ongoing engagement of veterans, service members and family members in eliminating barriers to treatment and in creating flexible treatment and recovery options.

Purpose: The Subcommittee will continue to develop mental health and substance use services for veterans. The Subcommittee will also address the broader behavioral health care needs of veterans, service members and their families, and work toward increased collaboration among providers in the public behavioral health system the VA and other provider networks that focus specifically on veterans, service members and their families.

Membership: Membership on the Subcommittee will be balanced to reflect the following stakeholders. Veterans and service members who experience behavioral health disorders, family members of veterans and service members, behavioral health service providers who are specifically funded to assist veterans and active duty service members, representatives from the public mental health system, state agency prevention staff, educators, and other stakeholders, including veterans service organizations. The Subcommittee will designate a chair or co-chairs. A state agency liaison will be appointed from KDADS to provide staff support to the Subcommittee.

Prospective Goals for 2017/2018:

1. Identify quality resources for veterans and their families. (Would like to identify resources in all 105 counties but, at the least the five regions.)
2. Initiate digital outreach for veteran and family services using Facebook, Twitter etc.
3. Engage veteran service organizations across the state such as VFW posts and American Legions.
4. Identify current available courses that train providers in military culture.
5. Expand the three-day crisis intervention training across the state for police/first responders concerning veterans in a mental health crisis.
6. Communicate/partner with Kansas Department of Veterans Affairs.

History of the veteran's subcommittee reactivation

This subcommittee reactivated in June of 2017. The state is divided into five regions with a designated mental health facility as the lead in that region. The plan of the subcommittee was to identify members in those five regions to help accomplish our goals. Many of the subcommittee members received training from SAMSHA technical assistance program for strategic planning in September 2017. From that training the committee established goals to identify quality resources for veterans, their families and children across the state. The committee presented these goals to Secretary Keck in December 2017. Secretary Keck was very supportive of the subcommittee goals.

Currently, this subcommittee is comprised of the chair, co-chair and 16 members from across the state. The group has decided to meet quarterly in 2018. Our first committee meeting was February 1st to begin work towards our goals. The subcommittee has met on April 16th and July 17th.

Goals pursued in 2018 by the veteran's subcommittee

Goal One: Identify quality resources for veterans and their families. (Would like to identify resources in all 105 counties but, at the least the five regions.) (Work still in progress)

- Veteran's subcommittee work on goal one: Several members of the group have identified resources in their region and across the state for veterans, their family and children. Numerous resources have been identified but this work is still in progress within the subcommittee. A broad range of resources are included such as; government at all levels, faith-based organizations non-profits etc. etc.
- Contact information on the KDADS website for veteran services has been updated.
- KDADS children's program manager is working on a resource/service map for children across the state. This would be a useful resource for veterans and their families.
- Members of the subcommittee attended a presentation of My RC a website created by a company in Johnson County. This website would be extremely beneficial for veterans and families. It would identify resources across the state and would be update daily.

Goal Two: Initiate digital outreach for veteran and family services using Facebook, Twitter etc. (Work still in progress)

- Once quality resources are identified a subcommittee member has the expertise to market these resources on social media such as; Facebook, Twitter, Instagram etc.

Goal Three: Engage veteran service organizations across the state such as VFW posts and American Legions. (Work still in progress)

- A subcommittee member is a member of a VFW post and has provided a list of VFWs' across the state and contact information. Subcommittee members will reach out to these posts to determine what type of services they may offer.

Goal Four: Identify current available courses that train providers in military culture. (Selecting a course completed reaching out to providers is a work in progress.)

- The subcommittee discussed several different military culture trainings. Most were free, and some had a cost. The subcommittee decided Psych Armor (15 things every veteran wants you to know) would be beneficial. This is a 15-20-minute video on military culture. The work that still needs to be completed is reaching out to CMHC's, SUD providers, hospitals etc. to have their employees view this video so they have a better understanding of veterans when they come in seeking services.

Goal Five: Expand the three-day crisis intervention training across the state for police/first responders concerning veterans in a mental health crisis. (No action taken at this time.)

- This goal is dependent upon the expansion of CIT across the state and a funding source. After receiving the 40-hour basic course this advanced there day course can be taken concerning veterans in a mental health crisis.

Goal Six: Communicate/partner with the State of Kansas Department of Veterans Affairs. (Completed)

- Veterans subcommittee liaison meet with Director Gregg Burden. Director Burden advised his agency would be happy to work with the subcommittee in any capacity that would be beneficial for veterans. Director Burden advised the primary mission of his organization is to assist veterans in the application process for federal benefits. Our subcommittee members can assist if they know of a veteran that needs federal benefits by directing them to the State Department of Veteran Affairs.

2019 goals and objectives of the veteran's subcommittee.

- The subcommittee will meet in the fourth quarter of 2018 to discuss the goals and objectives to pursue in 2019.
- At the subcommittee meeting in July it was agreed upon to expand the meetings from quarterly to bi-monthly.
- The subcommittee will determine whether to continue work on a few of the goals set in 2018.
- The subcommittee will determine whether to focus on suicide prevention and education efforts for veterans, their families and children in 2019.
- An initiative through SAMHSA in 2019 is to focus on suicide prevention/education for veterans. Topeka, Kansas was selected by SAMHSA as a site for this effort. This is a local effort with the city, county and state for the Mayor's Challenge. The key objectives are listed below.
    1. Build an interagency military and civilian team of leaders from your city and state that will develop consensus on priorities and action items to support implementation of a comprehensive approach to suicide prevention at the local level.

2. Acquire a deeper familiarity with the issues surrounding suicide prevention for SMVF.
3. Increase knowledge about the challenges and lessons learned in implementing strategies by utilizing city to city sharing.
4. Employ promising, best and evidence-based practices to prevent and reduce suicide attempts and completions at the local level.
5. Define and measure success, including defining assignments, deadlines, and measurable outcomes to be reported.

SAMHSA technical assistance personnel came to Topeka for the Mayor's Challenge Site visit on August 30th and 31st to provide attendees training to identify other key players, set goals and objectives, implement strategies, identify other agencies to partner with etc. The training had representatives from the Topeka Police Department, Valeo, VA Eastern Kansas, State of Kansas, City of Topeka HR and Municipal Court and the Shawnee County Suicide Prevention Coalition. Once the Topeka Coalition is established the goal will be to expand this prevention/education effort to other cities in the state. The first meeting of this group will be in November 2018.

Respectfully submitted by
Ron Jeanneret Liaison to the Veterans Subcommittee
ronald.a.jeanneret@ks.gov

Governor's Behavioral Health Services Planning Council Vocational Subcommittee

2017 Report

Accomplishments

A major strategic goal of the Vocational Sub-Committee (VS) has been to encourage implementation of the Individual Placement and Support (IPS) model of supported employment. Developed and researched through The IPS Employment Center at Rockville institute Westat, this evidence-based model provides successful strategies to empower persons with mental health disabilities to achieve competitive, integrated employment. The Committee is pleased to report the following important initiatives pertaining to this goal that are underway throughout the mental health system:

- Currently there are 12 IPS sites. KDADS is looking into ways to provide ongoing technical assistance and monitoring of fidelity measures to ensure that the quality of these programs supports achievement of the desired outcomes.
- The Kansas Department of Aging and Disability Services (KDADS) received a $4 million, five-year grant from the US Substance Abuse Mental Health Services Administration (SAMHSA) to expand access and use of the IPS employment services model to individuals with severe mental illness, including those with a co-occurring substance disorder and by employing peers (persons with lived experience) in their IPS teams. With the award of this grant, IPS Supported Employment Services was implemented at two Community Mental Health Centers; Compass Behavioral Health and Comcare of Sedgwick County. Both implementation sites augmented the IPS Supported Employment model by expanding the target population to include uninsured adults with a severe mental illness and those with a co-occurring mental illness and substance use disorder and by employing peers (persons with lived experience) in their IPS teams. Both implementation sites will convene local supported employment steering committees to address barriers for employment services in their communities and to develop resources or collaborations to enhance their services. The Governor's Behavioral Health Services Planning Council Vocational Subcommittee (GMHPSC) also serves as the Supported Employment Coordinating Committee (SECC) for the SAMHSA Grant. This committee coordinates activities across state departments and consults the grantee or statewide infrastructure measures that will promote and sustain supported employment.
- Kansas Rehabilitation Services, the state's vocational rehabilitation program in the Department for Children and Families (DCF), demonstrated support for the priority to implement IPS through its End-Dependence Kansas (EDK) initiative. IPS was included as one of the evidence-based models and promising practices to be implemented through EDK. As of July 2016 community service providers have been awarded contracts to deliver IPS to Vocational Rehabilitation consumers. The goals of End-Dependence Kansas include:
    1. Increased competitive, integrated employment options and outcomes for Kansans with disabilities.
    2. Further development and sustainability of evidence-based employment practices.

3. Collection of the data necessary to establish a sustainable cost structure for VR-funded services that allows services to be maintained after EDK ends and allows provider partners to succeed in the delivery of services.

In addition to DCF, four other state agencies are supporting the implementation of EDK. They are Health and Environment, Commerce, Corrections, and Aging and Disability Services.

- Previously, the Vocational Subcommittee (VS) undertook the task of educating itself on the new Ticket to Work (TTW) Program. We wanted to find the means and methods to make the program more available to community mental health centers and providers serving other disability populations; thereby, potentially adding another funding source.
- The VS was able to educate CMHCs and other service providers about the availability of the Benefits Planning Academies. These Academies are designed to train interested individuals in the various Social Security Administrations work incentives.
- The VS provided information regarding on-line training from Dartmouth as a low-cost option for training vocational and supported employment staff across the state.

2017 and 2018 Goals

Goal #1: Recommend that the State use their KanCare 2.0 renewal application to implement a 1915(i)-"like" waiver to provide employment supports and other services for individuals with behavioral health issues. An 1115 Demonstration Waiver, the federal authority under which KanCare operates, provides states with an opportunity to test whether a program works before making a long term commitment. Including a 1915(i)-"like" pilot as part of KanCare 2.0 would allow the State to test, over a five-year period, whether the supports provided through a 1915(i) result in an increased number of individuals becoming employed and living as independently as possible. If post program evaluation indicates that this pilot was not successful, the State would not have to continue it beyond the five-year demonstration period.

Goal #2: Mental health centers will use available resources to support getting consumers to work.

Recommendation #1: Encourage integration of Peers into employment services at the CMHC's

Recommendation #2: Statewide educational campaign to dispel the myth of working and losing benefits and decrease the barrier for consumers wanting to work.

Goal #3: The IPS Supported Employment model is the model of choice for the Kansas mental health system and should be made available at every Community Mental Health Center.

Recommendation #1: All CMHC's will use the IPS Principles whether they are an IPS site or not. Any new employment initiative will apply the IPS Principles as listed:

1. Eligibility is based on client choice.
2. IPS supported employment services are closely integrated with mental health treatment services.
3. Competitive jobs are the goal.
4. Employment contact begins rapidly after clients enter the program.
5. Employment specialists build relationships with employers based upon client job interests
6. Job Supports are continuous.
7. Consumer preferences are honored.
8. Benefits planning (work incentives planning) is offered to all clients who receive entitlements.

Recommendation #2: Provide outcome information about CMHCs that implement Supported Employment IPS model. Incentivize the system for better employment outcomes.

- More than 50% of the CMHC's do not offer IPS
- Currently, 40% of the individuals with SPMI do not have access to IPS services.
- 60% of this target population have a desire to work
- 85% of individuals with serious mental illness are unemployed

Recommendation #3: Require CMHC's that do not meet their employment outcome standard implement IPS-SE as part of their performance improvement plan.

Recommendation #4: Require that CMHC's survey consumers a minimum of twice per year to evaluate interest in achieving competitive employment using the Need for Change Scale. Have field staff work with individual Centers.

Recommendation #5: Actively seek out and provide grants to the CMHC's from the State General Funds to offset costs to initiating and implementing IPS services in rural and frontier counties.

Goal #4: Training and collaboration opportunities will be available across the state, to address areas of consistency of services and proper mental health and vocational rehabilitation training for all providers of supported employment services.

Recommendation #1: In SFY 2017, KRS in collaboration with KDADS will seek the participation of one or more community mental health centers to develop and pilot improved referral procedures and documentation, cross-training, and collaborative meetings.

Recommendation #2: Explore mechanisms to improve systems integration of MH & VR that will improve the state's overall goal of implementing IPS statewide.

- Faster referral process
- Increased and timely communication

Goal #5: Increase engagement of stakeholders, consumers, families and employers.

Recommendation #1: KDHE or KDADS require agencies implementing IPS to create opportunities for assertive outreach and engagement for consumers and families.

Recommendation #2 MCO's do more to engage stakeholders with the implementation and sustainability of IPS.

Updated 6/16/2017 MA

Included in this file are the minutes from meetings held on the following dates:

- July 18, 2018
- September 19, 2018
- January 16, 2019
- March 20, 2019
- May 15, 2019
- July 17, 2019

The Kansas Governor's Behavioral Health Services Planning Council meets every other month, or 6 times a year. In 2018, they did not meet in November due to the holiday.

Additional information about the Council, including its bylaws, annual reports, and information on its subcommittees, can be found at https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404

Kansas
Governor's Behavioral Health Services Planning Council

www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Ric Dalke, Vice Chairperson

Governor Jeff Colyer, M.D.

Governors Behavioral Health Service Planning Council
Minutes for May 16, 2018

Present: Wes Cole, Charles Bartlett, Rodney Shepherd, Guy Steier, Fran Seymour-Hunter, Al Dorsey, Victor Fitz, Jane Adams, Peg Spencer, Sandra Dixon, Robbin Cole, Patrick Hall, Denise Mitchell, Julie Hays, Jacob Box,

Guests: Linda Blasi, James Bart, Kim Nelson, Susan Fout

Call to order: 9:09

- Welcome, new member introductions and announcements
  - Introduced new members
    - Julie Hays - family member of Severe Emotional Disturbance (SED)
    - Jacob Box – family member of SED
    - Three other new members not in attendance
      - Christine Thompson, Chrissy Mayer, Stephanie Salisbury
      - Still have 4 vacancies, including the youth member
  - MH Task Force meeting again. Focusing on regionalization and privatization.
  - Problem Gambling Subcommittee is being worked on. Carol Spiker will be the KDADS liaison.
    - Part of the drive for this subcommittee is to continue pushing for getting access to more of the Problem Gambling And Other Addictions Fund (PGAF).
  - Wes attended Consumer-Run Organization (CRO) network meeting yesterday.
  - NAMI 30th annual conference in October 12th
  - MH Association conference in Manhattan September 11th-14th
  - Two new BH Crisis Centers were announced yesterday in Salina and Manhattan
    - Pawnee MH received funding for a 6-bed voluntary unit in Manhattan. Mainly to serve Pawnee clients but they're hoping to widen that. Currently looking for a location and have a start date of January 1, 2019. Looking into a sustainability plan.
    - Pawnee was not listed in the budget item mentioning ongoing funding for crisis centers; hopefully due to how contracts fell. Will be working to ensure Pawnee is included moving forward.
    - Charley would like some of our CIT/Co-responder folks come to respond
- Kansas Citizen's Committee on Alcohol and Drugs (KCC) FY18 Report
  - Subcommittee for the Council focusing on substance use and that system.
  - See attached report for recommendations.
  - Questions?
    - Institute of Mental Disease (IMD) waiver – change to continue the Substance Use Disorder (SUD) waiver just approved by the Center for Medicare and Medicaid Services (CMS) and push for the mental health one.
    - The grant position at KDADS is an important issue.

        - Targeted Medicaid expansion is the correct language to use to get attention.
        - What exactly is the workforce crisis?
            - Positions open for long stretches of time, counselors moving from one center to another. It's hard to keep master's level and licensed folks. Harder to find staff for evening groups. Competitive pay, tuition reimbursement vs what is available to MH.
            - Peer mentoring does help. But there are barriers getting paid for that from certain insurance companies.
            - Especially an issue in rural/frontier.
        - Does this reflect the work of the SQC?
            - The SQC is in the process of getting back on its feet.
            - Should meet again in September.
        - Does telehealth include medication management via computer?
            - Yes. But also more than that. Giving access to other resources/treatment that distance makes it hard for them to get.
            - There was a bill on the topic this year but it didn't include payment parity.
            - It's not good quality health care when they're just talking to someone on a computer screen.
            - We're working to make it better.
            - It is necessary because of workforce issues as well.
                - Who will payers recognize, will they pay, what can providers afford to pay for salaries.
                - When things are grant funded, there is no job security.
                - We need to do some radical, different things to attract people to the workforce.
            - Do you address the credentialing issue?
                - Needing to add new credentials to our workforce to cover broader array of services (co-occurring)
                - Have talked about a lot of things but nothing that made it into this year's report. Support staff who want to get multiple credentialing. Rarely, for those with both credentials, do they just want to stay and do group treatment.
                - Lose a lot of people to private practice.
                - Health Resources Services Administration (HRSA) National Health Service Corp expanded to include SUD providers. Kim sent out info about getting certified to attract those who want loan repayment options. Only for certain levels of licensure, though.
                    - There are some rules – sliding fee scale, provide services no matter what, etc.
                - Workforce is also about psychiatry and all levels of service. Everyone is competing for the same pool of staff. While costs of care have gone up, the treatment rate has not.
                - Vocational Rehabilitation also faces this issue. It's across a lot of social service programs.
                - Nationwide, not just in Kansas, and it's been going on awhile.
                - One of the Assistant Secretary (SAMHSA)'s priorities is behavioral health loan repayment.
- Kim Nelson - Substance Abuse and Mental Health Services Administration (SAMHSA) update
    - Funding
        - Opioid State-Targeted Response grants announced and in process. ($3million a year in Kansas)
        - Additionally, funding for SOR grant, applications currently being worked on, due in August ($4million for Kansas)
            - 2-year (2018-2020)
            - No requirements for how money is spent – expanded medication-assisted treatment (MAT) is probably a big priority.

            - Appendix K lists an annual amount – appropriation shows how much they have to spend in 2 years, unless congress does an additional appropriation for year two.
        - President's proposed budget for 19 includes more money for opioid.
            - Prescription opioid deaths on decline; synthetic fentanyl ODs on the increase.
        - CCBHC grant expansion
            - Kansas did not apply for the previous planning grant.
            - Congress is testing the model.
                - Those who were awarded the planning grant were eligible for the expansion one.
            - Why did we not apply?
                - State leadership was not interested; provider groups were.
                - Not sure if it was the Secretary's decision or was funneled through them by the Governor's office.
                - At the same time the state declined the health exchange money.
                - Would have brought in significant money and sustainable, non-fee-for-service funding.
                - 1-2-year planning grants, 8 states selected for demonstration grant.
                - If data from this looks good, the hope is they might change the funding model on a federal level.
                - A lot of momentum behind the model.
        - Various children's mental health grant options currently available
            - Early identification, diagnosis, treatment, partnering with NIH to prove that early intervention improves outcomes and prevents serious mental illness and emotional disturbance.
        - Ton of funding opportunities out there right now.
            - Corrections to children to SUD to, etc.
            - Most, she thinks, are State-based, not necessarily agency-based
    - Pregnant and parenting women
        - There are some new regulations that came out recently.
            - Increased expectation for states to provide follow-up for drug-exposed babies. (Plans of Safe Care). Increased scrutiny.
            - Addiction Technology Transfer Center working on peri-natal best practices. Focus on the entire family unit, not just the infant.
    - Suicide
        - Kansas 2nd in increase in percentage of those completing suicide. (CDC, 2016)
        - Multiple funding opportunities out there from SAMHSA about suicide.
        - Bringing together Prevention, Suicide Prevention, SYNAR, and Opioid person plus two additional people from the four states in the region to look at prevention.
        - Attorney General contacted her to be part of a youth suicide prevention group.
    - TA Changes
        - Moving towards a more inclusive, regional, TA process
        - Following the ATTC model
        - Looking for a MH TC, Prevention TC, and Center of Excellence PHI one, Center of Excellence for Eating Disorders.
        - STR and SOR TA is very much a regional process. (ATTC is the subcontractee for this)
            - There is now an opioid-specific module for mental health first aid.
            - Http://www.getstr-ta.org
    - New publications
        - Tips for Teens series has been redone
        - Lots of opioid-specific publications available.
        - New clinical guidelines for treating women with SUD
    - Treatment provider advertisements
        - Some of the ones running these ads are not quality, definitely exploitative

        - SAMHSA developed a how to you select a quality treatment provider one-pager.
        - Use the national treatment locator at SAMHSA
    - Questions?
        - With the changes in leadership, what is the direction of the agency?
            - 21st Century CURES Act details our direction.
            - Assistant-Secretary's focus is implementing what's in the Act.
            - Reorganization going on, but mostly internal and administrative, not moving away from the regional presence and structure.
        - What then is our state's response? We need to have someone here from the state who can respond to those and provide input we can respond to, can ensure we're taking advantage of the opportunities available, and so we can provide input on how to best take advantage of them.
            - The HHS leadership team meets with the Governor and his subcabinet once a year to discuss upcoming opportunities.
            - Maybe you need an annual planning meeting.
            - Be sure that the field and consumers need to have a voice.
        - Which of our neighboring states too advantage of the CCBHC?
            - Iowa and Missouri both had planning grants and Missouri was awarded one of the demonstration grants and has gone all-in on the model. Taken the federal dollars and invested state money as well and has required all their centers to transition to the model.
            - How is our relationship with the Council in Missouri to get that data?
                - It will be publicly available. Should be available…soon?
                - There has been discussing between Kim and Wes about getting the Council leaderships of the region together.
                - Kim could use some of her convening funds to pay for some travel. Someone would have to work on logistics. Maybe use some block grant funds?
                - Maybe a summit of the councils with education and training about our responsibilities and providing opportunities for each council to talk about how they function.
- Review Site Visit
    - Look at the council as well as the system in Kansas, especially things related to the Federal Block grant.
    - Executive Committee met with the reviewer during the visit.
        - Was supposed to have an hour and a half, spent almost the entire afternoon.
        - Sent a ton of information to the team before the visit.
        - Went away from the conversation feeling encouraged and empowered as a member of this Council. Left us feeling like we needed to take a critical look at things and push to be more involved.
        - We have an obligation to do more of that.
        - Cultural competency was a big issue, as well as peer services.
        - We are one of the few councils in the country that has integrated mental health and addictions.
        - The turnover at the state level has had an apparent impact on the system/providers.
        - "One of the best council's in the country."
        - How the council was involved in the budget; there needs to be a updated formula.
        - The needs assessment doesn't meet the population shifts
        - Lack of planning system-wide
        - Mentioned DCF child welfare issues.
        - Lack of a strategic plan for the state – the council should be involved
        - Implement policy and planning.
        - Shortage of housing resources.
        - Under-involved peer program
        - System vacillates from one extreme to the other (geographic access?)

        - Cultural diversity mentioned multiple times, especially the LGBTQIA+ community.
        - Relationship or lack there of between DCF and KDADS.
    - SUD Provider Visit – DCCCA Wichita
        - Women's facility
        - Gave really great feedback
        - Focused on their community collaborations.
        - Talked about some of the challenges in the Wichita community.
    - Also visited the Wyandot First Episode Psychosis program
        - Generally positive. Pointed out some cultural competency/diversity issues.
- SAMHSA TA on Advocacy and Future Training for Council and Subcommittees
    - This spring, Wes, Charley, and Jane participated in an advocacy technical assistance project with BRSSTACS.
    - The problem they identified to work on was that when they invite new consumers/family members to be council members without providing connection or guidance on how to be better advocates for the council.
    - Had to have a problem, then a plan on what to change.
    - Task group will develop a questionnaire to ask people what their priorities, interests, experience participating in these kinds of committees, etc.
        - Articulating our purpose as a council and why we are here
        - Describe opportunities for influence – in the council and beyond it.
        - Who is your constituency? Who are you representing? How do we help people connect to others like them?
        - Belonging to the council
        - How the council makes decisions.
    - Wes wants to have a training for the council, the liaisons, the chairs of the subcommittees, and any subcommittee members interested that brings them together to discuss how to get more consumer/family representation on the subcommittees and figure out how to make themselves feel heard.
    - We really need to understand what the role of an advocate is and what it means to advocate for something.
    - Questions/comments?
        - We're talking about putting together a survey of all the council members? And subcommittees? We can do better to help the subcommittee members feel more included and connected, instead of just there to put together a report once a year.
        - The subcommittees may be a more appropriate venue for people with a more targeted agenda, versus the council. The council may be too broad, and it would be better to drill down on specific issues at the subcommittee level. People need to understand maybe that the council isn't the place for that?
        - Council members in the past would attend/participate in conferences and network.
        - The council never does seem to vote. The subcommittees and executive committee seem to be the ones who do most of the work. Because of the broad nature of the Council, it is hard to get a grasp of it all. The frustration could be because the membership leans heavily towards professionals.
        - We don't talk much about the state hospitals.
        - How did our new members find out about the Council?
            - Jane.
            - When I started to research this, I realized the potential to have influence, a voice, as a parent or consumer was there. That I could be not only a voice for myself but for others going through the same thing.
            - There are so many people out there that need help and don't have anywhere to get it, or don't have a means of getting their voices heard.
        - If you're a part of a system, you have that support, as well as access to information. Do we need yo do a better job of taking advantage of existing statewide organizations to market, to look for

those who might be interested in participating? Maybe we need to reach out to them instead of creating a whole new system. Lean on what is already there and reach out to the organizations.
        - Do we make the conditions such that we make it easy for people to participate? Do we need to become more sophisticated about things like conference call or Skype? Learn to better manage a meeting over those platforms? Would that help a more diverse group participate?
        - As a family representative, I can see how a family member could get lost in this whole process, feel lost. This can be an intimidating environment.
        - We have a really great opportunity to be mindful about how we hear and really listen to the struggles that family members and consumers struggle through the system. Consumers, especially those with SUD, feel intimidated and uncomfortable.
        - I see opportunities for growth. We need to be careful how we approach public exposure and input. We do need consumer/family engagement and feedback.
        - I came to this meeting through town square. That hasn't been visible to people in the past. If I could spend 15 minutes on a call with Julie or Jacob, those are the ah-ha moments, when it goes beyond a meeting. Meet in the towns where the members are at so we can see what the community is. Meet people where they're at instead of expecting them to come to you.
        - We all come in with different experiences and levels of expertise. The subcommittees i'm on, the consumers have slowly shifted away, and they're often the same people across many subcommittees. And they get burnt out. Maybe the challenge we have is not only getting them here, but that they're willing to talk about their challenges. Need people here who are wanting to grow personally and share how you do that. I think you need a consumer on your planning committee for this, because they would know best what they need.
        - I think that sometimes we get lost in process and forget about those issues that keep people involved. And I would have to agree that a lot of people don't know who we are and what we're doing. People don't know we're here.
        - I think it's a great idea to include the members of the subcommittees. Maybe turn it into an online survey, and do it in a way where you can ask if they're a subcommittee member or council member. There are some questions that people might be more comfortable answering anonymously.
        - Maybe call them unrealized opportunities instead of problems.
    - Impactful statements
        - Better uses of technology.
        - Families get lost in this.
        - We don't vote.
        - Market the opportunities. Do more to support the consumer/family member representatives – the groups that recommend them sort of abandon them once they're appointed.
- KDADS Update
    - Changes
        - Susan is now a deputy secretary and also currently interim commissioner; the position is out for application now.
        - She is helping the new commissioners settle in and navigate the system.
        - Cissy McKinzie has taken the SUD program manager/block grant manager position.
        - Had the adult mental health position hired, but a family emergency came up and the position has been reposted
        - Children's program manager position open; Gary Henault is filling in for now.
        - Request For Proposals in and are being reviewed for 24/7 hotline and mobile crisis response and state hospital screens. Bids are in. Other states that went with the mobile response model have had a lot of success mainly because the state and the provider don't determine when a crisis happens; the family/consumer does. Statewide, not regional/pilot project is the intention, but we'll see where it goes.
            - Several people, the Secretary included are going to an SOC conference next week. Family members and a legislator are part of that group.

- There is a new final rule regarding waiver recipients, older americans act, and senior care act – will be using an EVV – electronic verification system. RFP out for that, too. A worker that comes into someone's home calls in/calls out (like punching a time card.) would alert a provider if a worker doesn't show up.
- Two new crisis centers added. Places closer to home to go to stabilize and maybe divert from hospital.
- CMHC contracts are out.
- MH First Aid train the trainer the last week of July. Funded by legislature.
- Working on peer support – asked CMHCs to increase their use of peers.
    - Working to integrate peer support. The ideal outcome is an integrated training.
    - Has there been any movement in increasing payment for parent support workers?
        - No, but this is the right time to discuss it. We're preparing the list for the legislature for next year.
    - CROs don't bill Medicaid currently. We've asked them to prepare sustainability plans, and part of some of those plans include becoming Medicaid providers.
    - SIDE just signed a contract to provide peer and respite for Wyandot.
- CRO contracts have been sent out as well. Lost two CROs this year. The three regional CROs are working to help create consumer support networks where brick and mortar CROs don't yet exist.
- Breakthrough Club in Wichita has been funded using the clubhouse model for another year. Had five requests to replicate model elsewhere.
- September is Recovery Month. Oxford Alumni group in Wichita is doing a picnic and Kansas City is planning a carnival.
- Oxford Houses opened their 119th house this month.
- World Oxford House convention will be held in October in KCMO.
- John Worley has left OSH. Interim Superintendent – Clayton Bledsoe.
- Any comments on the site visit?
    - No compliance issues.
    - Report in a year, year and a half with recommendations.
    - Biggest issue is our AIMS data.
        - Did a two-day AIMS training the week before the site visit. Clinical director, executive director, and someone from IT asked to attend from each Center.
- KCPC
    - Working on it. The issue is, our IT department is consolidating into a single state agency – OITS. Had led to prioritizing and their priorities are different than individual agencies.
    - We've talked to 3 different groups of people and got three different answers.
    - The users who really need it currently have a view of all clients, not just theirs.
- Working on opening up housing codes for transitional/supported housing.

- Future meetings, Public Comment, Announcements
    - September 19th, KDADS.
    - Visit OSH in November
    - Recovery Idol – 5th annual. Talent show at Century II Convention Hall in Wichita. Looking for people to perform, as well as partners. Holding auditions throughout the state in the month of August. Free tickets to clients of a provider. Afterwards, there will be a concert by the band Ask Vinnie. September 29th. First place winner gets $500.
    - Will set date for orientation and send out.

Adjourn: 3:31

Governor's Behavioral Services Planning Council
9-19-18

Present: Ric Dalke, Robbin Cole, Sandra Dixon, Rodney, Ethan Bicklehaupt, Stephanie Sailsbury, DeAnn Mitchell, Jane Adams, Christine Thompson, Julie Hays, Fran Seymour-Hunter, Jacob Box, Chrissy Mayer, Guy Steier, Mark Dodds, Victor Fitz, Charley Bartlett, Randy Bowman
On Phone: Al Dorsey
Guests: Nicole Tice, Tabitha Murski, Kolleen Garrison, Melissa Patrick, Erick Vaughn, Nancy Crago, Gary Henault, Christina Orton, Christy McMurphy, HHS vice-chair, Chad Childs, Mende Barnett, Matt Angell, Steve Christenberry, Melissa Bogart-Starkey,

- Announcements
  - Wes is interim superintendent at OSH and that is why he's not here today.
  - Held new member orientation yesterday.
  - JIYA will not be presenting. Missy will be presenting on Housing and there will be a BG update instead.
- KDADS Update
  - Christina Orton joined KDADS as Adult Program Manager
  - Gary filling in Linda Blasi's former role (children's inpatient manager)
  - Susan is still commissioner, probably until after election.
- Rural and Frontier Report
  - See handout:
  - Questions/Comments
    - Who would oppose adopting the KDHE definition and why?
      - If it effects funding, that might explain the resistance.
      - The Secretary supported it last year.
      - Is it a state or federal issue? State.
      - If we knew what the problem is, we would know how to approach.
      - Maybe it would be worth going for a legislative fix.
      - Andrew Weems - Governor's office, might be someone to ask.
    - What kind of support has there been?
      - Legislators we've talked to have been receptive.
      - Find a friendly legislator to sponsor bill.
    - Suggest including SEKS area as well - Four Co MHC, FQHCs, SUD providers in SE and Western Kansas.
- Children's Subcommittee
  - See handout:
  - Questions/Comments
    - What are Early Childhood Providers?
      - Specialize in services and supports for 0-5 children.
    - Drill down more specifically on the parent engagement. Specific examples.
    - What about ways for people anonymously providing comments/examples/feedback? Survey of parents receiving services.
    - Do we have to have so many committees? CCC and Children's Subcommittee as example.
      - We, as the Council, need to talk to our legislators every time a new task force is suggested, bring up cost/wasteful spending/duplication of effort, remind them the council and subcommittees exist for this purpose.

        - Add an agenda item to keep an eye on developing task forces.
        - Maybe make the CCC as a workgroup of subcommittee.
    - Who determines how much $ goes to services than administration?
        - Legislature, KDADS, feds.
    - Schedule meeting with council/chairs to review and prioritize recommendations.
    - Don't focus on the dataBASE but also data analysis.
- Vocational Subcommittee
    - See handout:
    - Questions/Comments
- Prevention Subcommittee
    - See handout:
    - Questions/Comments
        - Are you looking at data regionally?
            - Yes. And we're looking at ways to work with the R&F Subcommittee. There is also a shared member between the two subcommittees.
        - What are the tangible things being done in the prevention world?
            - ACEs outreach/education to parents and educators.
            - Look at the why's behind the risk factors and protective factors.
            - Who is doing the ACEs work?
                - Available on TASN website, DCCCA.
                - Hard to get parents to show up to a parenting workshop.
                - Not everyone is educated about ACEs or where to find relevant services.
                - How do we build resiliency/protective factors?
        - We should support expanding who can do and bill for SBIRT and expand the screening to include suicide early intervention.
        - Don't reenforce the focus on a single substance.
        - Increase SUD funding as well as restore CMHC funding.
- Housing and Homeless Subcommittee
    - See handout:
    - Questions/Comments
        - Is the number of Supported Housing Fund clients duplicated or unduplicated? Unduplicated.
        - Are there some CMHCs without SOAR workers? Yes.
        - Would the two FTEs recommended require increased funding, or be an unfunded mandate? Most people would balk without funding. Recommend the funding and the positions, maybe.
        - Would the centralized data system be housed at KDADS? Somewhere else?
    - Bridge Housing Pilot
        - See handout:
        - Questions/Comments
            - What is being done about kids going into PRTFs that lose benefits when they go in and those benefits pay the parents' rent?
                - Discussions need to be had and are being had.
                - People can talk to their local SS office or CMHC
            - How young does the HUD definition go? Missy will look into it.
            - Cost for the positions mentioned earlier: $52,000 for fidelity, $42,000 for each of the trainers.
- Veteran's Subcommittee

    - See handout:
    - Questions/Comments
        - None
- BG Update
    - See handout:
- Announcements/Questions
    - What's going on at KVC, re: the one child raping the other?
        - Sec made a statement today on the DCF Facebook.
        - Doing more monitoring, meeting with providers, getting daily updates on kids in need of placement/ran away.
        - Working diligently on finding the "missing" foster care kids.
        - 3rd week of safety and risk staffings - diverting kids from custody - 44 of 77 kids staffed.
    - 367 is responsible for all of the new kids in foster care?
        - No. It's a really small number of kids that cross CW and DOC.
        - Data is coming in now and should be included in their 2nd annual report in November.
            - Contact oversight committee to get them to report on it in January. Randy can get Charley a contact.
        - Hiring 2 investigators to go out looking for runaways is also making an impact.
    - Maybe the council should consider attaching financial tags/budget suggestions to the priorities.
    - Send out Doodle Poll for November dates

Governor's Behavioral Health Services Planning Council

January 16, 2019

Members Present: Charley Bartlett, Wes Cole, Robbin Cole, Matthew McGuire, Rodney Shepherd, Stephanie Salisbury, Deann Mitchell, Julie Hays, Guy Steier, Ric Dalke, Kathie Washington, Cherie Bledsoe, Chrissy Mayer, Sandra Dixon, Brenda Groves, Jacob Box – joined on the phone during the business meeting portion: Jane Adams, Patrick Hall, Fran Seymour, Peg Spencer, Sherri Vaughn, Patricia Long

Guest Present: Iryna Yeromenko, Vicki Vossler, Leslie Bjork, Debra Day, Koleen Garrison,

Meeting called to order, introductions around the room.

Patient Panel: three patients came into share their experiences at Osawatomie State Hosptial. Council asked questions as they occurred. Patients shared what they would like to see added to the program. One patient shared he would like to see them have a in/out program. Three days in your own apartment and return to OSH for therapy and guidance with issues as they occur 3-4 days a week. This would be to slowly introduce them to the independence of being on their own and how to handle situations as they need guidance.

Leslie Bjok, Elizabeth Layton MHC – spoke about their program and provided handouts added to the bottom of this document if you would like to review them.

Sexual Predators Therapy Program (SPTP) presented the steps to the program and how it works. Shared that each program has 16 patients. They have released 11 patients that have successfully completed the program.

OSH & AAC Hospital Updates—Adair Acute Care shared what their program offers and how it works. 1-2 week treatment/stabilization then discharged to hopefully an inpatient treatment center if needed. She discussed the issue with many of their patients was releasing them was releasing them to homelessness.

Adair Acute Care using Art and Music Therapy to help their patients.

July 1 – Jan 16 they have had 623 admissions.

41% of these admissions discharge to homelessness. They have been working with KDADS to help identify housing for these individuals prior to discharge.

They have added Triage Nurses to their staff to evaluate if they can treat the patients being sent to them for admissions. Can they meet the medical needs of these patients?

OSH/AAC are working on getting their nurses Psych certified. They are also providing management training to empower their staff.

Wait list to AAC/OSH is less than 72 hours to get a bed. OSH has added beds to help alleviate the wait list issue.

76% of OSH budge goes to Salary & Wages.

Iryna Yerokmenko, Asst Superintendent at OSH – shared budge concerns and creative ways they have found to get what was needed without breaking the bank.

Business Meeting: KDADS – Charley Bartlett shared the announcement of the new Secretary. The hiring of Matt McGuire – VA/CIT Program Coorindater, issues KDADS is having in getting the Opioid position filled. System of Care Coordinator went to KDHE. KDADs has hired Ryan Haggerty as the Youth Engagement Specialist.

Charley shared the creation of the PEER Support Services – SUD System – WSU is working on an on-line class to be rolled out soon. This training is a two-tiered training. 1st tier (Level 1) is an online class that once you are certified you can have up to 20 hours a week contact with supervison. 2nd tier is an inperson training that you must complete within one year of being certified to be a Level II Certified PEER Specialist which allows you 30 hours a week contact with a different level of supervision.

The inperson training will be a traveling training to help accommodate participants. This program will have ongoing CE requirements to stay certified. CE cost is a concern. Charley indicated this training was to be a high impact – low cost training.

Question – how long can you be out of the PEER support services before you must be re-certified.

OSH has offered to open their training to anyone in the PEER Support program without cost.

At this time this is an Adult PEER support – you must be 2 years older than the person you are PEER supporting. You must be 18 years of age and have a high school diploma. Next KDADS will be working on Child PEER support.

KDADS is looking at the Tier 2 to be cross-trained in SUD/Mental Health.

KDADS is concentrating on getting the on-line course up and running at this time.

Charley introduced the February 12 Sub-Committee Chairs, Co-Chairs, Executive GBHSPC Board, any council/committee members who wish to attend may do so. Please RSVP by February 6. The goal is to: get on the same page, so that the same message is being sent by each committee, this will make us better heard, give us Uniformity through the committees, increase Consumer Voice, advocate for funding for the Consumer Voice, improve communication. The

end goal is to get a letter sent from the Council to the Governor requesting funding to improve the participation of the consumer on the Council and Sub-Committees.

Wes indicated we will have to identify the barriers to get funding for the addition of more consumers to the committees.

Pay reimbursement for overnight travel has been approved for the February 12 meeting for KCC and GBHSPC.

They would like Laura Kelly to speak at this meeting, if they can get her there.

Jane Seymour asked if there could be a pre-meeting with consumers/parents/families, so that their voice could be heard at this meeting.

Jane Seymour also asked about the System of Care – SAMSHA spending on PEER support for children and to make sure that other are a part of this training.

Charley discussed the possible changes with the expansion of Medicaid. Who can receive treatment through the Block Grant money could be expanded.

Ric Dalke asked who determines where the Block Grant money is spent. Wes answered KDADS.

Charley shared that Kansas is 1 of 5 states asked to participate in the Governor's Challenge. For Vets Suicide Prevention. Andy Brown, Matt McGuire and Charley will be going to Washington to get technical assistance with this statewide initiative for Vets and Families SAMSHA is paying for the travel. Kansas has one of the highest rates of Vet suicide..

Wes discussed the letter needing to be sent to the Governor requesting help with the Children's Waitlist for Mental Health Inpatient Treatment, money for Consumer participation Koleen Garrison indicated her issue with CAC was resolved by Carrie Billbe and Andy Brown. They have agreed to fund with an 18 month budget.

The Justice Involved committee is in need of members. They have lost several committee members.

Roger Woreholtz is back as the Secretary of Kansas Department of Corrections. He has agreed that Ted will be at the February 12 meeting. Roger was instrumental to get mental Rehab support for prisoners. He implemented the diversion program, DUI programming and Re-entry pgoram.

GBHSPC – next meeting we will discuss planning for the new year.

Self-Assessment – what have we done right, what could we do better and what should be changed.

Budget

Crisis Center visits – new one in Salina, Central Kansas and Larned.

Invite the Secretary to this meeting.

Wes apologized to the committee for not being as focused on the committee as normal as he has been busy at OSH.

Wes thanked Charley for his great work on the Committee.

FYI – Al Dorsey has retired and has a new e-mail address.

Committee participated in the Hearing Voices training.

Meeting adjourned.

ELIZABETH LAYTON CENTER

For Hope and Guidance

Annual Report 2017

OUR MISSION

The Elizabeth Layton Center's mission is to provide timely, effective and comprehensive behavioral health services to improve quality of life and recovery for the citizens of Franklin and Miami Counties in partnership with individuals, families and our community.

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Overview of Services

The Elizabeth Layton Center is a private not-for-profit community mental health center serving the mental health treatment needs of the residents of Franklin and Miami counties providing a comprehensive array of behavioral health services for our communities.

Outpatient

- Diagnostic Evaluation/Intake Assessment For Mental Health and Substance Use Disorders
- Individual/Family Therapy
- Group Counseling
- Psychological Testing/Evaluation
- 24/7 Crisis Services

Medical/Psychiatric

- Psychiatric Medication Evaluation
- Psychiatric Prescription Management
- Medication Injections
- In-County Residents Only

Community Based Services
Children/Youth—Serious Emotional Disturbance

- Case Management
- Attendant Care
- Psychosocial Group/Individual
- Early Childhood Program (Preschool-aged Children)
- Parent Support Services
- HCBS SED Waiver Services
- Circle of Security Parenting Program

Community Support Services
Adults—Severe and Persistent Mental Illness

- Case Management
- Attendant Care
- Psychosocial Group/Individual
- Supported Housing
- Peer Support
- Integrated Healthcare Coordination
- Medicaid Non-Emergent Medical Transportation

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Psychiatric Medication & Psychological Evaluations

1,287 Medication Management Clients Served in 2017

Franklin County — Adults 566 and Children 164 **Miami County** — Adults 378 and Children 179

Medication Management

ELC offers a full range of psychiatric medication services for adults, adolescents and children residing in Franklin or Miami counties. Medication can be useful in the treatment of anxiety, depression, mood disorders, bipolar, psychotic illnesses, ADHD and other mental disorders. An initial evaluation is completed and if medication treatment is recommended, the client is monitored on a follow-up schedule to determine the ongoing effectiveness of the prescribed medications and changes are made as clinically appropriate. Patient Assistance Programs and generic medications can offer cost effective solutions.

Advancements in the area of psychiatric medications have been remarkable in the last 20 years, allowing more options for clients in managing mental health symptoms. Our psychiatrist and advanced practiced registered nurses work closely with other providers at ELC, local primary care providers and with other referral sources when indicated to ensure a comprehensive, coordinated and holistic approach to treatment.

Psychological Evaluation Services

Psychological evaluations use a combination of techniques to help arrive at some hypotheses about a person and their behavior, personality and capabilities. These findings assist referral sources in making decisions regarding treatment, educational placements, and other matters. Clients may request this service by self referral or as a recommendation by an ELC provider, school personnel, court, attorney, medical provider or others. ELC utilizes a variety of specialized testing/assessments as part of the evaluation process. Types of Psychological Evaluations include: ADD, ADHD, Bariatric, Parenting Assessments, Diagnostic, IQ, Achievement, Substance Use Evaluation, DUI Evaluations, and Spinal Cord Stimulator Assessment related to pain management. Some evaluations may require a formal Intake Assessment.

Outpatient Therapy Services

1,530 Initial Appointments in 2017
738 Franklin County—792 Miami County

Common Reasons for Seeking Services at ELC: stress, anxiety, depression, problems at work, relationship issues, behavior issues in school, can't concentrate, can't focus, substance use is interfering with life, etc.

Outpatient Services for Adults/Children/Families

Licensed mental health professionals provide a wide array of mental health services designed to help improve the qualify of life through timely, collaborative, effective and appropriate evidenced based treatment. Our therapists utilize a variety of techniques and best practices to help clients achieve personalized treatment goals including cognitive behavioral therapy (CBT), Dialectical Behavior Therapy (DBT), Motivational Interviewing, Exposure Therapy among others.

ELC has staff trained in play therapy to help younger children resolve issues. Teaching parenting skills through various techniques and educational classes are also utilized to help achieve treatment goals.

Substance Use Services

The program focuses on providing adults and adolescents with the skills and support necessary to remain abstinent from alcohol and drugs through individual and group therapy. Educational materials, group therapy, motivational techniques, and relapse prevention are included in this process.

STEPS TO ACCESSING A NON-CRISIS APPOINTMENT

1. **Call and ask** for the **Intake Coordinator**
2. Provide **basic information** name, address, phone number reason for seeking services, insurance and/or household income.
3. **Schedule the Appointment**
4. Plan to **arrive early** (30 minutes for adults, 60 minutes for children), meet with the Intake Coordinator to complete necessary paperwork for the Intake Appointment and then be seen by the mental health provider for approximately an hour.
5. **Bring** the following to the Intake Appointment:
   - **Photo ID**
   - **Health Insurance Card** (to assure an in-network provider)
   - **Proof of Residency** (utility bill, lease agreement, etc)
   - **Proof of Income** (pay stub, income tax form, bank statement, etc)
6. Upon completion of the Intake Appointment, the person will **receive a diagnosis** and an **individualized treatment plan**.

1 in 4 (lifetime prevalence) diagnosable mental illness

Centers for Disease Control and Prevention

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Crisis Services & Mental Health First Aid

671 Crisis Services/State Hospital Assessments in 2017
Franklin County — 338 Miami County — 333

Crisis Services and Critical Incident Stress Debriefing

ELC has **crisis services available 24/7** providing **mental health emergency** and **suicide prevention services** for Franklin and Miami counties. Inpatient admission to State Psychiatric Hospitals requires an assessment by our crisis staff. Staff coordinate with local resources to reduce inpatient admissions by keeping people safe in the community through the delivery of comprehensive mental health services. We partner together with law enforcement, hospital emergency departments and other emergency responders to help those in crisis. Local law enforcement officers have incorporated practices of the **Crisis Intervention Team (CIT)** program, which is a model to help first responders to act appropriately to situations involving mental illness, developmental disabilities or emotionally disturbed persons in crisis.

Critical Incident Stress Debriefing (CISD), is available to partnering community agencies following a traumatic event within our communities. CISD gives people an opportunity to share with others involved in the incident the facts, the feelings, the impact and perspectives on the incident helping to work through the loss and horror of the tragedy. When completed within 72 hours of the traumatic event, CISD helps minimize the number of people who may experience Post Traumatic Stress Disorder as a result of encountering a traumatic event.

Mental Health First Aid is an **8-hour best-practice curriculum** that provides tools to assist someone experiencing a behavior health crisis. The course teaches participants to identify risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Participants leave with a **5-step action plan** to help others who are showing signs or symptoms. **Two courses** are available one focusing on **Youth related disorders** and one focusing on **Adult related disorders**.

- **Adult Course Topics:** Depression, anxiety, psychosis (hallucinations or delusions), and substance use, disorders.
- **Youth Course Topics:** Anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including ADHD), and eating disorders.

ELC receives some funding through the local United Way organizations in both Franklin and Miami counties to provide this training. Classes are offered on a scheduled basis throughout the year. Participants have included school personnel (teachers, administrators, and other school district staff), law enforcement officers, healthcare professionals and other community members. Individual classes for an agency may also be arranged for more information contact Miami County Operations Director, Loree Love.

2017
ELC Trained/Certified
83 in the **Youth Course**
46 in the **Adult Course**

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Community Based Services for SED Youth

385 Youth with SED Served in 2017

Number Served Franklin County — 213 Miami County — 172

ELC provides intensive support for youth struggling with a **Serious Emotional Disturbance (SED).** To qualify for **Community Based Services (CBS),** children must be having significant difficulties managing behavior at home, in school or in the community. Children may be diagnosed with such disorders as oppositional defiant disorder, ADHD, depression, anxiety and others. Services are provided at the mental health center, in the family home, the community and staff are welcome at many of the area schools to provide support to students during the school day.

Services focus on a strengths-based model of treatment and are developed within the family's cultural context. Specially trained staff collaborate with the family to develop a treatment plan to encompass the child's individual needs and determine what services will be most helpful in achieving the treatment goals. This program expands the traditional array of therapeutic services and may include: Targeted Case Management, Community Psychiatric Supportive Treatment (CPST/case management), mental health attendant care and psychosocial treatment group. ELC works with youth of all ages from toddlers, preschoolers, grade

STEPS Program (Supportive Therapy Early Prevention Services)

This year-round program is designed for children ages 2 to 6 who have difficulty participating in regular community preschool settings due to emotional or behavioral concerns. Children may be referred by families physicians, daycare facilities, preschools, Tiny-k, and Head Start among others. Staff use evidence-based, brain-based programming in helping to manage behaviors.

Psychosocial Group Programming:

Psychosocial group programming is used to teach essential behavioral and social skills to support youth in making appropriate choices within their homes, schools and communities in group settings. Our staff work with youth to improve their abilities to relate to peers and authority figures in a cooperative and appropriate manner. Staff utilize best practice materials in developing group curriculum.

Summer Psychosocial Group Program

This specialized summer program is designed to meet the needs of SED youth ages 3 to 17. The program works in a group format to help youth work on the skills that prevent them from functioning well at home, at school and in the community. ELC provides a safe, structured environment to help youth improve social skills, anger management, problem solving and emotional expression.

Circle of Security Parenting Program

This grant-based program assists parents of children 0-5 years of age in learning developmentally appropriate parenting techniques. The program teaches parents to respond the their children's cues and develop healthy attachments. This program is free of charge to parents.

Community Support Services for Adults with SPMI

385 Adults with SPMI Served in 2017
Franklin County — 128 and **Miami County** — 75
107 Referred to the Program, 109 Exited the Program

ELC provides intensive support for adults who meet the State criteria as struggling with a **severe and persistent mental illness (SPMI)** . This can include diagnoses such as Bipolar Disorder, Schizophrenia, Mood Disorders, Major Depressive Disorder, Psychosis, and others. Using a variety of services, including case management, staff work with clients to help individuals obtain and use needed community resources in the areas of housing, medical services, financial support, social interaction, education and employment. Our goal is to help consumers in mental health recovery to maintain increased stability within the community by improving their ability to manage their symptoms and overcome challenges of everyday life.

Treatment goals are developed with clients on an individualized basis. Most consumers achieve their goals through the use of case management and psychosocial group programming provided at the mental health center, within the community or at their home. Consumers often include individual therapy, group therapy and medication management to assist them in meeting their treatment goals.

ELC also offers some specialized services for those with severe and persistent mental illness including:

SSI/SSDI Outreach Access and Recovery (SOAR): This program provides support to consumers during the application process for obtaining disability benefits.

Supportive Housing Program: ELC has in each county housing for consumers needing additional support with daily living skills in order to remain in the community. In Miami County, ELC has one designated crisis bed available to assist in the prevention of an inpatient hospitalization. ELC provides attendant care when medically necessary and staffs the houses according to need.

Medication Support: Staff can also provide voluntary medication drops within the community to assist consumers in taking their medication as prescribed to manage symptoms.

PhotoVoice is a psychosocial group developed in 2017 that teaches skills that enable individuals to tell personal stories through photographs that offer insight and teach others about their experiences. Photographs offer the ability share life experiences in a way that words simply cannot capture. The above exhibit was recently on display at the Ottawa Library

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Client Success Stories and Testimonials

An adult Client presented for issues regarding social anxiety. Treatment focused on the Cognitive Behavioral Therapy model. Through treatment, this Client was able to successfully challenge maladaptive thoughts with alternative thoughts and engage in social activities such as a vacation with friends, going to parties, and interacting with staff at stores and restaurants. Client reported that he used to think of these events as something to 'make it through' and he now looks forward to them.

ELC received flowers and the following feedback from a Consumer: "Elizabeth Layton, Just a note to let you know that I appreciate each and every one of you and all of your hard work you do. Have a great day."

An adult presented to ELC with significant social anxiety and difficulty leaving the home. Through a course of outpatient therapy with David Walter, this Client can now leave the home regularly and has developed a circle of friendship within the community.

"Dear Barbara Cordts – Thank you for letting me come and talk to you! You helped me so very much. I have less problems and I always wanna come back. Thank you for today."

ELC's Community Corrections Clinician works with an adult on probation with a long history of violent behavior. He was placed on probation previously, but within a month had re-offended. This time the Client is engaged in multiple services in the community as well as through ELC. Through coordinated efforts, the treatment team has helped this individual avoid offensive behaviors for almost three months. Recently, the Client had an incident at a convenience store where someone physically hit him. Instead of retaliating the Client thought about his consequences and walked away. He is very proud of himself for making different choices.

CSS Consumer reported being "absolutely pleased" with provider Candi Dials. She described Ms. Dials as "amazing" and that she helps with emotions, encouragement and can recognize symptoms sometimes before the Client can identify them

A Youth has been successful in maintaining placement for over seven months, despite a past history of multiple placements due to behavioral difficulties. This Youth's caregiver recently expressed a greater understanding of CBS services, noted progress being made, and the

Parent of a CBS Consumer reported that providers Quincy Garrett and David Walter are fantastic with care coordination meetings, client check-ins and do a good job providing suggestions that really help her son.

A young adult recently verbalized progress by realizing that past trauma endured was not their fault, and that while they are changed by the trauma, they are able to "deal with it and learn from it."

"I love ELC."

A Youth began CBS services in 2012. At that time he was unable to manage symptoms in a typical classroom and was living with grandparents because parents were not able to care for him. After a course of treatment through ELC, some of which was offered at the alternative school (ECKA) this Youth has transitioned back to school in his community full time and has successfully graduated from CBS

During a routine quality call, one MiCo consumer reported she was very thankful for case management services from Starla Medlin. She stated Starla is "always there for me, is kind spirited and would do anything to help" and that this is very helpful to her.

Overall Client Demographics

Total Clients Served in 2017: 4,051

Total Services Provided in 2017: 102,547

Gender

Male	1922	48%
Female	2124	52%

Age

<6	103	2.5%
6-12	609	15.1%
13-18	682	16.9%
19-24	341	8.4%
25-34	650	16.1%
35-44	576	14.2%
45-54	486	12.0%
55-64	406	10.0%
65>	193	4.8%

Admissions — 1530

Average per month	130
Average per week	30
Average per working day	6

Annual Household Income

$0 to $11,490	1675	47.0%
$11,491to $15,282	264	7.4%
$15,283 to $22,980	452	12.7%
$22,981 to $35,000	463	13.0%
$35,001 to $42,000	151	4.2%
$42,001>	561	15.7%

Ethnicity

White	3538	91.0%
Multiracial/Unknown	121	3.1%
Black/African American	93	2.4%
Hispanic	80	2.1%
Native American	46	1.2%
Asian	12	.3%

Client Insurance Coverage

Medicaid	1566	38.3%
Commercial Insurance	1336	32.7%
Self Pay (includes Medicaid Spenddown)	673	16.5%
Medicare	514	12.6%

Diagnostic Summary of Primary Diagnoses

Depression	27.5%
Anxiety (Phobias, PTSD, Trauma)	21.4%
ADHD	13.0%
Adjustment Disorders	9.0%
Bipolar	7.8%
Conduct/Oppositional Disorders	6.0%
Schizo Spectrum Disorders	5.9%
Substance Use	1.7%
Personality Disorders	1.0%
Autism Spectrum Disorders	.5%

Client Demographics - By County

FRANKLIN COUNTY

Total Clients Served: 2,040
Total Services: 57,657

Admissions — 738

Average per month	61.5
Average per week	14.1
Average per working day	2.8

Gender

Male	972	47.7%
Female	1066	52.3%

Age

<6	47	2.3%
6-12	294	14.4%
13-18	302	14.8%
19-24	176	8.6%
25-34	343	16.8%
35-44	297	14.6%
45-54	263	12.9%
55-64	205	10.1%
65>	112	5.5%

Ethnicity

White	1858	92.4%
Other/Unknown	44	2.2%
Black/African American	38	1.9%
Hispanic	35	1.7%
American Indian	29	1.4%
Asian	6	0.3%

Annual Household Income

$0 to $11,490	938	47.4%
$11,491 to $15,282	151	7.7%
$15,283 to $22,980	260	13.2%
$22,981 to $35,000	262	13.3%
$35,001 to $42,000	111	5.6%
$42,001>	251	12.8%

Client Insurance Coverage

Medicaid	793	38.8%
Commercial Insurance	341	28.9%
Self Pay	591	16.7%
Medicare	318	15.6%

MIAMI COUNTY

Total Clients Served: 2,011
Total Services: 44,890

Admissions — 792

Average per month	66.0
Average per week	15.2
Average per working day	3.0

Gender

Male	950	47.3%
Female	1058	52.7%

Age

<6	56	2.8%
6-12	315	15.7%
13-18	380	18.9%
19-24	165	8.2%
25-34	307	15.3%
35-44	279	13.9%
45-54	223	11.1%
55-64	201	10.0%
65>	81	4.0%

Ethnicity

White	1680	89.4%
Multiracial/Unknown	77	4.1%
Black/African American	55	2.9%
Hispanic	45	2.4%
Native American	17	.9%
Asian	6	.3%

Annual Household Income

$0 to $11,490	743	46.5%
$11,491 to $15,282	113	7.1%
$15,283 to $22,980	192	12.0%
$22,981 to $35,000	201	12.6%
$35,001 to $42,000	40	2.5%
$42,001>	310	12.4%

Client Insurance Coverage

Medicaid	773	37.8%
Commercial Insurance	745	36.4%
Self Pay	332	16.2%
Medicare	196	9.6%

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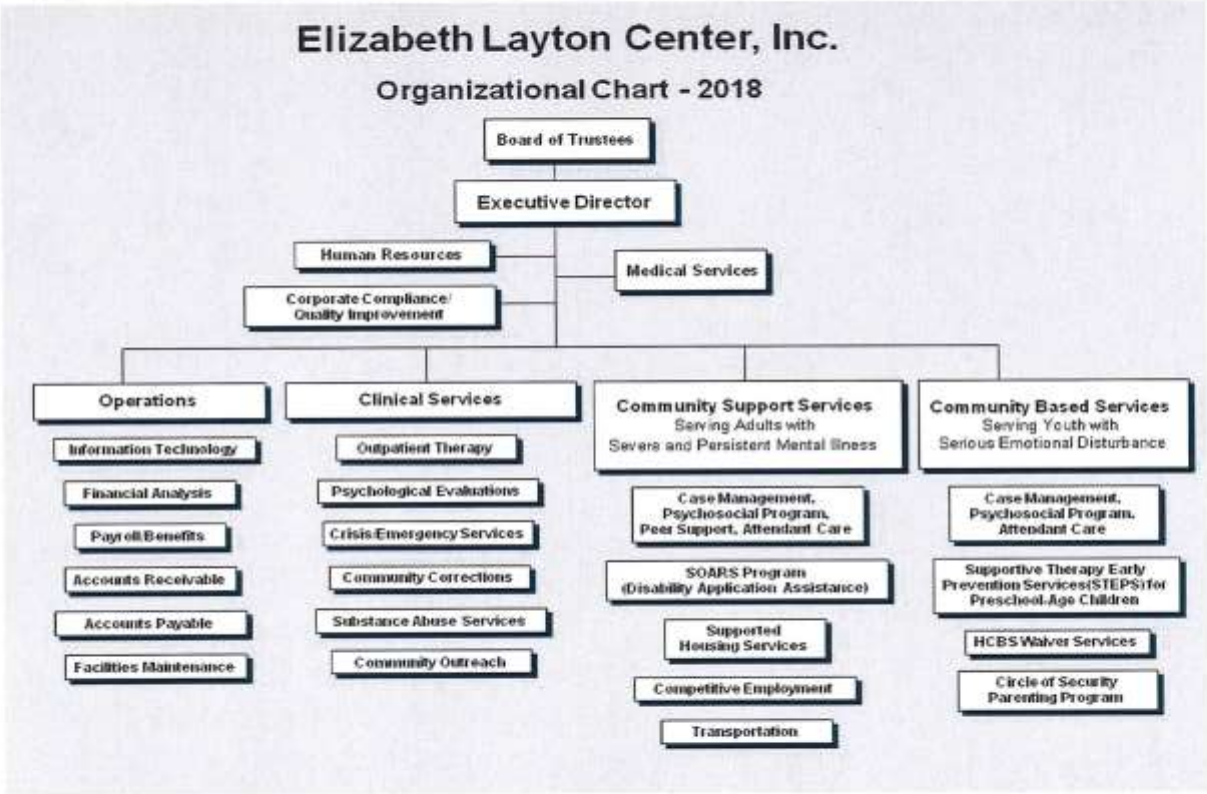
Organizational Structure



Average Number of Employees in 2017:	**151**
Total Hours Worked in 2017:	**252,875**

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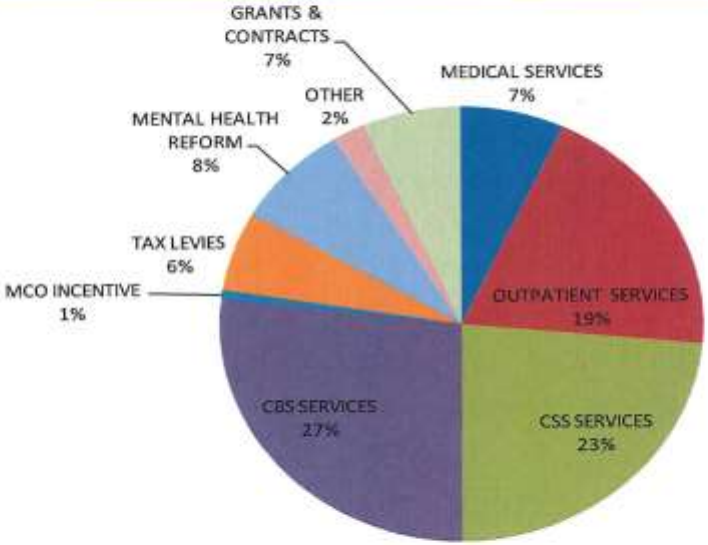
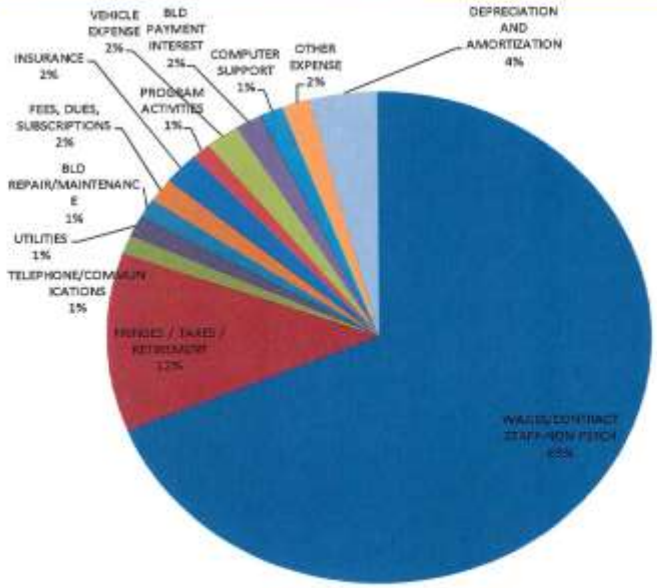
2017 By the Numbers

REVENUE
$7,088,711



EXPENSE
$7,036,646



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Board of Trustees, Administration & Locations

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Paul Luce, Vice President
Tom Lundblad, Secretary
Matt Heyn, Treasurer
Don Cawby
Donna Dornes
David Green
Debra Horne
Lisa Johnson
Cathy Macfarlane
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2017 Board of Trustees

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Clinical Director

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Amy Wacker, LPC
Director of Community Based Services

Donna Johnson, LCP, LCAC
Director of Quality Assurance/Risk Management

John Schlegel
IT Director

Kiki Heck
FrCo Operations Director

Loree Love
MiCo Operations Director

Briana Madsen
HR Director

After Hours Crisis Services
1.800.241.1266

Franklin County Locations

Outpatient & Children's Services
2537 Eisenhower Road
PO Box 677
Ottawa, Kansas 66067
Telephone: 785.242.3780
Facsimile: 785.242.6397

Community Support Services
204 East 15th Street
PO Box 677
Ottawa, Kansas 66067
Telephone: 785.242.3780
Facsimile: 785.242.3593

Miami County Locations

Outpatient & Children's Office
25955 W 327th Street
PO Box 463
Paola, Kansas 66071
Telephone: 913.557.9096
Facsimile: 913.294.9247

Community Support Services
102 Baptiste Drive
Paola, Kansas 66071
Telephone: 913.557.9096
Facsimile: 913.294.4996

www.laytoncenter.org

CHARITABLE DONATIONS APPRECIATED

ELIZABETH LAYTON CENTER
For Hope and Guidance

ELC Client Summary for 2018

Total Clients Served: 4,116
Number of Services Provided: 102,382

Gender	Number	Percentage
Male	1977	48.0%
Female	2136	52.0%

Ethnicity	Number	Percentage
White	3650	90%
Black/African-American	99	2.4%
Hispanic	58	1.4%
American Indian	36	0.9%
Asian	9	0.2%
Other/Unknown	216	5.3%

Age	Number	Percentage
Under 6 years:	79	1.9%
6-12 years:	624	15.2%
13-18 years:	732	17.8%
19-24 years:	423	10.3%
25-34 years:	645	15.7%
35-44 years:	566	13.8%
45-54 years:	441	10.7%
55-64 years:	417	10.1%
65 years & over:	182	4.4%

Household Income	Number	Percentage
$0-11,490	1793	47.9%
$11,491-15,282	265	7.1%
$15,283-22,980	420	11.2%
$22,981-35,000	491	13.1%
$35,001-42,000	172	4.6%
$42,001 and above	599	16.0%

Payer Source	Number	Percentage
None/Self-Pay	793	19%
Medicaid	1452	34.7%
Medicare	475	11.3%
Commercial	1464	35%

outpatient only

2018 ELC Community Partnership Highlights

24-hour Mental Health Crisis Assessment Services (regardless of ability to pay)
CBCAP Grantees (enhanced community detection of early childhood mental illness)
City of Ottawa funding partner
COF Services, Inc. psychiatric medication services provider
Community in-service presentations to various organizations
Community Board Representation

- 4th Judicial District Community Corrections
- 6th Judicial District Community Corrections
- Hope House
- My Father's House

Community Corrections Clinicians through KDOC grant
Community Health Fair participants
Connect Kansas Coalition member
Crisis call triage training for Osawatomie State Hospital
Crisis Intervention Team member
Critical Incident Stress Debriefing for community organizations
Emergency Preparedness Planning (LEPC) member
Franklin County funding partner
Franklin County Children's Coalition Member
Franklin County Crisis Intervention Training partner
FrCo Sexual Assault, Domestic Violence & Human Trafficking Team member
Headstart Consultation to Franklin, Miami and Anderson Counties
Medicalodge of Paola- Liaison + Mental Health First Aid training
Mental Health First Aid training – Youth and Adult
Miami County funding partner
Miami County Intergovernmental Committee member
Multidisciplinary Team member for Community Corrections
Multidisciplinary Team member for MiCo Court CINC case management
Osawatomie Chamber member
Osawatomie State Hospital Liaison
Ottawa Chamber member
Ottawa Mindful Community partner
Ottawa Police Department televideo consultation services
Ottawa-Wellsville Early Childhood Council member
Paola Chamber member
Paola "Support Our Schools" partner
Ripple Effect Suicide Prevention movie event partner
Statewide Board Representation

- Association of Community Mental Health Centers/Executive Committee
- Governor's Task Force subcommittee on Children's Continuity of Care
- Healthsource Integrated Solutions
- Kancare Clinical Committee

Tri-Ko psychiatric medication services provider
United Way member agency & funding partner

ELIZABETH LAYTON CENTER
For Hope and Guidance

USA MENTAL HEALTH FIRST AID

MENTAL HEALTH FIRST AID TRAINING

Elizabeth Layton Center is excited to offer Mental Health First Aid training! This fun and ground-breaking training course gives people the tools to identify when someone might be struggling with a mental health or substance use problem and how to connect them with appropriate support and resources when necessary.

1 in 5 Americans has a mental illness, but many are reluctant to seek help, or might not know where to turn for care. Unlike physical conditions, symptoms of mental health and substance use problems can be difficult to detect. Those in need of mental health services often do not get help until it is too late.

Just as CPR helps those without clinical training to assist an individual having a heart attack, Mental Health First Aid prepares participants to interact with a person experiencing a mental health crisis. Mental Health First Aid teaches a 5-step action plan that guides through the process of reaching out and offering appropriate support. More than 550,000 Americans are certified Mental Health First Aiders and that number is growing every day.

Visit www.meantalhealthfirstaid.org to learn more.

Elizabeth Layton Center offers two evidence-based Mental Health First Aid courses, both with an 8-hour curriculum. **Adult Mental Health First Aid** focuses on how to identify and help Adults in crisis. **Youth Mental Health First** aid teaches how to identify crises in Youth, and how to distinguish mental health crisis from typical adolescent development. Continuing Education Credit available.

For more information on Mental Health First Aid (MHFA) training through ELC, contact Loree Love at 913-557-9096 or llove@laytoncenter.org. With a limited class size of 25 people, participants must register for each class in advance. Special off-site trainings at YOUR community organization may be available upon request.

2019 MHFA Training Dates through Elizabeth Layton Center

January 25th – Paola - Adult Mental Health First Aid from 8:30am to 5:30pm

March 1st – Ottawa - Adult Mental Health First Aid from 8:30am to 5:30pm – funded by United Way of FrCo!

April 12th – Paola - Adult Mental Health First Aid from 8:30am to 5:30pm

May 31st – Ottawa - Youth Mental Health First Aid from 8:30am to 5:30pm

June 17th – Paola - Adult Mental Health First Aid from 8:30am to 5:30pm

July 17th – Ottawa – Adult Mental Health First Aid from 8:30am to 5:30pm

August 23rd – Paola – Adult Mental Health First Aid from 8:30am to 5:30 pm – funded by United Way of MiCo!

September 27th – Ottawa – Adult Mental Health First Aid from 8:30am to 5:30pm

October 10th – Ottawa – Youth Mental Health First Aid from 8:30am to 5:30pm

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404

Kansas
Governor's Behavioral Health Services Planning Council

www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Ric Dalke, Vice Chairperson

Laura Kelly, Governor

Governor's Behavioral Health Services Planning Council Minutes
March 20, 2019

Committee Members *P - Present A – Absent T – Present via Telephone*					
P	Wes Cole, Chair	**P**	Brenda Groves	**A**	Christine Thompson
P	Ric Dalke, Vice Chair	**P**	Patrick Hall		
P	Jane Adams	**A**	Julie Hayes		
A	Denise Baynham	**A**	Patricia Long		
P	Ethan Bickelhaupt	**P**	Christine Mayer		
A	Cherie Bledsoe	**A**	Deann Mitchell		
P	Randall Bowman	**P**	Stephanie Salisbury		
P	Jacob Box	**A**	Kurt Schott		
A	Robbin Cole	**P**	Fran Seymour-Hunter		
T	Sandra Dixon	**A**	Rodney Shepherd		
T	Al Dorsey	**A**	Peg Spencer		
P	Victor Fitz	**P**	Guy Steier		Charles Bartlett

Guests

Cissy McKinzie, Gary Henault, Misty Bosch-Hastings, Andrea Clark. Mende Barnett, Debra , Cynthia Fitz, Carrie Billbe, Christina Orton,

Announcements from the Chair

- The state is very fortunate to have this group (this council)
  - If it had not been for this council and its subcommittees, groups like the Mental Health Task Force would not have had the information they needed to make their recent recommendations.
- Think we have an opportunity to redirect some ideas with this new administration.
- Probably won't be a lot of changes until the Legislature confirms the acting secretary.

Topic/*Name*	**Agenda Items**
Prevention Update – *Mende Barnett*	• Mende is currently the interim Prevention Program Manager since Andy Brown got moved to Interim Commissioner ○ Things are a little on hold while we wait to see what happens permanently with these positions. • Have some grants coming to an end in 2020, working on plans. • Under-aged drinking and drug use grant coming out in April • Submitted Garret Lee Smith grant Monday evening.

	○ A lot going on around suicide prevention in the state Working on getting more dollars for that into the state
Presentation on the all subcommittee meeting - *Mende Barnett*	• Consistency and communication were the two main areas that stood out from the feedback. • Had amazing turn out – expected 20-25 people, had close to 60 in attendance. • The Oxford House presentation really reinforced the power of the consumer voice. • The coalition of Keys/NAMI/CAC is hoping to help recruit and support consumers who want to participate on the subcommittees. ○ The Executive Committee plans to continue seeking funding for consumer travel to subcommittee meetings; plan to have an orientation with the Secretary and Deputy Secretary and will discuss this issue specifically. • Mende will work on getting minutes/notes out to the council and subcommittees • Will be interested in knowing if the subcommittees could come and tell us their goals for the year, then report again at the end of the year to see what progress they made on them, to help keep them moving forward. ○ Maybe at each one of our meetings we have the chairs/co-chairs come and report? ○ Maybe we should make a goal as a council that, at the beginning of the year, we find out what their goals are so we have a better idea what they want to work on and what progress they're making, instead of just waiting until the end of the year with their annual reports. ○ How does the council look at all those recommendations and try to align them so we can put movement behind them? ○ We should do some sort of follow-up from the meeting – here's what was shared, here is what you're asking for, here is how we can help. ○ Communication has to be formed between the subcommittees themselves as well as between them and the council. ○ Have more of these all-subcommittee meetings to help encourage this communication. ○ The sharing of goals and reporting out at the end of the year provides mutual accountability. ○ Have to make it clear that it's different than the annual report-out. ○ We have to look at the entire system and what it's doing and how it's working. We have to lookout for burnout on the subcommittees and not letting them think their voices aren't being heard. We need to pull things together and really look at the recommendations. ○ Want to make sure the agendas for the council sent out to the subcommittees so they can call in as well. ○ Have quarterly updates from the subcommittee chairs. ○ One of the things we focused on during the meeting was subcommittee leadership structure and terms. ○ People proud of what they're doing but wanting more direction to do more. ○ The liaisons from the council to the subcommittees can also provide updates/bring things to the meeting that are being discussed at the subcommittee level

	○ Maybe make it known members, not just the chair, can attend a meeting to discuss an issue? ○ Want to make it clear to leadership that the council and the subcommittees are a resource and they don't need to look at other committees or consultants. ○ Do we need a retreat? Discuss instructions for the annual reports, orientation packets for new members of the subcommittees. ▪ Do new members of the council/subcommittees get summaries of what's going on, what has been discussed, what the issues are? ▪ Discuss the statute, what our function is, what the purpose is. Make sure we fulfill our statutory responsibilities. ▪ Does the council need some kind of social media platform? Closed Facebook group? Somewhere subcommittee members/chairs/council members can communicate? ▪ If there is a retreat, let there be some tangible action steps/next steps.
Update on Children's Initiatives and PRTFs – *Gary Henault*	• **Handout from Gary – testimony presented to the ways and means committee** • PRTFS ○ Currently we have 282 licensed beds in the state; a couple in-process requests for bed increases. ○ This week, we have 262 kids in PRTFs ○ Over 200 are foster kids, 43 are from out of state ○ 156 on the wait list as of Monday, 38 of them foster care. ▪ Working to improve the wait list – it previously gave us little information. We're getting much more information from the MCOs. Working to make it a more in-house process. ▪ It will also allow us to identify who has been on the list the longest; what services are they receiving? Are they appropriate? Are these the services they need to avoid PRTF placement? How can we keep them out of the PRTFs? ○ Working on collecting data so we can get a better view of lengths of stay, especially foster care vs. non-foster care kids. ○ Also need to be looking at the family as a whole, not just the kid. ○ What are the kids getting before they go in, what are the barriers to getting them services they need when they leave the PRTF. ○ Is visiting the PRTFs, announced and unannounced. ○ Working on opening up the communication between PRTFs, CMHCs, and KDADS. • Also visiting the mental health centers to build relationships so that when there is an issue, we can reach out and resolve the issues without too many concerns. • Kids are being discharged from PRTFs and have to reapply for SED Waiver they were already receiving before they entered. ○ Child SOAR (Social Security Outreach Access and Recovery) – getting people trained to allow the kids to access benefits sooner. ○ Got a couple pilots going on across the state. ○ Will focus on transition-aged youth that age out of SSA benefits; there's a difference between being eligible as a child and being eligible as an adult. ○ Kansas is third in the country for number of trained Childhood SOAR workers.

	▪ Training available on the PRAINC national website. We're still doing the certification; you have to keep your certification up or SSA will not process your cases. ▪ If you want additional information, feel free to reach out to melissa.bogartstarkey@ks.gov or gary.henault@ks.gov, for email Charley and he'll forward. ▪ **Handout from Missy – State of Kansas Submitted SOAR Medicaid Cases** ▪ Has been active in Department of Corrections with adults for a few years; hoping to replicate for children. o What role do MCOs have in the admission process? ▪ Request made to MCO directly. ▪ MCO decides if they have the info to make decision or need to reach out for more information from the CMHC. MCO as 14 days to say if they're approved or diverted. ▪ Interview with MCO case manager; clinical interview with CMHC; CMHC makes recommendation to MCO. ▪ If MCO says no, parent/guardian can appeal process. Expedited, peer-to-peer. o What is the length of stay on a wait list? ▪ It depends. Age of the child is a factor. How many PRTFs the parent requests access to is a factor (request only one specific one, the ones in their area, all of them). The MCOs are helping with that by helping the parent focus on which will be the best help to the child, which will allow them to be the most involved with the treatment. o If they are diverted what happens? ▪ MCO looks at what other services available might help, what the barriers are, what additional services are needed? o How are we treating these kids? What services are we providing? We need to get the family involved in the process. Sometimes "family" is their DCF worker. o Is there help out there for teachers? ▪ Youth mental health first aid being used as cirriculim in some social service/education programs. ▪ Mental health in schools pilots ▪ The education system is forming a task force to focus on that. • Children's Mental Health Awareness Day, May 9th o Submitted a draft proclamation for the Governor's Office o Collecting information on what they're doing for the day. Suggesting the communities also draft their own local proclamations.
SUD treatment, KCPC and Block grant update – *Cissy McKinzie*	• **Handouts from Cissy: NASADAD Fact Sheet, Beacon Kansas Block Grant Data** • Block Grant o The 2019 Combined BH Assessment and Plan, FY19 MH Block Grant report, FY19 Substance Abuse BG report, and the FY19 Substance Abuse BG Annual Synar report were all submitted timely and are pending approval from SAMHSA.

	○ Draft for 2020/2021 is out for public comment. Www.samhsa.gov/grants/blockgrant • KCPC ○ Regarding KCPC, KDADS has contracted with a project manager and a business analyst to create a new SUD data system to replace the current KCPC system. ○ KDADS, Block Grant and Medicaid contractors, and providers are also working on a Workaround policy for the KCPC. The policy will eliminate Prior Authorizations for the lower levels of care and creates one standard request form and process for providers to request SUD Intensive Outpatient and Higher Level of Care services. The policy will go into effect on April 15th. • NASADAD has just updated and released their fact sheet on the Substance Abuse Prevention and Treatment BG. I am sharing it with all of you. ○ A couple quick things I wanted to bring to your attention is found in the grey box on the top left that shows the Block Grant is at level funding for FY2019. Funding has been at the same level for several years. ○ In the grey box on the back, there is some national data from 2016 that over one third of individuals admitted to treatment in the publicly-funded system cited heroin or prescription opioids as their primary substance of use in 2016. ▪ I thought it might be interesting to you to compare this to Kansas Block Grant data. I am passing around a couple statewide reports Beacon submits monthly. One of the reports is primary diagnosis for Higher LOC and the other is for the Lower LOC. Both reports are for the month of February 2019 and please note that this information is pulled from Block Grant claims. Amphetamines dependency and Alcohol dependency are the two highest diagnosis for those seeking treatment from the BG in Kansas. This has been consistent over several months. A question from one of the council members during the meeting was whether the Beacon data is broken out by adult and children? The data in the report provided to the council is all ages. Cissy followed up with Beacon after the meeting to see if they had the data available for adults vs. children. Beacon's local office followed up with their national office. They do not have the data broken out into age groups without doing a special ad hoc query. • Was the Kansas opioid information substantially lower last year? ○ A lot of the opioid treatment is going through the STR/SOR so the numbers might be a little higher. ○ Stimulants are still the drug of choice for youth; alcohol and marijuana are popular too. ○ Death by opiates are still going up; prescriptions and treatment are leveling off.
Introduction of new Staff member –	• Working on week two • Last worked for the Douglas County Sheriff's office with substance use prevention for women as well as screening and assessment • Also worked in the CMHC system.

Cissy McKinzie	

CMHCs and NFMHs – *Christina Orton*	• CMHCs
	  ○ Has been touring the CMHCs with Gary; has been to 25 of the 26. Plans to visit them annually.
	  ○ Goal was to get an idea of what they each do and get feedback and concerns from them.
	  ▪ Each center's concerns and needs are different.
	  ○ Received positive feedback from the executive directors.
	  ○ Been working to familiarize herself with the contracts and Mental Health Reform Act.
	  ○ Making sure CMHC reports are getting reviewed and they're getting paid in a timely manner.
	• NFMHs
	  ○ Ten in Kansas
	  ○ Have had two quarterly meetings since November, 2018
	  ○ Next meeting in May; will be inviting the CMHCs, NFMH administrators, both associations, and KDADS staff.
	  ○ They're sending in a monthly census so we can better get a list out to the CMHCs for the Screens for Continued Stay.
	  ○ Identified and implemented ways to streamline the SCS process.
	  ○ Would like to restart the NFMH workgroup to address unaddressed recommendations and new barriers.
	  ○ Issues they currently see – lack of community support, no transitional options or placements for those discharging.
	  ○ Would love to invite the Council to tour a/all of the facilities.
	  ○ What's happened since 2006 in regard to reducing beds/number of facilities?
	  ▪ There are 600-some beds currently licensed, and 535 beds currently filled.
	  ▪ Haven't seen a push to not use the NFMHs; do want to see those that are ready and want to leave get transitioned successfully.
	  ▪ Part of that push was that we had lost track of that population and wanting to make sure they didn't just get stuck in a facility for 20/30 years. Also, Olmstead.

Update on the Certified Peer Specialist Certification Training – *Carrie Billbe*	• **Handout from Carrie on the new Kansas Certified Peer Specialist Training**
	• CROs
	  ○ Currently 11
	  ○ Have several groups hoping to launch new ones – Salina, Junction City
	  ○ Working on RFP for contracts for FY2020
	  ○ Might RFP out for the new groups, sort of a start-up fund. Something to help them expand/grow.
	  ○ Journey to Recovery had to recently relocate, moving at the end of month.
	  ○ The Open Door moving to Arkansas City from Winfield, soon
	  ○ Three regional CROs continue to provide peer support in the state hospitals (Passport to Recovery program): SIDE (KCK), Morning Star (Manhattan), High Plains Independence (Hays)

	▪ Upon discharge, a lot of them are continuing to stay connected to the CRO. ▪ Did present to the NFMHs yesterday about trying to start a similar program in the NFMHs o What's the likelihood of an SUD CRO/CRO pilot? ▪ Different CROs do have groups within their group that offer SUD support. ▪ If medicaid expansion happens, it might free up some block grant money that might allow us to use some block grant funds for some pilot programs like this. o SIDE still has a strong youth population. They have a studio where they can make music. We use it as an example to other CROs as a way to connect with their own youth populations. • Kansas Certified Peer Specialist Training o Goal is to build capacity and workforce quickly due to recent lack of access to the training. o Manual will be released when it goes live, policy will follow. o Online option increases access to the training, will be available on KSTrain website. o Supervisor training is in progress as well o Face-to-face trainings will be held regionally to reduce cost of travel for folks. o First in-person training in May, location/day tbd. Location will probably be based on where they have the most registrations for. o Will grandfather-in those CPSs who have previously been certified; if they have been employed in the last two years, they will need to complete Level One to achieve re-certification; if they have been employed in the last five years, they will need to complete both levels. o Had a broad spectrum of people providing feedback on the training options and model. o Questions? ▪ SUD – are there going to be allowances for agencies that do ICM that want to cross-train? Is this something our peer mentors could do? • Not limited to SPMI, but do have to have lived experience. • Want to get this moving first before looking into co-certification. • Take the on-line training and get the level one. • Most people on the designed team still wanted to see lived experience maintained on both sides of the issue. • We do want to get peer specialists hired places beyond CMHCs. • Want to also look into specializing in things like youth, or veterans, or parent, or corrections. ▪ How many are currently certified? • We don't really know, since it was done by WSU ▪ How many do you plan to certify? • Would need to have capacity for a couple hundred peers across the state.

	▪ Is there anyway to build Ticket To Work into this?
Cam Adair Presentation – *Carol Spiker*	• **Handout from Carol for Cam Adair gaming addiction presentations** o Topeka town hall meeting, March 26th; presentation for providers the morning of March 27th o Wichita presentation the afternoon of March 27th. o Is there any way to record it so it can be streamed? ▪ The wichita townhall meeting will be streamed through WSU. ▪ If we can get the link out to folks (go-to-meeting, signons limited) ▪ Will check about recording the presentation. ▪ There are lots of educational youtube videos on his website. (GameQuitters) o The average age of a gamer is 34. o We have clinicians across the state who are seeing youth who have a gaming issue if not an addiction, so it is here in Kansas. • Gambling Task Forces handed out information to legislators last week. • The 2% Lottery Fund was established to provide services and education for alcohol and other addictions. Gambling services gets between 8-11% of that 2%. Which means the rest of it goes somewhere else. • Currently have 35 gambling counselors, including a provisional in Liberal and 2 provisional in Wichita. One more in Kansas City just finished her training and will be starting supervision soon. • No gaming-specific counselors; residential gambling addiction treatment is handled by Vanguard out of Minnesota?
SAMHSA Update - *Kim Nelson*	• SUD Block Grant data o Amphetamines, as Cissy mentioned earlier, has outpaced alcohol in Kansas for treatment admissions; this is not the case in other parts of the country. o A lot of the funding coming from the feds is for opioids, but it can also be used for poly-substance use (we know people aren't *just* using opioids. o The opioid use has switched from prescription to heroin. We've also seen an increase in overdoses of cocaine and amphetamine from the two being cut with fentanyl. o 70,000 people died from opioid overdose in 2018 o Seeing increase in daily marijuana usage especially among pregnant women o Meth is such a big issue in the midwest that SAMHSA Regional is putting on a one-day pre-conference on it before MATTC's conference in Sioux Falls, SD May 5th and 6th. Have requested a fact sheet on information on new treatments/initiatives for meth. o What Valley Hope sees is treatment for opiates go down and meth go up but alcohol is still highest. o Is there an average age for meth use? ▪ That info is probably available from Beacon (Toby) ▪ 24-35 is probably the highest age range ▪ The point of prevention efforts is reducing those risk and protective factors so those kids, as adults, don't fall into those same traps • Technical Assistance shift at SAMHSA

	○ We have several new TA centers in our region who are very implementation-focused. ○ MATTC in Missouri and MHTTC in Nebraska ○ New TA Center focused on Privacy (HIPPA and 42 CFR and the overlap for FQHCs and primary health care) ○ New center of excellence on eating disorders as well. • Suicide Prevention ○ CDC data shows Kansas as #5 in the country for increase in suicide rate. (45% increase) ○ Kansas has gotten some increased attention for a Mayorial Challenge and Governor's Challenge to reduce suicide among veterans and their families ○ New National Survey on Drug Use • Several funding opportunities open right now ○ PFS grant is now open to communities and not just states ○ Drug-free communities grants no longer going through SAMHSA; check out the OMDCP website. Jane Adams was appointed to the national mental health council.
Commissioners report and update on KDADS – *Andrew Brown*	• Submitted SAMHSA GLS grant on Monday • Been at the Governor's Challenge meeting today • Reorganization information (get from exec notes) ○ Who controls the children's hospitals? ▪ The kids hospitals are private hospitals; we fund beds there and they are licensed by the agency through the SCC Commission. ▪ The contracts for KVC shouldn't be transferred. • KVC Wheatland update ○ In 2017, discovered they weren't really operating as their license indicated they should. ○ Several attempts were made to fix it. ○ Sent a letter in February to KVC indicating they would need to keep their PRTF beds separate from Acute beds (12/12). At KVCs request. ▪ Were functioning with 24 swing beds versus 12 PRTF beds and 12 Acute beds. ○ Had a phone call with Great Plains to discuss what is happening at the hospital ○ It's really about the co-mingling of patients at different acuity levels, per CMS. ○ Was some concern that the beds were going away. ○ We are making every effort we can to maintain them currently. ○ KVC has not been filling their acute beds as much as they would like. ○ Working on more PRTF beds in Western Kansas as well as acute beds in Wichita. ▪ PRTFs have requested 8 more beds in Salina and 24 more beds in Hays ○ HAPHY is in danger ▪ Not fully funded. ▪ If we're not able to find a way to fund that is fiscally stable for the providers, they may pull out. ▪ We are really trying to find a way to provide the best care we can for these kids. ○ Let's start talking about community-based services for kids.

- Kids/families have plans, but they can't get the services in the plans.
- Have had one inter-departmental meeting about youth hospitals. Will become an ongoing discussion. Thinks it's perfectly fine if we have members of this council represented at those meetings.
- Legislature is currently looking at an addition $4-5 million for CMHC funding; we're always going to be looking for more funding for CMHCs when they're the only on-ramp for access. How else can we provide services to unclog the bottleneck?
    - Opening up peer mentor billing to providers beyond CMHCs (CROs, for instance)
    - How are we standing in the way of people getting services?
    - What's the first step? What can advocates do?
        - Make sure your legislators, your city commissioners, your county commissioners all know they have a role to play in mental health. We have to find a way as advocates to get priorities made of these issues.
        - Douglas county/lawrence partnering with hospital, CMHC, FQHC to support this effort. None of the solution involves the legislature. There are community-level solutions that need to be part of the puzzle.
        - The state needs to serve as a backbone, a support for these communities to make policy change, get funding, etc.
        - The state alone is not going to be able to fund a robust system that can address all of the issues we have right now.
        - How do we work with the state, as a community, to make our community/state better?
    - Schools are an underutilized collaborator. Education groups and schools are now inviting MH in to help with the issues being seen in schools.
    - Plant seeds with the council who would be the best people to have input with the Administration, the Legislature, etc.
    - Also need to keep in mind the impact of SUD on these issues, physical health, trauma.
    - There are 4 treatment centers in kansas that allows women to bring their children with them (2 DCCCA, Ashby House, Mirror); DCCCA is moving to a new building that should allow them to include fathers with children too.
- Keys is looking for a way to get children's people on the other subcommittees to make sure they're all talking about kids.

- Medically-Assisted Treatment
    - Getting $2.? Million supplement for MAT services.
    - Working on getting money for MAT established at Beacon.
    - STR dollars are about out for MAT; started using SOR to cover through the end of the year. Should be putting out an RFP for the remainder of this fund probably in April.

	▪ Working on getting budgets in place for the new rewards Every patient that receives MAT through the STR has to do this 104-page questionnaire throughout their treatment (GPRA)
Introduction and update on Veterans and CIT initiatives – *Matthew McGuire*	• **Handout from Matt: CIT/Veterans Program Coordinator Update** o CIT – Crisis Intervention Teams ▪ In 8 weeks, completed Dodge City Training ▪ Training in KC, Topeka, talking about veterans as well ▪ Next trainings: Johnson Co. ($200, June), Sedgwick Co. (June, KLETC) • Most are free • Would like to see anybody attend – family members, educators ▪ Working on the FY2020 CIT training contract ▪ Getting CIT committees started in three cities. o Veterans ▪ Spent the last two days working on the Kansas plan for the Governor's Challenge. ▪ 25% of suicides in Kansas are veterans. ▪ Family Readiness Groups, Future Soldier Program ▪ Rural and Frontier specific governor's challenge training. o Mayor's Challenge ▪ Utilizing peer training throughout the schools – train students to be on the lookout for identifying suicide risk signs. ▪ Also looking at the stress that would put on the trained student as well. • Questions: o Does talking to people before they go in include kids? ▪ FSTP can be anytime up to 30 days before they go in, get their minds ready for the stresses of service and how to deal with it. ▪ What about talking to the families beforehand, too? The family readiness groups are part of that.
GBHSPC Business Meeting: Updates, Discussion, and Member Updates – *Wes Cole, Members*	Lady Gaga may be the spokesperson for the new MHFA initiative to get teens to talk to teens.

Action Steps

▪ Mende will get notes from the subcommittee workshop/meeting out to the council and subcommittee chairs.

----------No Further Actions Required----------

The Council meets every other month, unless additional events are needed. Meetings are usually held at KDADS offices, 503 S. Kansas Avenue, Topeka, KS.

Diana Marsh, Senior Administrative Assistant, KDADS BHS

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Governor's Behavioral Health Services Planning Council Minutes
May 15, 2019

Committee Members *P - Present A – Absent T – Present via Telephone*					
P	Wes Cole, Chair	**P**	Brenda Groves	**P**	Christine Thompson
P	Ric Dalke, Vice Chair	**P**	Patrick Hall		
P	Jane Adams	**A**	Julie Hayes		
A	Denise Baynham	**A**	Patricia Long		
P	Ethan Bickelhaupt	**P**	Christine Mayer		
A	Cherie Bledsoe	**P**	Deann Mitchell		
P	Randall Bowman (Jeff Butrick)	**P**	Stephanie Salisbury		
P	Jacob Box	**A**	Kurt Schott		
P	Robbin Cole	**A**	Fran Seymour-Hunter		
P	Sandra Dixon	**P**	Rodney Shepherd		
P	Al Dorsey	**T**	Peg Spencer		
P	Victor Fitz	**T**	Guy Steier	**A**	Charles Bartlett

Guests

Cissy McKinzie, Linda Buchheister, Colin Thomaset, Stuart Little, Amy Campbell, Gary Henault

Announcements from the Chair

- Charley has been named Adult Services Director for the Behavioral Health Services Commission. He will continue to be the liaison to the Council.
- Andy Brown has been appointed Commissioner of Behavioral Health Services
- The Assistant Sup at OSH was involved in a meeting at Harvard last week. 36 invitees. Made a very good impression. Another team will be attending the second phase of this conference.
- The Executive Committee met with KDADS Leadership and oriented them on the council.
    - Reinforced what a great choice Laura Howard is, not just because of her history with us but because of her mission and vision.
    - Felt good about everyone there making time to meet with us and converse with us. Felt heard by people who make a difference in what we do.
    - They really want to utilize us for input in their decision making.
    - The difference between being a vendor and a partner.
    - Thinks we have people listening about getting money restored through the block grant to finance travel for consumers going to subcommittee meetings.
    - Heard nothing about closure or privatization; lots about the resources we have in Kansas.

Topic/*Name*	**Agenda**

Discussion for Council Retreat
Wes Cole
	• We need to sit down in a relaxed environment and look at things:
	  ○ Orientation of council members.
	  ○ Deal with misconceptions about council makeup.
	  ▪ This may have arose out of the super-coalition's work.
	  ▪ The belief that consumers can't be involved with the council or the subcommittees without going through this group, which isn't true.
	  ○ How we prioritize recommendations from the subcommittees.
	  ○ Integrating substance use, mental health, and physical health.
	  ○ How we evaluate the council, how we communicate and get our message out.
	  ○ Two-days?
	• Suggestions from members
	  ○ Should be ready to discuss where we are with the consumer recruitment.
	  ○ Opportunities for technical assistance.
	  ○ Make sure we talk about prevention and substance abuse too.
	  ○ Ask state staff to come with data.
	  ▪ There is really good epidemiological data that isn't directly related to treatment that tells us a lot about our state.
	  ○ The continuum of care.
	  ▪ Right treatment at the right time in the right place.
	  ▪ NFMHs
	  ▪ What is the system. Let KDADS come and explain it to us.
	  ▪ Peer respite.
	  ○ Current shortages in staffing/workforce shortages and how to address the issue.
	  ▪ Recruitment/retention, barriers, both the ones we create ourselves and the ones we don't.
	  ○ How better non-clinical members can make themselves useful, why they might feel they don't have something to contribute.
	  ○ Who are we/why are we/what are our overarching responsibilities (maybe start the retreat that way).
	  ○ Continuation of the subcommittee coordination discussion from the joint meeting.
	  ○ Come up with three or so overarching-goals the subcommittees can work on.
	  ▪ Make sure they are Kansas-focused goals, based on Kansas data.
	  ○ We need to hear from families/consumers.
	  ○ First day discuss the council; second day, discuss the system and the issues with it.
	  ▪ The NRI report on the PRTFs should be ready by the time of the retreat.
	  ▪ Maybe the council needs to have a few summits, like the New Freedom Commission summits, focusing on the different areas within mental health and SUD.
	  ○ Council representation on various bodies (like the Coalition)

Systems of Care Update and Summit *Linda Buchheister*	• Attach summit flyer to minutes. • Event supported by National Training and Technical Assistance Center TA network through SAMHSA to help us decide where to go next, how to expand and sustain. • Goal is to make a statewide system of care. • June 17th and 18th, Capitol Plaza Hotel, in Topeka. • Grant will assist with Council and subcommittee travel. • Inviting consumers, professionals, or anyone interested in the event. • Keys will offer travel support for consumers and families. • Purpose is to have a voice to share your thoughts, concerns, opinions.
Update reports on Vet and CIT work report *Wes Cole*	• See handout from Matt McGuire, updating the group on what he's been doing and what's going on with CIT and Veteran's services.

Strategic Plan/Goals from SAMHSA and Discussion
Wes Cole
	• Will be adopting these goals and objectives into our strategic plan and the KDADS Strategic plan.
	• Review this, we will discuss it more later.
	• The opioid issue is arriving in Kansas, it's no longer on its way.
	  o 3 opioid overdose deaths in Wichita last week.
	  o In region 7 and 8, meth continues to be the drug of choice, but the new speedball – meth and fentanyl – is on the rise and it's lethal.
	  o How do we create interventions?
	  o What preventative measures can we take?

KAAP Legislative Update
Colin Thomaset
	• 35 bills KAAP was tracking
	• BSRB SB15 – Social Work Reciprocity Bill
	  o Reduced hour requirements for licensing for people coming into the state.
	  o Expands workforce, potentially.
	• SB28 – Affirmative Defense for CBD oil with 5% THC.
	  o Can't create it or sell it in Kansas, but if you're found with it.
	• Hearing on Medical Marijuana, bill not moved out of committee.
	• Budget Bill
	  o KDHE
	  ▪ Proviso on health homes to discuss how to do analytics
	  ▪ Adding language that KDHE will seek IMD Waiver, SUD-specific.
	  • .
	  ▪ Facilitating review of costs and rates for mental health and SUD, will report to multiple committees.
	  • Related to MH Task Force report
	  o KDADS
	  ▪ Shore up crisis center and clubhouse funding.
	  • Lottery vending machine money not there; other funding had to be found.
	  • $200,000 for clubhouse models
	  o Additional money put into SB123 - $1.2 million

	▪ Treatment in lieu of incarceration. ▪ Sentencing Commission expanded population for it, but not funding ▪ This year they expanded funding. o Additional money for SUD services - $500,000 for treatment "or some type" o CMHCs received $5million to serve underserved/uninsured. ▪ Should take them above the 2007 funding peak. ▪ Original ask was around there? Envisioned another 2-year budget. • Was a pretty policy-light session for Behavioral Health. • Medicaid Expansion deal o End of session, there were a number of House members that were yes votes o Made a deal to craft a plan and move it pretty quickly through the process next session. ▪ Might be a modified expansion ▪ Will probably see an interim committee. ▪ This session isn't really officially over until the 29th. • Questions o What is KAAPs position on the marijuana issue. ▪ KAAP opposes legalization. ▪ DCCCA is sponsoring a summit on legalization, discuss policies we need to put into place for when it does happen. (Limiting youth access, etc.) • Colorado speaker will discuss pros and cons. • Should be a pretty balanced approach. ▪ $25.00 fee for those outside of Douglas Co. ▪ www.dccca.com, on the training calendar ▪ June 24th? (Sandra will send email) • KCTC survey – survived committee, hope it will be pushed forward. o Change to state law in 2015 reduced participation ▪ Bill went from parent opt-out to opt-in. ▪ Reduced participation=reduced data. • Medicaid Expansion was a big blow. o Is an absolute need
KMHC Legislative Update *Amy Campbell*	• Governor really prioritized DCF and child welfare, KDHE eligibility processing, and corrections. • Mental health, as a program, didn't really have any of its supplemental requests put into the governor's budget announcement. o Federal Housing grant not being funded o Additional money for KVC in Hays beds didn't make it in. • KDADS plans to use the MH Legislative Task Force as a roadmap moving forward. • We were lucky that some legislators stood firm and got SUD and CMHC money were added to the budget. • No steps taken to deal with OSH Moratorium, legislatively. o Proviso asking KDADS to put forward a plan to end it, though.

- LMHTF recommends regionalized hospital beds and crisis intervention act beds.
- Comfortable that this administration wants to move forward on these recommendations.

- We went into this session anticipating a $900 million dollar unspent balance, drops dramatically moving outward.
  - This legislature tried to make some wise investments via expenditures to help us right the ship.
- AG got the youth suicide prevention coordinator approved, without money to pay for the position. Hoping to fund it internally.
  - If filled, the idea is that they will reach out to schools with suicide programs and create some kind of centralized coordination. Maybe a communication campaign and a crisis hotline.
- Family First Act called for the creation of a youth crisis center.
  - No RFP currently out; heard it may be underway again.
  - How does this cross over to the services needed for kids heading into the corrections system?
- Questions?
  - Could you say a little bit about your perspective about the Council and the Coalition? Should we be doing more together?
    - KMHC does have dues, based on type of membership.
    - Meet the 4th Wednesday of the month, discuss policy.
    - Purpose: to develop policy initiatives to lobby the agencies or legislature.
      - Anything that there is consensus on, we develop a position and move forward.
    - We develop policies and initiatives, sometimes based on the recommendations of the council
    - Great relationships with legislature, agencies.
    - Council has a more official role, but the coalition brings things forward that may get stuck up the chain.
    - Co-sponsor the KS Legislative MH caucus with the ACMHCK.
    - Wes was attending until being appointed a superintendent. Has been getting a monthly report from someone who may have been at a council meeting. Would love a more consistent representative.
      - The council recommends a consistent representative be identified until Wes can attend regularly again.
    - Meet at Valeo from 9-11; also have a teleconference option available.
    - Their website: http://kansasmentalhealthcoalition.onefireplace.com – can become a member from the website.
  - Is the clubhouse model being expanded throughout the state?
    - Wichita breakthrough club has to train other locations.
    - Olathe is almost ready to open.
    - Expansion is the goal.

BHAK Legislative Update
Stuart Little
	• $25 million into KDOC for Hepatitis C epidemic, make salaries competitive and fair ("we need more staff")
	• KPERS fully funded
	• $5 million increase for CMHC grants
	• $2 million community health clinics.
	• $500,000 for SUD
	• $11 million for school mental health pilot projects for 5 districts. (Continuation of last year's pilots)
	  o Adding new schools within those districts, but not the number of districts
	  o Wichita PS, KCK PS, Abilene area, Parsons, Garden City
	• Senate Bill 123 – over $8million in funding now, almost 2.5 million more than previously.
	• Family First Preservation Act
	  o $9 million between state and federal
	  o 4E funds for parents of youth at risk of going into custody, to keep them out.
	  ▪ SUD, parent training, mental health
	• KDHE was also charged with a BH rate study
	• Will be discussing Medicaid expansion again next year
	• Farm Bureau will be able to provide health insurance, but it can't be called health insurance because it is not ACA compliant. (Health care product). Can exclude for a variety of issues.
	• CBD Oil Affirmative Defense 5% THC
	  o Must have a prescription and other requirements.
	• Next year to look out for
	  o KCTC Opt-In
	  o Expand APRN Scope of Practice
	  o Medical Cannabis Bill
	  o Child Welfare legislation.
	• Questions?
	  o DCF staffing budget?
	  ▪ Budget asked for 50 or so new social workers, staggered over the next few years

Block Grant Update
Cissy McKinzie
	• Regarding the Block Grant and recent major federal deliverables:
	  o An update from last quarter is that the FY19 SABG Annual Synar report was approved on 4/16/19.
	  o The 2019 Combined BH Assessment and Plan, the FY19 Substance Abuse Block Grant (SABG) report, and the FY9 Mental Health Block Grant (MHBG) report are all pending approval by SAMHSA.
	• KCPC
	  o KDADS has contracted with a project manager and a business analyst to replace the KCPC (KDADS substance use disorder data system). The first step of the project is developing an interim solution for collecting the SAMHSA required TEDS data. This project is in process.
	  o At the request of providers and to streamline processes, the Medicaid and Block Grant contractors were asked by the State to collaborate and

	develop one common eligibility form for Block Grant members and member service authorizations (Block Grant and Medicaid). This process also changed requirements to end prior authorizations for the substance use disorder lower levels of care. The related KCPC Workaround policy was effective 4/15/19. Contractor trainings with providers related to the policy form and instruction sheet are occurring. Beacon, the Block Grant contractor, has already held their training with providers. There are two All MCO trainings with providers. One was held yesterday and there will be another training Friday.
	• The Family Recovery Pathways conference in South Dakota was discussed. There were Kansas providers that participated in a 9-month collaborative on Family-Centered care. We had providers attend and one of our providers presented on a panel about the collaborative. State representatives from KDHE, DCF and KDADS were present. One of the days also focused on methamphetamine. The link to the slides was shared with the group: https://attcnetwork.org/centers/mountain-plains-attc/bring-them-all
	  o One of the slides, Methamphetamine Use: Current Trends , Impact on the Brain, and Implications for Treatment and Recovery slide deck, was also passed around to share with the group.
	• Questions
	  o The process for gathering old data
	  ▪ Still being discussed
	  ▪ Met with contractors yesterday.
	  ▪ Different means of storing the data
	  o Single Form and process
	  ▪ Is the expectation that the MCOs adhere to this?
	  ▪ Rumblings that there are still people doing it differently.
	  ▪ Beacon was represented at the MCO training for consistency earlier and hopes to attend the Friday training.
	  ▪ Let Cissy know If you hear anything otherwise.

Public Comment
Public
	• Recovery Idol 2019
	  o September is National Recovery Month
	  o Sixth-annual, statewide
	  o Talent event for those in recovery
	  o Century II Convention Hall in Wichita
	  o Auditions in Topeka, Overland Park, Salina, Hutchinson, Wichita.
	  o If your agency would like to sponsor the event, contact Victor.
	  o It helps raise money for services provided in the Wichita community.
	• More presentations from consumers and family members

	•

Action Steps

- Sandra will send email about DCCCA conference to Diana; Diana will disseminate to group.

----------No Further Actions Required----------

_____

Diana Marsh, Senior Administrative Assistant, KDADS

The Council meets every other month, unless additional events are needed. Meetings are usually held at KDADS offices, 503 S. Kansas Avenue, Topeka, KS.

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404

Kansas
Governor's Behavioral Health Services Planning Council

www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Ric Dalke, Vice Chairperson

Laura Kelly, Governor

Governor's Behavioral Health Services Planning Council Minutes
July 17, 2019

Committee Members *P - Present A – Absent T – Present via Telephone*					
P	Wes Cole, Chair	**P**	Brenda Groves	**A**	Christine Thompson
A	Ric Dalke, Vice Chair	**A**	Patrick Hall		
P	Jane Adams	**A**	Julie Hayes		
A	Denise Baynham	**A**	Patricia Long		
P	Ethan Bickelhaupt	**P**	Christine Mayer		
A	Cherie Bledsoe	**A**	Deann Mitchell		
A	Randall Bowman	**A**	Stephanie Salisbury		
P	Jacob Box	**A**	Kurt Schott		
P	Robbin Cole	**P**	Fran Seymour-Hunter		
T	Sandra Dixon	**P**	Rodney Shepherd		
A	Al Dorsey	**A**	Peg Spencer		
P	Victor Fitz	**P**	Guy Steier	**P**	Charles Bartlett

Guests

Kimberly Lynch, Shawna Wright, Judy Johnston, Nicole Tice, Gary Henault, Linda Buchheister, Doug Bowman, Cissy McKinzie, Mende Barnett, Missy Bogart-Starkey, Cara Sloan Ramos, Janet DeBoer, Koleen Garrison, Monica Kurtz

Announcements from the Chair

- Executive committee held last week. Discussed a potential new subcommittee on Evidence-Based Practices. The council will vote on this today.
- Wes led a remembrance of Eric Harkness, NAMI member and president, chair of the Kansas Mental Health Coalition, and member of the Housing and Homelessness subcommittee, who died by suicide this weekend.
    - There was discussion of a need for careful messaging around this issue, and mentioned the need for caution when using terms like "suicide is preventable," and the guilt it can inflict on the friends and family of someone who has died by suicide.
        - The need for a "response plan" for the agency, for the Council, etc.. How to communicate about it, how to support the people affected.

Topic/*Name*	**Agenda**
KDADS Hospital Commission Presentation *Commissioner Kimberly Lynch*	• Kim thanked the group for the work that the Council does. • New Hospital Commission here to support KNI, Parsons, LSH, and OSH. • Kim started with KDADS in 2012 in the Legal division. Has worked with the state hospitals in that capacity since her arrival. • Main goal – make sure people hear the positive things that come out of the hospitals, not just the negative.

- Be a platform to talk about the good things, as well as work on the other things. Continue to carry them forward and move the system into the future.
- Creating mini task forces to look at different issues.
    - First is the competency process
    - Plans to also look at modernizing and making more flexible the Care and Treatment Act.
        - Regional beds
        - Telehealth/televideo
    - The moratorium – how to lift it safely and partner with community providers. Perhaps modify the moratorium statute as well.
- A lot of these things are Legislative Proviso-driven and based on recommendations from the Mental Health Task Force Report.
    - Like adding 33-60 beds (recommendation from the MHTF) within 24 months.
    - Will be working closely with the Behavioral Health Services Commission
- Questions/Comments?
    - Also need to think about it from a marketing perspective – the negative attention of the state hospitals is well publicized. Because the problems are so well documented, the successes also need to be, and I don't think they are. The general public is still living with the belief that those issues are still ongoing or haven't been addressed. Living under the shadow of those issues, unfairly.
        - Going to involve some rebranding. What they're doing and what they're capable of doing.
        - Part of it will happen with the legislature.
        - Also can't ignore the challenges while discussing the successes.
    - Will the commissioner be dealing with co-occurring issues as well and the challenges involved there?
        - We are hoping to immediately help address gaps in the system. It will take time; especially with IDD, the SMHH are not a great fit for those individuals, but looking at how to face those situations.
        - There is a judicial committee looking at the issue from that angle as well.
        - The council might start looking at where the gaps in the system/continuum are and how the hospitals can address them.
    - From your perspective, what does the regional bed idea look like?
        - There isn't allocated funding for it now. Hoping there will be funding available somewhere for a pilot.
        - Get the right RFP in place that might provide psychiatric beds as well as forensic ones.
        - Find out who might be interested and what would be necessary to do so.
        - Before we write the RFP, communicate with the communities to see if they were to do it, what would it need to look like. The meter of the need. It doesn't have to be a 30-bed unit, could be smaller, beds that are part of a larger unit.
        - Working closely with OSH to evaluate the beds there.

	○ Is this a short-term commission? ▪ No. ▪ The crisis centers will become a helpful stepping stone between the community and the state hospital. ○ Will you consider adding a consumer advisory group to the commission, so you hear from the people most affected by the decisions you make? ▪ And how do you help people in the hospitals who have children talk to their families/children about what they're going through and? ▪ Will take all of this into consideration. ▪ OSH has a patient council/committee that could be of use in this way.
Proposal by the Rural and Frontier Subcommittee for Rural Behavioral Health Study *Shawna Wright, Judy Johnston*	• Powerpoint handout attached. • Mission: Behavioral Health equity for all Kansans. • Subcommittee disseminated a paper survey in 2011 regarding telehealth. ○ One of the findings is that people are not opposed to tele behavioral health, but not aware of how to access it or what's available. ○ What are the barriers? ▪ Broadband, availability of providers, payment source. ○ Tasked with how to broaden the audience and take the survey further. • Background ○ May 2017 – High Plains Midwest Ag Journal releases Mental Health in Rural America article ▪ 1-5 residents of nonmetropolitan areas have some sort of mental illness. ▪ Barriers • Access • Availability • Stigma ▪ Providers offered their vision of what it could be • Services offered in every community with even more partnerships • Access to speciality mental health either in person or telehealth. • Insurance covers treatment • Bilingual services • VA working more effectively with the community so veterans don't have to travel ○ KHI published a report in October of 2017 ▪ Historical changes in what is available in Kansas via Mental Health Reform: • Community mental health vs. inpatient institutionalization • Expansion of CMH services • Elimination of two state psychiatric hospitals • Effectiveness ○ MHTF Reports

	▪ January 2018 • Systems, policy, funding • 150 recommendations previously released reviewed • Characterized recommendations in target areas. ▪ 2019 followup • Developed strategic plan • Looked at strategies that could be utilized • System capacity, funding, and policy o Kansas Telemedicine Act ▪ KU and the Rural and Frontier subcommittee have pushed for telemedicine legislation. ▪ Private payers were not allowing billing for it, which made it not cost effective for providers, like CMHCs. ▪ Bill dropped the first year; requested specifically that behavioral health was included in the act (2018) ▪ Act legitimized tele behavioral health. • Gave parity for treatment – insurance company cannot deny the service if it is the only way to get the service. • Did not create payment parity o Providers need to advocate for equal payment in their contracts with private payers. o Out of state practitioners must be licensed in Kansas to provide services in Kansas. o Standard of care is what should be evaluated when billing – can we provide the same level of care via telehealth that I can in person? o When working with skilled nursing facilities, would provide training to CNAs as needed, had access to EHRs to thoroughly note and make recommendations for treatment. o The private payers have defined what their approved location types are (not in the home, specific settings) • Draft Proposal o Specific Aims ▪ Increase understanding, awareness, attitudes, experiences, and perceived barriers of rural and frontier dwelling adult consumers/potential consumers • (a different project going on with children) ▪ Expand perceptions and needs in providers ▪ Use data to develop educational opportunities and Extension for Community Healthcare Outcomes (ECHO) clinics - Telehealth clinics/feedback/assessment for primary care physicians. ▪ Use data to develop education opportunities to communities/adult consumers in communities to reduce stigma. ▪ Provide consumer and provider data to workgroup to access outcomes.

- Framework
  - Year One – Electronic and phone surveys (one of three surveys) of consumer/potential consumers of behavioral health and/or substance abuse in 6 rural/frontier counties -Kearney, Thomas, Wilson, Haskell, Grant, Chase.
  - Year One and Two – Access attitudes, knowledge, practices, barriers, and educational needs related to use of behavioral telehealth in rural communities.
  - Year Two – Possible follow-up focus groups with professionals (CMHCs, CHCs, addiction clinics, or private practice; primary care physicians and emergency department clinical staff; administrators)
  - Year Three – Provide educational opportunities to address identified barriers to the effective and ethical use of behavioral and/or substance abuse treatment tele-health in Kansas. Pilot projects.
  - Year Four – Evaluation of the process as well as changes in awareness, attitudes, and perceived barriers.
- Next Steps
  - Work with subcommittee
  - Identify partners
  - Develop budget

- HRSA Grant
  - KS Kidsmap to Mental Wellness
    - KDHE
    - KDADS
    - KU-Center for Public Partnerships
    - KUSM-W
  - Focus
    - Workforce development
    - Warm Line for consultation
    - Telehealth services
    - Children and adolescents
  - Project
    - Year One – data collection from children/adolescents and providers (primary care, physicians, mental health) of services to them. Sponsoring REACH Training as well and six-months of followup; also building ECHO clinics.
    - Year Two – identify ECHOs
    - Year Three - Evaluate
    - Three-year project
- Questions?
  - What are the compositions of these coalitions
    - Healthcare, public health, work sites in their communities, schools, early childhood and education, faith communities, K-State Research and Extension, community environment

	○ Make sure to get consumer representation/survey volunteers – Consumer-Run Organizations, Consumer Advisory Council. ▪ And the Kansas Health Association. ▪ Youth Leadership ○ How were the six counties identified? ▪ Self-identified
Children's Services & System of Care Update *Gary Henault, Linda Buchheister, Doug Bowman*	• Gary is now the Youth Services Director ○ Youth Services covers SOC, Prevention, the Inpatient and Community Services position (Gary's old position) ○ Have identified a candidate for the open position who has accepted it; will announce when we can. ○ Doug Bowman is the new Youth Engagement Specialist. ○ Hoping to be able to take advantage of new opportunities – new grants, program changes/improvements. ▪ Meets with the MCOs, DCF, and KDHE bi-monthly to discuss the kids on the PRTF waitlist ▪ Currently 207 kids on the wait list. More accurate than it was a year ago; probably still not perfect, but we're getting there. Holding the MCOs accountable to serve the kids on the wait list. ▪ What is stopping KDADS from providing information on advocacy groups to those families on the waiting list? (Keys, Families Together, DRC) ▪ Need to look at the effect of SB367 • If this is a child we can't serve in the PRTF system, where do we serve them? ▪ Workforce, acuity, gender complicate the ability to move kids off the list. ▪ Disparity between with PRTFs/CMHCs/MCOs consider the criteria for admission and continued stay • New workgroup starting tomorrow to set a standard across the board. • SOC ○ Service Guide created (handout) – walks through how to get services, how to apply for the SED waiver. KDADS, KDHE have looked at it to make sure everything is accurate. ○ Provided a folder of information from the summit that has lots of information about the SOC.
Block Grant Update *Cissy McKinzie*	• There are several federal deliverables for the Block Grant. Regarding recent major federal deliverables: ○ The 2019 Combined BH Assessment and Plan (mini-App) submitted in August last year is now approved. ○ The FY19 Substance Abuse Block Grant (SABG) BH report submitted last November is now approved. ○ The FY19 Mental Health Block Grant (MHBG) BH report submitted last November is pending approval by SAMHSA.

	o The KCPC replacement SUD data system project is still in process. The developers continue to work on the first phase which is the Federal required data sets (primarily TEDS). o SAMHSA distributed the FY2020 estimated Block Grant allocations based upon the FY2020 President's Budget. For Kansas, the Mental Health Block Grant decreased by about $9,000. The Substance Abuse Block Grant reduced a little over $3,000. o The Block Grant is now in a very hectic time period related to Federal deliverable timelines and will continue to be very hectic until at least the end of the year. The FY2020-2021 two-year Block Grant planning application became effective and available 7/1/19 on the Federal BG system. o The turn-around time for the application is very fast (two months) with some major components to accomplish. o I developed an overarching project plan for the application submission that includes sections of the application tied to responsible parties or teams within KDADS (including the Secretary's office and Behavioral Health Services (BHS) commission, Fiscal, and Data) to start drafting or complete. o There are approximately 45 sections/components to the application. SAMHSA requires both GBHSPC feedback and public comment (the draft will be posted on our website at a later date). Governor's BH Services Planning Council has been handled in different ways and at different points in the process in the past. We were submitting the entire plan to the Executive Council after public comment and prior to submission. We would like your feedback earlier in the process. o So, a heads up that the project plan includes Governor's Behavioral Health Services Planning Council and Committee assistance with consulting or drafting (where needed) and feedback on drafts via the KDADS Liaisons and other KDADS staff. So, KDADS staff will be coming to the Council and Committees with drafts. o The draft Substance Abuse Treatment section went to the Kansas Citizens Committee of the Council yesterday for review. I have asked liaisons to include GBHSPC subcommittee reports and recommendations be incorporated where applicable. o I am sharing the DRAFT Step One narrative for Section II – Planning Steps to the full council for your review and feedback. o In order to make our 9/3 application deadline, I plan to enter the full application into the Federal system by 8/29/19 to avoid any issues with the federal submission. I would appreciate feedback from the Council and Subcommittees any time during the drafting process but probably no later than 8/25/19. o A heads up to the council that any feedback from the council will need to be in writing as we will need to compile and submit with the application. Please send your feedback on the Step One narrative to Diana and me as Diana is compiling all the feedback together for submission with the application.

	○ Right after the application is completed, there will be both the MH and SUD Behavioral Health reports due by December.
Prevention Update *Mende Barnett*	• Mende passed out a map of the coalitions. (Attached) Funded four new communities recently. ○ KPCCI – Kansas Prevention Collaborative Community Initiative - SABG communities. ▪ Start in a planning and assessment phase. ▪ Eligible to enter implementation phase. • Different cohorts = different stages of implementation. • Those in the last year begin work on sustainability. ○ PFS – Partnership for Success (SAP, Under Aged Drinking) ▪ Will move into last year of funding in October ○ Problem Gambling Regions ▪ Funded differently. ▪ Regional coalitions ○ Still a challenge to get the Western Kansas communities onboard/to apply. ○ Start orientation with the four new grantees next week. ▪ Required to have certain sectors/partners from their communities on their coalitions, like mental health centers, etc. • Working on Block Grant application ○ Gathering data, working on priority areas – underaged drinking and marijuana. ○ Making a couple changes from the previous plan. ○ Plan is to have most of the information out to subcommittee chairs to provide feedback before it reaches the council for feedback. • Kansas Communities That Care survey percentage increased to 80% of Kansas public schools. • Entering last year of the Kansas Prevention Collaborative. Will be putting contracts back out for bid next year and do an assessment of the prevention system. • Subcommittee almost completed state plan; added two consumers to membership. • Questions? ○ Suicide prevention workgroup – September is Suicide Prevention Awareness Month. Will be working with them and other subcommittees to craft a proclamation for the Governor. ▪ Just met this week to work on updating the Suicide Prevention State Plan. ○ How are mental health and substance use integrated? They don't feel or look like they're integrated. ▪ One of the barriers, on the prevention side, is the difference between prevention and primary prevention. Primary prevention is the portion that the KDADS staff work with – individuals/youth who are not in need of treatment. Raising awareness of how substance use can affect them. Treatment prevention is a different, more clinical piece. The team doesn't really work much on mental health.

	▪ The two block grant fundraising streams have remained separate, even if the application is now combined. ▪ Closest thing SAMHSA has done towards funding MH prevention is the First Episode Psychosis 10% set-aside. In most states, the two systems are still learning to talk to each other. ▪ Providing services for dual diagnosis people, giving adequate attention to both is difficult. Making it work practically, deciding which side to focus on… ▪ Could licensing visits for MH and SUD be done at the same time? Integrated licensing regulations. o Where will NAMI and Keys be in the new collaborative? ▪ Can't necessarily answer that right now, what the plan is for starting FY21, but has suggestions ▪ Has not integrated as much as originally intended. ▪ Opportunity to discuss how we want it to look moving forward. ▪ Just concerned about where we fit.
New OCI Policy, Hospitals & Medicaid, SOAR, IPS EBP *Missy Bogart-Starkey*	• Attach Missy's handout. • Hospitals and Medicaid o In 2017 we started training social work staff in how to work with Medicaid and Social Security o In March of 2019, KDHE designated a single contact to help Missy work these cases, daily. ▪ Hospital has completed a total of 143 cases ▪ Majority out of OSH and AAC ▪ 95 cases completed and connected by to benefit ▪ 22 cases closed. ▪ 19 cases pending – being worked by Missy and KDHE contact. ▪ 4 cases are brand new and need to be registered. ▪ 3 need a new application. ▪ 1 case was Medikan, the rest have been full Medicaid. ▪ Taken about 72 hours for the cases to show up in KMAP • Now connecting with CMHC directly to work on getting these connected. o SOAR expedited cases – homeless or people at risk of homelessness ▪ Have had 42 CMHC cases ▪ 17 connected ▪ 12 pending ▪ 6 cases closed, usually due to loss of contact ▪ 7 are brand new and need to be registered. o In May of 2019, we started working hospital suspension cases. ▪ As of today, 25 cases remain open • For those people who come in who have SSI/SSDI, their cases are being put on a tracker and suspended instead of closed. o EBP IPS agreement ▪ Coming to a close in September

	▪ Create another subcommittee under council that looks at nothing but EBPs and that there is definitely family and peer involvement to make recommendations. • A Prevention EBP workgroup just started up. Might be a good idea to work together, speaking of integration. ▪ SAMHSA awarded us 25,000 technical assistance in October. Some of that was used on fidelity. Rest has been used to bring the National Council here for TA to build infrastructure ▪ What can we do to ensure, no matter what staff are in place, that the EBP system doesn't break? • OCI Policy o Medicaid billing codes for supported housing o Integrated policy for MH and SUD. o Not just Medicaid, also people who are presumptively eligible for Medicaid. o Target pop – people discharging from SUD programs, NFMHs, private psych hospitals, PRTFs, juvenile detention, foster care, state hospitals, corrections, and/or other Medicaid eligible settings; high utilizers • Questions? o Can SOAR and the presumptive determination happen for youth leaving PRTFs? ▪ Technically, yes, if the youth is hooked up with a SOAR worker prior to discharge who works on getting their medicaid eligibility worked before their discharge. ▪ Child SOAR, at a federal level, just started this year.
KDADS Communications Update *Cara Sloan Ramos*	• Public Information Officer o All publicly shared information comes through her office. ▪ Media inquiries, KORA requests, research information requests, ▪ Press releases ▪ Manages KDADS FB and Twitter ▪ Constituent concerns that come from the Governor's Office. ▪ Website Administrator
KDADS Updates *Deputy Secretary Janis DeBoer*	• Strategic Planning work is being done. o Modernization of the system ▪ With the help of technology and new ideas. o Increased employment opportunities ▪ Working on a pilot. o Improving housing options ▪ Housing First o Prevention Framework • The state hospitals are important, but we have other responsibilities as well. o Created a Hospital Commission o Collapsed HCBS and Aging into Aging and Community Services o The five current commissions better represent the focus of the agency and allow the commissions the ability to focus on their arenas. • Met with members of the MHTF to go over their recommendations.

	○ What they said, basically, was to go to the legislature with a plan on what the agency wants to do to move towards the recommendations. • Meeting with NFMH administrators on Monday (July 22nd) ○ Work on rebuilding collaboration with the facilities. • Council update to the Deputy Secretary ○ Problem Gambling, Aging, and EBP subcommittees. ▪ Why separate out the PG from the Prevention Subcommittee, since they already incorporate it? • Sports betting coming to Kansas, kids and gaming, • Funding mechanisms • Will coordinate between the subcommittees. • We want to integrate, but this subcommittee is moving away from integrating. • If it has a specific task and it fulfills that task, it may end or become a workgroup of another subcommittee. • Questions? ▪ One of the responsibilities of the council is the block grant, as well as oversight of the system, including the hospitals. ▪ The subcommittees will be presenting to you and Secretary Howard in the fall. ○ The changes in how guests are handled in the reception lobby is wonderful. ○ Any key staffing changes? ▪ Behavioral Health is working on filling a lot of vacancies. ▪ Getting a lot more applicants under the new administration. ▪ Seeing a lot more cooperation, people working together, more of a family-feel, camaraderie ▪ It's important to hear the good things going on in KDADS ▪ How might we?.
Public Comment	• Vote on EBP Subcommittee ○ Should pull in the members of the Prevention EBP Subcommittee for the purpose of integration. ○ Subcommittees should exist for a purpose, not just to meet. ○ Elevate the workgroup to a full subcommittee? ▪ They likely need to be separate, but communicate more? ○ The executive committee needs to perhaps review the missions and charters of the subcommittees. How many workgroups are there, what are their focus? ○ Motioned; seconded ▪ Motion passes • Recommend that the council release/draft a statement about suicide prevention. ○ Robin and Jane will work together on it.

Action Steps

- Robbin and Jane will work on a draft statement from the Council on suicide prevention.
- Diana will include the articles from Carol Spiker and the Consumer Affairs update handout with the minutes.

The Council meets every other month, unless additional events are needed. Meetings are usually held at KDADS offices, 503 S. Kansas Avenue, Topeka, KS.

----------No Further Actions Required----------

_____

Diana Marsh, Senior Administrative Assistant, KDADS

The Council meets every other month, unless additional events are needed. Meetings are usually held at KDADS offices, 503 S. Kansas Avenue, Topeka, KS.

FFY 2020-2021 Behavioral Health Assessment and Plan

Kansas Response

Section 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Requests for Governor's Behavioral Health Services Planning Council Subcommittee Review and Feedback

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Wednesday, July 17, 2019 12:48 PM
To: Krista Machado
Subject: RE: Feedback on BG Application and KCC Annual Report

Thank you!

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Krista Machado <kmachado@dccca.org>
Sent: Wednesday, July 17, 2019 9:51 AM
To: Shane Hudson <shudson@c-k-f.org>; Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; Kayla Waters <kayla.waters@washburn.edu>; Al Dorsey <adorsey@kshousingcorp.org>; chislu@aol.com; Dana Schwarz <dschwarz@parstopeka.com>; ezv2003@yahoo.com; Krista Machado <kmachado@dccca.org>; molliejac@gmail.com; Nancy Kepple <njkepple@ku.edu>; pcecil@newchance.org; Sara Jackson <sara@hradac.com>; Tina Abney [DCF] <Tina.Abney@ks.gov>; toniragland9391@gmail.com; Victor Fitz <victor@sackansas.org>; Brad Sloan <bsloan@valeotopeka.org>; Ethan Bickelhaupt [OSH] <Ethan.Bickelhaupt@ks.gov>; imaikori@mhasck.org; Josh Klamm <jklamm@topeka.org>; mturner@aarp.org; Warren, Daniel [BOHA-EXT] <dwarren@kumc.edu>
Cc: Diana Marsh [KDADS] <Diana.Marsh@ks.gov>; Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: Feedback on BG Application and KCC Annual Report

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Hello all,

Attached is the draft response to the Block Grant Application - Environmental Factors and Plan Section 10 SUD Treatment (Required SABG). As discussed in the last KCC meeting, KDADS would like the KCC subcommittee members to review and provide feedback in writing to Cissy McKinzie, Tamberly.McKinzie@ks.gov, as well as Diana Marsh. If there is anything you can think of to enhance the responses, that would be immensely appreciated too including around Evidence Based Practices used by the field. Note: Criterion 2, there isn't any fields to complete. This section just refers back to a different section of the application.

Please provide your feedback on the BA Application by July 31st. The application is due September 3rd so this gives Cissy some time to integrate feedback.

Also, as we discussed at our meeting our Annual Report is due in September as well. I have attached the very rough draft, please send me your **feedback by August 7th.**

Thanks,

Krista Machado, MS
Program Coordinator
DCCCA
Prevention Services
3312 Clinton Parkway
Lawrence, KS 66047
(785) 841-4138
www.DCCCA.org

DCCCA
IMPROVING LIVES

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Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Friday, July 26, 2019 11:33 AM
To: 'Krista Machado'; 'Shane Hudson'
Cc: Andrea Clark [KDADS]; Wes Cole [OSH]
Subject: FW: BG Application - Planning Steps 1 and 2
Attachments: 07-26-19 Planning_Step 1_DRAFT.docx; 07-24-19 FY2020 Combined BG Application_Step 2 _DRAFT.docx

I thought I'd share my latest drafts of the BG Application Planning Step 1 (updated) and Planning Step 2 (new) with the KCC in case you would like to review and/or had any feedback.

Thanks a million,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Tuesday, July 30, 2019 1:52 PM
To: Krista Machado; Shane Hudson; Wes Cole [OSH]
Cc: Charles Bartlett [KDADS]; Misty BoschHastings [KDADS]; Melissa Bogart Starkey [KDADS]; Matthew McGuire [KDADS]; Gary Henault [KDADS]; Andrea Clark [KDADS]; Carrie Billbe [KDADS]; Linda Buchheister [KDADS]
Subject: GBHSPC feedback, please - BG App Section 16. Recovery
Attachments: File.pdf

Krista and Shane: Several BHS staff contributed to this section (thank you Linda, Carrie and Missy). Please see BG App Section 16. Recovery draft for KCC review and feedback. Please note that our response to this section only accepts unformatted narrative so a little difficult to read and we can't include graphs, etc. Thank you in advance for your assistance!

GBHSPC Liaisons: Please feel free to share this section with your subcommittees for review and feedback too.

Thanks,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From:	Cissy McKinzie [KDADS]
Sent:	Friday, August 02, 2019 5:20 PM
To:	Charles Bartlett [KDADS]; Mende Barnett [KDADS]; Misty BoschHastings [KDADS]; Melissa Bogart Starkey [KDADS]; Matthew McGuire [KDADS]; Gary Henault [KDADS]; Andrea Clark [KDADS]; Krista Machado; Shane Hudson
Cc:	Wes Cole [OSH]
Subject:	9. Statutory Criterion for the MHBG - GBHSPC review
Attachments:	File.pdf

Liaisons: Please feel free to share this draft (9. Statutory Criterion for the MHBG) with your subcommittees for their review and feedback.

Krista and Shane: More optional for the KCC (MHBG). However, thought I'd share with your subcommittee as well in case anyone would like to review and provide feedback.

Many thanks everyone,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Friday, August 09, 2019 4:55 PM
To: Shane Hudson; Krista Machado; Mende Barnett [KDADS]; Misty BoschHastings [KDADS]; Melissa Bogart Starkey [KDADS]; Matthew McGuire [KDADS]; Gary Henault [KDADS]
Cc: Andrea Clark [KDADS]; Charles Bartlett [KDADS]; Wes Cole [OSH]
Subject: BG Application - Table 1 Priority Areas and Annual Performance Indicators
Attachments: File.pdf

Krista and Shane: Please see Table 1 Priority Areas and Annual Performance Indicators section attached for the KCC's review and feedback.

GBHSPC Liaisons: Please feel free to share with your subcommittees.

Thank you,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Monday, August 12, 2019 5:05 PM
To: 'Krista Machado'
Cc: Diana Marsh [KDADS]
Subject: RE: BG Application - Table 1 Priority Areas and Annual Performance Indicators

Thank you, Krista. I will update the draft.

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Krista Machado <kmachado@dccca.org>
Sent: Monday, August 12, 2019 3:16 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: RE: BG Application - Table 1 Priority Areas and Annual Performance Indicators

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Sent. And it looks good to me. Only one thing – typo on the first page missing a "T" in The - Kansas Communities that Care Student Survey.... Under description of data.

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Friday, August 9, 2019 4:55 PM
To: Shane Hudson <shudson@ckfaddictiontreatment.org>; Krista Machado <kmachado@dccca.org>; Mende Barnett [KDADS] <Mende.J.Barnett@ks.gov>; Misty BoschHastings [KDADS] <Misty.BoschHastings@ks.gov>; Melissa Bogart Starkey [KDADS] <Melissa.BogartStarkey@ks.gov>; Matthew McGuire [KDADS] <Matthew.McGuire2@ks.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>
Cc: Andrea Clark [KDADS] <Andrea.Clark3@ks.gov>; Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; Wes Cole [OSH] <Wes.Cole@ks.gov>
Subject: [External] BG Application - Table 1 Priority Areas and Annual Performance Indicators

This email contains a link!
This email originated from outside the organization. Do not click any links or open attachments unless you are sure of the content.
- Helpdesk

Krista and Shane: Please see Table 1 Priority Areas and Annual Performance Indicators section attached for the KCC's review and feedback.

GBHSPC Liaisons: Please feel free to share with your subcommittees.

Thank you,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Monday, August 12, 2019 7:30 PM
To: Krista Machado; Shane Hudson
Cc: Charles Bartlett [KDADS]; Mende Barnett [KDADS]; Misty BoschHastings [KDADS]; Melissa Bogart Starkey [KDADS]; Matthew McGuire [KDADS]; Gary Henault [KDADS]; Andrea Clark [KDADS]
Subject: BG Application Section 20. Support of State Partners
Attachments: File.pdf

For GBHSPC subcommittee review – please see BG Application Section 20. Support of State Partners attached.

Thank you!

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Tuesday, August 13, 2019 6:49 PM
To: 'Krista Machado'; Shane Hudson
Cc: Charles Bartlett [KDADS]; Mende Barnett [KDADS]; Misty BoschHastings [KDADS]; Melissa Bogart Starkey [KDADS]; Matthew McGuire [KDADS]; Christina Orton [KDADS]; Gary Henault [KDADS]; Andrea Clark [KDADS]
Subject: BG App - Planning Steps - Quality and Data Collection Readiness.docx
Attachments: 08-13-19 Quality and Data Collection Readiness.docx

Please see draft attached for review and feedback.

GBHSPC Liaisons: Please feel free to share with your subcommittees.

Many thanks,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Wednesday, August 14, 2019 5:26 PM
To: Krista Machado; Shane Hudson
Cc: Andrea Clark [KDADS]
Subject: FW: BG App - 13. Criminal and Juvenile Justice - requested
Attachments: File.pdf

From: Cissy McKinzie [KDADS]
Sent: Wednesday, August 14, 2019 5:24 PM
To: Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; Mende Barnett [KDADS] <Mende.J.Barnett@ks.gov>; Misty BoschHastings [KDADS] <Misty.BoschHastings@ks.gov>; Melissa Bogart Starkey [KDADS] <Melissa.BogartStarkey@ks.gov>; Matthew McGuire [KDADS] <Matthew.McGuire2@ks.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>; Andrea Clark [KDADS] <Andrea.Clark3@ks.gov>
Subject: BG App - 13. Criminal and Juvenile Justice - requested

Please share with subcommittees for their review and to provide feedback. This section is requested (not required), but I wanted to share some highlights for our State.

Thanks,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Cissy McKinzie [KDADS]

From: Cissy McKinzie [KDADS]
Sent: Friday, August 16, 2019 6:24 PM
To: Shane Hudson; Krista Machado
Cc: Christina Orton [KDADS]; Gary Henault [KDADS]; Charles Bartlett [KDADS]; Mende Barnett [KDADS]; Misty BoschHastings [KDADS]; Melissa Bogart Starkey [KDADS]; Matthew McGuire [KDADS]; Andrea Clark [KDADS]
Subject: BG Application - 4. EBP for Early Interventions to Address ESMI
Attachments: File.pdf

Krista and Shane: For subcommittee review and feedback.

GBHSPC Liaisons: Please feel free to share with your subcommittees.

Thank you,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Cissy McKinzie [KDADS]
Sent: Monday, August 19, 2019 3:07 PM
To: Krista Machado
Cc: Melissa Bogart Starkey [KDADS]; Diana Marsh [KDADS]; Mende Barnett [KDADS]; Gary Henault [KDADS]
Subject: RE: BG Application Environmental Factors and Plan Section 10 SUD Treatment (Required SABG)
Attachments: 20190722134156252.pdf

Krista,

Really good feedback – thank you so much!

Regarding Criterion 3 (page 3) – I have updated the application since I sent this out for subcommittee review. Missy reviewed section 10 also. We do have Health Care Navigators, and she shared the attached list of navigators and the counties they are located in with me. She noted that KDOC, SOAR staff across the state work very closely with the Health Care Navigators that are funded by the ACA Federal Act.

Regarding Criterion 8,9 & 10 (pg. 6) Statewide Needs Assessment – I am copying Mende and Gary on your feedback for their review.

Regarding Criterion 7 & 11 (page 8) STR-TA – I changed our response. I knew Sharon was following up on TA for the STR but wasn't sure if that had actually happened or not. Thank you for the confirmation.

Thanks again for the careful review, Krista.

I am also copying Diana so she can combine your feedback with the others we received.

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Krista Machado <kmachado@dccca.org>
Sent: Tuesday, July 23, 2019 12:30 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: RE: BG Application Environmental Factors and Plan Section 10 SUD Treatment (Required SABG)

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Thanks Cissy.

Here is my feedback on the BG document.

* Criterion 3 (page 3) – the Kansas Rx and Opioid Advisory Committee has identified "health navigators to assist clients with community linkages" as a need in the state. Is there opportunity to indicate that as a yes on the application, or does that hinder some other aspect of the application? The AC didn't recommend that it come specifically with BG but in general something needed in the state.
* Criterion 8,9 & 10 (pg. 6)– statewide needs assessment (#1) – is this something the SQC could take on? They could probably work in collaboration with the Prevention Sub and the State Epidemiological Outcomes Workgroup (SEOW), I believe Lisa Chaney from Greenbush chairs the SEOW.
* Criterion 7 & 11 (Pg. 8) – Professional Development - #3: We have worked with and requested assistance from the STR-TA provider in the past. She presented to the AC and I believe KDHE has worked with them to develop some trainings. Not sure if that counts or not.

Thanks,
Krista

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Tuesday, July 16, 2019 2:27 PM
To: Shane Hudson <shudson@ckfaddictiontreatment.org>
Cc: Krista Machado <kmachado@dccca.org>; Diana Marsh [KDADS] <Diana.Marsh@ks.gov>; Andrea Clark [KDADS] <Andrea.Clark3@ks.gov>
Subject: RE: BG Application Environmental Factors and Plan Section 10 SUD Treatment (Required SABG)

Great questions and very much appreciated as I believe you are the first subcommittee to get a draft to review. (Let us know what works and what doesn't for you all for next year).

I thought this specific section is related to SUD treatment, so belongs with the KCC subcommittee as subject matter experts. To illustrate, there is an entire Planning Step One Narrative (about 15 pages that I have drafted so far) that I hope to take tomorrow to the Full Council during my report out for early feedback as it would cross the entire council.

I have an entire project plan for the application across KDADS departments and external stakeholders. There are approximately 45 sections/components to the application. SAMHSA requires both GBHSPC feedback and public comment (the draft will be posted on our website at a later date). In order to make our 9/3 application deadline, I plan to enter the full application into the Federal system by 8/29/19 to avoid any potential issues with submission by a lot of entities. I would appreciate feedback from the subcommittee any time during the drafting process but probably no later than 8/25/19. As far as who you want to review within the KCC, please use your best judgement. For example, since there is pieces related to the priority populations, it would be great if a DWF provider could review using their lens as a DWF, etc.

Thanks,
Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Shane Hudson <shudson@ckfaddictiontreatment.org>
Sent: Tuesday, July 16, 2019 2:10 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Cc: Krista D. Machado <kmachado@dccca.org>; Diana Marsh [KDADS] <Diana.Marsh@ks.gov>
Subject: Re: BG Application Environmental Factors and Plan Section 10 SUD Treatment (Required SABG)

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Is this for the entire committee to consider at the next meeting in September, or is a response needed before then? The two of us could review and provide comment, OR we could circulate to the KCC by email for feedback, OR we could wait until September to review as a group.
Thanks, Cissy.

Shane

Shane Hudson, MS, LCP, LCAC
PRESIDENT & CEO
617 E. Elm, SALINA, KS 67401
785.825.6224
www.ckfaddictiontreatment.org

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email (ckf@c-k-f.org) or call (CKF Addiction Treatment) at (785-825-6224) advising that you have done so. We appreciate your cooperation.

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Tuesday, July 16, 2019 1:37 PM
To: Shane Hudson
Cc: Krista D. Machado; Diana Marsh [KDADS]
Subject: BG Application Environmental Factors and Plan Section 10 SUD Treatment (Required SABG)

Shane and Krista,

Attached is my draft response to the BG Application - Environmental Factors and Plan Section 10 SUD Treatment (Required SABG). As discussed in the last KCC meeting, could the KCC

subcommittee please review and provide feedback in writing to me and Diana too? If there is anything the Subcommittee can think of to enhance our responses, that would be immensely appreciated too including around Evidence Based Practices used by the field.

Thanks,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

Update 7/16/19 COVER KANSAS NAVIGATOR PRIMARY LOCATIONS - Many serve multiple county / locations. Also refer to coverks.org to search Navigators in area by zip code.						Cover Kansas
County	**Organization**	**Address**	**City**	**Zip**	**Phone**	**Appointment type**
Allen	Thrive Allen County	9 S Jefferson St	Iola	66749	620-365-8128	Appointments and walk-ins welcome
Allen	K-State Research and Extension Southwind District	1 N. Washington	Iola	66749	620-233-3720	Appointments only
Atchison	Atchison Community Health Clinic	1412 N 2nd St	Atchison	66002	913-367-4879	Appointments and walk-ins welcome
Bourbon	K-State Research and Extension Southwind District	210 S National	Fort Scott	66701	620-223-3720	Appointments only
Brown	Northeast Kansas Area Agency on Aging	1803 Oregon St	Hiawatha	66434	785-742-7152	Appointments and walk-ins welcome
Cheyenne	Cheyenne County Health Department	221 W 1st St	St.Francis	67756	785-332-2381	Appointments only
Cowley	Community Health Center In Cowley County	221 W 8th Ave	Winfield	67156	620-221-3350 ext 3 (English) 2 (Spanish)	Appointments and walk-ins welcome
Ellis	First Care Clinic	105 West 13th St	Hays	67601	785-621-4990	Appointments and walk-ins welcome
Ellis	Northwest Kansas Area Agency on Aging and ADRC	510 West 29th St Ste B	Hays	67601	1-800-432-7422 or 785-628-8204	Appointments only
Finney	LiveWell Finney County	310 E Walnut St Ste 202, 2nd Floor	Garden City	67846	620-275-3047	Appointments and walk-ins welcome
Finney	Genesis Family Health--Garden City	712 St John St	Garden City	67846	620-275-1766	Appointments only
Ford	Genesis Family Health--Dodge City	1700 Ave F	Dodge City	67801	620-225-0625	Appointments only
Geary	Konza Prairie Community Health Center	361 Grant Avenue	Junction City	66441	785-238-4711	Appointment only
Grant	Genesis Family Health--Ulysses	113 S Main St, Ste D	Ulysses	67880	620-424-1580	Appointments only
Harvey	Health Ministries Clinic	720 Medical Center Dr	Newton	67114	316-281-7329	Appointments only
Johnson	Health Partnership Clinic	405 S Clairborne Rd Ste 2	Olathe	66062	913-730-3653	Appointments and walk-ins welcome
Johnson	Health Partnership Clinic	1604 Industrial Park Dr	Paola	66071	913-730-3653	Appointments and walk-ins welcome
Johnson	Johnson County Department of Health and Environment	11875 S Sunset Dr Ste 300	Olathe	66061	913-826-1200	Appointments and walk-ins welcome
Lyon	Flint Hills Community Health Center, Inc.	420 W 15th Ave	Emporia	66801	620-342-4864	Appointments and walk-ins welcome
Marshall	K-State Research and Extension Marshall County	1201 Broadway, Courthouse	Marysville	66508	785-562-3531	Appointments only
Marshall	RSVP of Northeast Kansas	813 Broadway	Marysville	66508	785 562-2154	Appointments only
Mitchell	Mitchell County Hospital Health Systems	400 W 8th St	Beloit	67420	785-738-9202	Appointments only

County	Organization	Address	City	Zip	Phone	Appointment type
Nemaha	Nemaha Valley Community Hospital	1600 Community Dr	Seneca	66538	785-336-6181	Appointments only
Neosho	Neosho Memorial Regional Medical Center	629 S Plummer	Chanute	66720	620-432-5324	Appointments only
Neosho	K-State Research and Extension Southwind District	111 S. Butler	Erie	66733	620-233-3720	Appointments only
Pratt	Pratt Regional Medical Center	Hope Center 314 S Main St	Pratt	67124	620-450-1153	Appointments only
Reno	Hutchinson Regional Medical Center	1701 East 23rd Ave	Hutchinson	67502	620-513-3780	Appointments only
Riley	North Central-Flint Hills Area Agency on Aging	401 Houston St	Manhattan	66502	785-776-9294	Appointments and walk-ins welcome
Rooks	Rooks County Health Center	1210 N Washington	Plainville	67651	785-688-4443	Appointments only
Sedgwick	Evergreen Neighborhood Resource Center	2700 N Woodland	Wichita	67214	316-303-8042	Appointments only
Sedgwick	GraceMed Health Clinic	1122 N Topeka	Wichita	67214	316-977-9308	Appointments only
Sedgwick	HealthCore Clinic	2707 E 21st St N	Wichita	67214	316-691-0249	Appointments only
Sedgwick	Hunter Health Clinic	527 N Grove	Wichita	67214	316-262-2415	Appointments only
Seward	Genesis Family Health - Liberal	121 W 3rd St	Liberal	67901	620-271-7400	Appointments only
Shawnee	GraceMed Capitol Family Clinic	1400 SW Huntoon St	Topeka	66604	785-478-5904	Appointments only
Shawnee	Jayhawk Area Agency on Aging	2910 SW Topeka Blvd	Topeka	66611	785-235-1367	Appointments only
Sheridan	Hoxie Medical Clinic	816 18th St. Ste A	Hoxie	67740	785-677-4172	Appointments only
Stevens	Stevens County Health Department	505 S. Polk	Hugoton	67951	620-544-7177 x 20	Appointments and walk-ins welcome
Thomas	Citizens Medical Center, Inc.	310 E College Dr	Colby	67701	785-462-6184	Appointments only

Contact the Cover Kansas Navigator Project at 785-249-7199

Debbie Berndsen, Project Director

updated 7-16-19

sfh/vm

From: Cissy McKinzie [KDADS]
Sent: Monday, August 12, 2019 5:05 PM
To: Krista Machado
Cc: Diana Marsh [KDADS]
Subject: RE: BG Application - Table 1 Priority Areas and Annual Performance Indicators

Thank you, Krista. I will update the draft.

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Krista Machado <kmachado@dccca.org>
Sent: Monday, August 12, 2019 3:16 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: RE: BG Application - Table 1 Priority Areas and Annual Performance Indicators

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Sent. And it looks good to me. Only one thing – typo on the first page missing a "T" in The - Kansas Communities that Care Student Survey…. Under description of data.

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Friday, August 9, 2019 4:55 PM
To: Shane Hudson <shudson@ckfaddictiontreatment.org>; Krista Machado <kmachado@dccca.org>; Mende Barnett [KDADS] <Mende.J.Barnett@ks.gov>; Misty BoschHastings [KDADS] <Misty.BoschHastings@ks.gov>; Melissa Bogart Starkey [KDADS] <Melissa.BogartStarkey@ks.gov>; Matthew McGuire [KDADS] <Matthew.McGuire2@ks.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>
Cc: Andrea Clark [KDADS] <Andrea.Clark3@ks.gov>; Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; Wes Cole [OSH] <Wes.Cole@ks.gov>
Subject: [External] BG Application - Table 1 Priority Areas and Annual Performance Indicators

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This email originated from outside the organization. Do not click any links or open attachments unless you are sure of the content.
- Helpdesk

Krista and Shane: Please see Table 1 Priority Areas and Annual Performance Indicators section attached for the KCC's review and feedback.

GBHSPC Liaisons: Please feel free to share with your subcommittees.

Thank you,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Theresa Douthart <cdouthart@valeotopeka.org>
Sent: Wednesday, July 31, 2019 8:17 AM
To: McMurphy, Christy; alfonzodorsey67@gmail.com; brianna.frits@va.gov; Charles Bartlett [KDADS]; Diana Marsh [KDADS]; Douglas D. Wallace (Douglas.D.Wallace@sunflowerhealthplan.com); Houser, Cynthia A; Hussain, Sarah; Jason Hess; Kate Watson (kwatson@kshomeless.com); lcarr1@tps501.org; Maggie Flanders (margaret.flanders@sedgwick.gov); Matt Faulk; Melissa Bogart Starkey [KDADS]; Messmer, Joseph S; Misty BoschHastings [KDADS]; Nate Miller; Sarah Barnhart [KDOC]; Stephanie Cline - United HeathCare (stephanie.cline@uhc.com); Victor Fitz - SACK (victor@sackansas.org); Worth, Elizabeth, MNH
Subject: RE: GBHSPC feedback, please - BG App Section 16. Recovery

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.
Looks good Misty!

Theresa Douthart
Housing Resource Specialist
Valeo Behavioral Health Care
2401 SW 6th Ave Topeka, KS 66606
Phone: 785.233.1730 x2157 Fax: 785.233.1450
cdouthart@valeotopeka.org
http://www.valeotopeka.org/
http://www.facebook.com/ValeoBehavioralHealthcare
Valeo Job Openings

From: McMurphy, Christy [mailto:mcmurphy_c@WMHCI.org]
Sent: Wednesday, July 31, 2019 8:10 AM
To: alfonzodorsey67@gmail.com; brianna.frits@va.gov; Charlie Bartlett (Charles.Bartlett@kdads.ks.gov) <Charles.Bartlett@kdads.ks.gov>; diana.marsh@kdads.ks.gov; Douglas D. Wallace (Douglas.D.Wallace@sunflowerhealthplan.com) <Douglas.D.Wallace@sunflowerhealthplan.com>; Houser, Cynthia A <cynthia_a_houser@uhc.com>; Hussain, Sarah <smhussain@ku.edu>; Hess, Jason <Jason@hradac.com>; Kate Watson (kwatson@kshomeless.com) <kwatson@kshomeless.com>; lcarr1@tps501.org; Maggie Flanders (margaret.flanders@sedgwick.gov) <margaret.flanders@sedgwick.gov>; Matt Faulk <mfaulk@bertnash.org>; Melissa Bogart Starkey <Melissa.BogartStarkey@kdads.ks.gov>; Messmer, Joseph S <MessmerJ@aetna.com>; Misty BoschHastings [KDADS] <Misty.BoschHastings@ks.gov>; Nate Miller <nmiller@swguidance.org>; Sarah Barnhart (Sarah.barnhart@ks.gov) <Sarah.barnhart@ks.gov>; Stephanie Cline - United HeathCare (stephanie.cline@uhc.com) <stephanie.cline@uhc.com>; Theresa Douthart <cdouthart@valeotopeka.org>; Victor Fitz - SACK (victor@sackansas.org) <victor@sackansas.org>; Worth, Elizabeth, MNH <Elizabeth.Worth@jocogov.org>
Subject: FW: GBHSPC feedback, please - BG App Section 16. Recovery

KDADS wants your feedback on the attached document. Please send it directly to Misty. Thanks!

From: Misty BoschHastings [KDADS] [mailto:Misty.BoschHastings@ks.gov]
Sent: Wednesday, July 31, 2019 7:14 AM
To: McMurphy, Christy; Liz Worth
Subject: FW: GBHSPC feedback, please - BG App Section 16. Recovery

Will you please share with the subcommittee? Thanks!

Thank you,

Misty Bosch-Hastings
Housing and Homelessness Project Coordinator/State PATH Contact
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services
503 S Kansas Avenue
Topeka, KS 66603-3404
Phone: 785-368-6245
Fax: 785-296-0256

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From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Tuesday, July 30, 2019 1:52 PM
To: Krista Machado <kmachado@dccca.org>; Shane Hudson <shudson@ckfaddictiontreatment.org>; Wes Cole [OSH] <Wes.Cole@ks.gov>
Cc: Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; Misty BoschHastings [KDADS] <Misty.BoschHastings@ks.gov>; Melissa Bogart Starkey [KDADS] <Melissa.BogartStarkey@ks.gov>; Matthew McGuire [KDADS] <Matthew.McGuire2@ks.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>; Andrea Clark [KDADS] <Andrea.Clark3@ks.gov>; Carrie Billbe [KDADS] <Carrie.A.Billbe@ks.gov>; Linda Buchheister [KDADS] <Linda.Buchheister1@ks.gov>
Subject: GBHSPC feedback, please - BG App Section 16. Recovery

Krista and Shane: Several BHS staff contributed to this section (thank you Linda, Carrie and Missy). Please see BG App Section 16. Recovery draft for KCC review and feedback. Please note that our response to this section only accepts unformatted narrative so a little difficult to read and we can't include graphs, etc. Thank you in advance for your assistance!

GBHSPC Liaisons: Please feel free to share this section with your subcommittees for review and feedback too.

Thanks,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission

Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

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From: Cissy McKinzie [KDADS]
Sent: Friday, August 02, 2019 3:20 PM
To: Krista Machado; Mende Barnett [KDADS]
Cc: molliejac@gmail.com; Diana Marsh [KDADS]
Subject: RE: GBHSPC feedback, please - BG App Section 16. Recovery

My thoughts are definitely yes but including Mende here.

Thank you for your feedback!

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Krista Machado <kmachado@dccca.org>
Sent: Friday, August 02, 2019 3:13 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Cc: molliejac@gmail.com
Subject: FW: GBHSPC feedback, please - BG App Section 16. Recovery

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Cissy, Mollie had a suggestion under the prevention services piece.

From: Mollie Thompson <molliejac@gmail.com>
Sent: Friday, August 2, 2019 7:48 AM
To: Krista Machado <kmachado@dccca.org>
Subject: Re: GBHSPC feedback, please - BG App Section 16. Recovery

In the section referring to prevention services , would it strengthen the proposal to include the strong community adult & youth coalitions across the state (consisting of the necessary sector leaders according to the (SPF) model , who are doing primary prevention at its best and involving /impacting communities to move the risk data toward decreasing ATOD use among youth.
Sent from my iPhone

On Jul 30, 2019, at 1:56 PM, Krista Machado <kmachado@dccca.org> wrote:
FYI

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Tuesday, July 30, 2019 1:52 PM
To: Krista Machado <kmachado@dccca.org>; Shane Hudson <shudson@ckfaddictiontreatment.org>; Wes Cole [OSH] <Wes.Cole@ks.gov>
Cc: Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; Misty BoschHastings [KDADS] <Misty.BoschHastings@ks.gov>; Melissa Bogart Starkey [KDADS]

<Melissa.BogartStarkey@ks.gov>; Matthew McGuire [KDADS] <Matthew.McGuire2@ks.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>; Andrea Clark [KDADS] <Andrea.Clark3@ks.gov>; Carrie Billbe [KDADS] <Carrie.A.Billbe@ks.gov>; Linda Buchheister [KDADS] <Linda.Buchheister1@ks.gov>
Subject: GBHSPC feedback, please - BG App Section 16. Recovery

Krista and Shane: Several BHS staff contributed to this section (thank you Linda, Carrie and Missy). Please see BG App Section 16. Recovery draft for KCC review and feedback. Please note that our response to this section only accepts unformatted narrative so a little difficult to read and we can't include graphs, etc. Thank you in advance for your assistance!

GBHSPC Liaisons: Please feel free to share this section with your subcommittees for review and feedback too.

Thanks,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

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<File.pdf>

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community mental health centers (CMHCs) provide a variety of services in order to enable individuals with mental illness and co-occurring disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Many substance use disorder providers are dually licensed as CMHCs enabling them to coordinate both mental health and substance use disorder care for those with co-occurring diagnoses.

In the CMHCs contract with KDADS, there are specific services for the uninsured/underinsured (which is funded by Block Grant and State funds) that must be given first priority for use with individuals who meet SPMI or SED criteria: 1) Intensive Case Management (CPST) 2) Attendant Care, 3) Peer Support, 4) 24-hour crisis response, triage, stabilization and treatment services, 5) Psychiatric services, and 6) Psychosocial Rehabilitation Services. These services are prioritized as they have been identified as particularly critical in assisting individuals in maximizing their independence and capabilities.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational Services	(●) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

In 2017, thirteen of the Kansas CMHC's were licensed to provide M/SAT. Kansas identified a growing need for co-occurring mental health and substance use services. As of 2019, there are currently nineteen CMHC's licensed to provide M/SAT.

3. Describe your state's case management services

CMHC case managers provide Community Psychiatric Support and Treatment (CPST). CPST provides goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the consumer's individualized treatment plan. CPST is a face-to-face intervention with the consumer present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the consumer lives, works, attends school, and/or socializes. CPST may include the following components: assist the consumer and family members or other collaterals to identify strategies or treatment options associated with the consumer's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the

NOT FINAL

consumer's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration; individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the consumer, with the goal of assisting the consumer to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living; participation in and use of strengths-based planning and treatments, which include assisting the consumer and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; to use personal strengths, resources, and natural supports to address functional deficits associated with the consumer's mental illness; and, assist the consumer with effectively responding to or avoiding identified precursors or triggers that would risk the consumer remaining in a natural community location, including assisting the consumer and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or as appropriate, to seek other supports to restore stability and functioning.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Kansas Department for Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waivers. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use disorder services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. Addressing Social Determinants of Health and Independence are key themes in the current waiver application.

KDADS contracts with 25 CMHC's to provide six services that must be given first priority for use with individuals who meet the Severe and Persistent Mental Illness (SPMI) or Severely Emotionally Disturbed (SED) criteria. Those six services are particularly critical to consumers in maintaining their independence and maximizing their capabilities, they are as follows: 1) Intensive Case Management (CPST) 2) Attendant Care 3) Peer Support 4) 24-hour crisis response, triage, stabilization and treatment services 5) Psychiatric services and 6) Psychosocial Rehabilitation Services. Within these contracts KDADS also identifies goals which focused monitoring for reduction of hospitalities and hospital stay.

KDADS also funds several Crisis Centers across the state with impressive early outcomes. These centers with detox beds and beds for stabilizing people in mental health crises give police officers and medical teams a place to take people where they can stay up to 23 hours instead of housing them in jails or emergency rooms. For example, the Sedgwick County Community Crisis Center (a joint endeavor between a Community Mental Health Center and a Regional Alcohol Drug Assessment Center) is estimated by the Wichita State University Public Policy and Management Center to have resulted in community cost avoidance to hospitals, EMS, and law enforcement of between $13.2 and $21.6 million in its first three years of operation.

NOT FINAL

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	4.8%	0.6%
2.Children with SED	6.3%	1.6%

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Automated Information Management System (AIMS) is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Using the 2017 Census population estimates and KDADS database, Automated Information Management System (AIMS), the prevalence and incidence rates were identified by taking the past five-year accruals and by finding the average percentage increase or decrease and applying it to get the estimated totals. The rate was then identified by taking the estimated totals divided by the census population estimate for Kansas.

NOT FINAL

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(●) Yes ( ) No
b)	Educational services, including services provided under IDE	(●) Yes ( ) No
c)	Juvenile justice services	(●) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(●) Yes ( ) No
e)	Health and mental health services	(●) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(●) Yes ( ) No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' mental health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

There are several subcommittees of the GBHSPC in Kansas including a Rural and Frontier subcommittee. Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

The Subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as the Secretaries of relevant state agencies.

The GBHSPC's annual subcommittee's charter, bylaws and reports can be found on the KDADS website at this link: https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc.

Rural and Frontier Subcommittee
The Rural & Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, [the committee] assures accessibility/availability of mental health services in frontier/rural Kansas counties. In the Committee's 2018 annual report, FY2018 goals and recommendations include: statewide adoption of KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order, strengthening continuum of care in rural/frontier areas, and continuing to diversify subcommittee membership to ensure that needs and resources are considered both within and alongside the behavioral health system.

SAMHSA was onsite in May 2018 for a 10-year comprehensive onsite review. The SAMHSA Lead on the Review indicated onsite that Kansas has one of the best Planning councils in the country.

b. Describe your state's targeted services to the homeless population.

The Housing and Homelessness subcommittee (HHS) is another subcommittee of the GBHSPC. Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees.

Housing and Homelessness subcommittee (HHS)
The Housing and Homelessness Subcommittee (HHS) focuses on helping adults experiencing severe and persistent mental illness and children diagnosed with severe emotional disturbance and their families obtain and maintain safe, decent, affordable, and permanent housing. The HHS acts as the body in Kansas who offers guidance and recommendations to the Governor's Behavioral Health Services Planning Council and to KDADS, so they can effectively exercise leadership in this arena. The subcommittee recommendations for FY19 are that the subcommittee will work with KDADS to coordinate the Subcommittee's goals and strategies with the Kansas Interagency Council on Homelessness, the subcommittee will explore options for a centralized data system within the housing and homelessness field that other State and local entities have access to for finding housing and services for our shared customers, and the subcommittee will ask the three Managed Care Organizations to recommend someone from their respective organizations to serve on the subcommittee with the intent to explore Evidence-Based Practices and/or Promising Practices that support the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders.

The Kansas Department for Aging and Disability Services currently offers multiple programs to assist individuals that are homeless or at risk of homelessness and experiencing an SMI:

NOT FINAL

Supportive Housing Recovery Supports

In 2016 through the support of the Cooperative Agreement to Benefit Homeless Individuals (CABHI), the State of Kansas BHS Commission partnered with Sam Tsemberis to bring the Housing First Model to Kansas. Kansas continues to work on our internal statewide infrastructure to bring this training to scale across the State. In January of 2019, Sam Tsemberis came to Kansas to provide an Introduction to Housing First to members of the Governors Behavioral Health Policy Council and other community stakeholders, peers and families. Sam will be returning in September of 2019 to provide a statewide Housing First training to our Mental Health and SUD provider networks. In 2017 through the CABHI agreement the BHS Commission began to partner with the HUD Continuum's of Care (COC's) and KDADS currently is partnered with the Kansas Statewide Homeless Coalition the Balance of State COC to provide information, education and HUD Housing related trainings to our Behavioral Health Services Provider Networks across Kansas. In July of 2019 in partnership with Kansas Department of Health and Environment the state added a per-diem CPST Medicaid code to ensure that Medicaid eligible consumers exiting institutions ie., state hospitals, state and county correctional facilities, nursing homes for mental health and ER's have immediate access to Housing Supportive Services to either sustain or obtain client housing using the Housing First Model. This Operation Community Integration Program per diem code is an integrative code that both SUD and MH providers can use to ensure that consumers have the Housing Supportive Services necessary to sustain independent living in the community and support the consumers through the transition process to full community integration. All consumers that are participants in this program must be connected to a Federal HUD Access Point to ensure that BHS consumers who are HUD eligible will have access to HUD Access Points, and Coordinated Entry. Consumers participating in this Medicaid code will have the ability to select recovery support services that they feel will help them be successful in community integration. Programs/Supportive Services included in the (OCI) Recovery Support Services Array include; SAMHSA's Cognitive Behavioral therapy Intervention work book, Medication Assisted Treatment, Housing First Support Services, IPS Supported Employment, SOAR/Entitlement Benefits Counseling (referral to a C-WICK), Mobile Crisis Response, CIT Interventions.

IPS Supported Employment (Enhancing Supported Employment in Kansas-ESEK) and the Employment First Act

Kansas was one of the first states in the United States to sign into law the Employment First Act. In 2014 the State was awarded a Federal Cooperative Agreement from SAMHSA to expand our state infrastructure for IPS Supported Employment. Over 5 years through two-evaluation sites, Kansas is strengthening and enhancing services and supports to promote employment as a part of recovery and towards economic self-sufficiency for employment age youth and adults with mental health needs. The ESEK Federal Award was essential to our state and will allow us to strengthen, enhance and sustain an evidence based participant guided and empowering approach for addressing the employment needs and desires for youth and adults with SMI. More than 3,000 youth and adults will have been impacted and introduced to IPS Supported Employment. Through a Technical Assistance award funded by SAMHSA under the ESEK Cooperative Agreement the State of Kansas has contacted with the National Council for Behavioral Health to look at developing a statewide Center for Excellence and a State of Kansas Resource Center for Evidence Based Practices to ensure that our provider networks have access to the most recent evidenced based and promising practice programs that will assist our consumers down their individual path of recovery. Our first consulting meeting took place in July of 2019 and we will meet on a monthly basis until September 20th, 2019. The Governors Behavioral Health Policy Council has given permission for KDADS to create a sub-committee group specific to Evidence Based Practices, to ensure that consumers, families, stakeholders and our providers all have input into the selection of EBP programming within the State of Kansas. In 2019 as part of an 1115 demonstration waiver for KANCARE 2.0, the State of Kansas will be introducing an Employment Program for consumers with Behavioral Health diagnosis, consumers on the HCBS waivers and consumers who would like to return and/or enter the workforce.

Projects for Assistance in Transitioning from Homelessness (PATH)

PATH is a SAMHSA-funded program designated to support the delivery of eligible services to persons who have an SMI and may also have a co-occurring disorder and are homeless or at risk of becoming homeless. Through outreach services provided by CMHCs, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive services.

Interim Housing (IH)

IH projects is a state-funded program that involves short-term (up to six months) project-based housing that provides immediate community-based housing for persons who meet HUD's definition of homeless; who are homeless and being discharged from inpatient or residential mental health or substance use treatment facility (e.g., a state psychiatric hospital (SPH), nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program). There are currently six CMHCs that have Interim Housing Projects. In addition, the state requires CMHCs to have Housing Specialists, who are responsible for increasing the array of housing options available to consumers. The CMHC Housing Specialists assist persons with behavioral health issues, including co-occurring mental health and substance use disorders, to access safe and affordable housing of their choice and to provide the necessary supports and services that ensure the person lives a safe, healthy, self-determined life in their own homes. CMHC Housing Specialists actively participate in and assist with local, regional, and/or statewide efforts to decrease homelessness and to address situations where individuals are precariously housed. KDADS' Behavioral Health Services Commission and the Commission on Aging are jointly responsible for programming and funding statewide. In addition, while all CMHCs serve individuals regardless of age, multiple CMHCs provide services that target older adults.

Social Security Outreach Access and Recovery

Consumers exiting state hospital and state correctional facilities now have access to a SOAR/Benefits Specialist to assist them with

NOT FINAL

transition into the community. In 2017 the State of Kansas KDADS partnered with the State Medicaid Agency KDHE to ensure that federally disabled consumers who had become dis-connected from their benefit could be re-connected to both SSA and Medicaid with assistance from a SOAR staff. State of Kansas Hospital Staff are also participating in the Social Security Administrations TI Benefit Program to ensure that consumers who are hospitalized because of an illness who may be at risk of homelessness can work with the Social Security Administration under the TI program to request that SSA benefits remain active to avoid homelessness, evictions etc. which we believe will decrease some of our housing issues in Kansas. Consumers who participate in this program can now have their Medicaid placed into suspension status instead of being shut off when they enter the State Hospitals allowing consumers to access medications and services on the day of discharge. The Kansas Department of Corrections and Kansas Department for Aging and Disability Services have MOU's with the Social Security Administration to ensure that consumers exiting institutions can be re-connected to benefits to ensure that federally disabled consumers have access to services on the day of discharge/release. The State of Kansas continues to grow our SOAR program within our provider networks and HUD Continuum of Care locations in Kansas. We have increased the number of SOAR Certified Staff within the state and in fiscal year 2018-2019 we doubled our SOAR staff across the State. We have partnered with Kansas Statewide Homeless Coalition and 2019 will be a year of cross over training with our COC's and BH provider systems. We hope to have a SOAR point of contact at each provider agency or within each HUD COC so that our Homeless or At Risk of Homelessness population have an advocate across the Social Security Systems and can have access to recovery oriented programs such as Ticket To Work, PACE, and the SSA Trial Work Period.

c. Describe your state's targeted services to the older adult population.

Kansas Department for Aging and Disability Services
Kansas recently elected a new governor. Governor Laura Kelly became the 48th governor of the State of Kansas in January of 2019. Under Governor Kelly, Laura Howard was appointed the new Secretary for the Kansas Department for Children and Families (DCF) and the Kansas Department for Aging and Disability Services (KDADS). Janis DeBoer was appointed the Deputy Secretary of the Kansas Department for Aging and Disability Services.

Under Secretary Howard, KDADS was reorganized into five commissions: Financial and Information Services Commission, Aging and Disability Community Services and Programs Commission, State Hospital Commission, the Survey, Certification and Credentialing (SCC) Commission, and the Behavioral Health Services (BHS) Commission.

Aging & Disability Community Services and Programs Commission (A&D CSP)
Amy Penrod was appointed the Commissioner of the Aging & Disability Community Services and Programs Commission. The Aging & Disability Community Services and Programs (A&D CSP) Commission manages a system of community-based supports and services for persons with disabilities, which are delivered through the Medicaid Managed Care system (KanCare) in partnership with organized networks. These services include programs for those with physical disabilities, intellectual/developmental disabilities, frail elderly and children with autism. It is responsible for coordinating intra-agency KDADS activity around KanCare. The Commission works with each KDADS Commission to ensure that client services are monitored appropriately. The Commission coordinates with all three KanCare Managed Care Organizations (MCOs) regarding KDADS-specific program areas (home and community-based service waivers and behavioral health).

A&D CSP also administers a variety of community-based programs for the aging population through contracts and grants of state and federal funds. The programs administered include Older Americans Act, congregate and home-delivered meals, caregiver programs, in-home services, Senior Care Act services, and Client Assessment, Referral and Evaluation (CARE) program, as well as quality assurance programs for the Older Americans Act and Senior Care Act. In addition, it is responsible for the Aging and Disability Resource Center, or ADRC, the single-entry point for older adults and persons with disabilities to connect with local experts who can help them choose a long-term care option. The Commission oversees and implements grants that assist individuals who are aging or have a disability under Senior Health Insurance Counseling for Kansas (SHICK), Senior Medicare Patrol (SMP), Lifespan Respite and Community Transition Opportunities. The SHICK program assists individuals with questions related to Medicare. The SMP program educates the community about reporting Medicare/Medicaid and health-care fraud and abuse and how to identify and report scams. The Commission's Community Transitions Opportunities program works with nursing facilities to identify residents who wish return to living in a community setting.

Governor's Behavioral Health Services Planning Council Subcommittees
There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Suicide Prevention and 8) Veterans and Vocational. In addition, the GBHSPC has approved forming subcommittees for problem gambling, aging, and evidence-based practices.

NOT FINAL

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

To ensure that emergency health staff and first responders are able to train others in their arenas of work, KDADS supports Youth Mental Health First Aid training for trainers. Community Mental Health Centers (CMHCs) also offer Mental Health First Aid training within their communities for educators, families, clergy, health care professionals and other stakeholders. Each CMHC also participates in disaster planning and training at both the local and state levels. KDADS has taken a comprehensive approach to train law enforcement, first responders, and other personnel in the area of mental health issues throughout the state. They have provided grant funding to enable emergency health responders including law enforcement, mental health providers, those who work with Veterans, and others, to receive Crisis Intervention Training (CIT). CIT training programs include instruction, classroom materials, and student room and board. Law enforcement officers trained will earn continuing education hours through the Kansas Law Enforcement Training Center (KLETC). KLETC will also produce an online training video and testing instrument for use by law enforcement agencies that are unable to send staff to the training center. More than 1,000 first responders have been trained to date. There are plans to provide a series of six one-day mental health awareness training sessions throughout the state, which will lay the ground work for more specialized behavioral health training in the future. Regional training events will target smaller, rural law enforcement agencies that do not have the local mental health resources to provide such training.

NOT FINAL

Footnotes:

NOT FINAL

FFY 2020-2021 Behavioral Health Assessment and Plan

Kansas Response

Public Comment on the Mental Health/Substance Abuse Block Grant Application

BEHAVIORAL HEALTH ASSOCIATION OF KANSAS

29 August 2019

Secretary Laura Howard
Kansas Department for Aging and Disability Services
503 S. Kansas Ave.
Topeka, Kansas 66603

Transmitted Via Email

Secretary Howard,

Please accept the following as our comments on the *Kansas Uniform Application: Substance Abuse Prevention and Treatment and Mental Health Services Block Grant*.

The Behavioral Health Association of Kansas (BHAK) is the State's trade organization dedicated solely to substance use disorders treatment and prevention providers seeking integrated behavioral health care. BHAK believes that true integrated behavioral health means access and funding for mental illness and substance use disorder treatment without regard to where our consumers seek services in the publicly funded behavioral health system.

Our providers serve Kansans statewide with substance use disorder and mental health treatment at all levels, from education, individual and group therapy, medication-assisted treatment, residential services, to pregnant women. The Federal Block Grant, Medicaid, Senate Bill 123 treatment in lieu of prison, private insurance, self-pay, and grants fund our services. A member organization map is attached.

We welcome the opportunity to provide feedback on the Block Grant application. The State of Kansas has invested significant time, energy, and resources, toward the production of the application. We appreciate the broad overview that characterizes the entire system providing federally funded block grant treatment and prevention services.

We have several comments specific to the substance use disorder (SUD) treatment portion of the application.

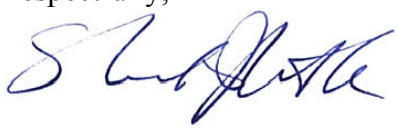
- Block grant funds served 13,380 individuals in SFY 2018. The amount of funding is well below need and the provider rates are well below costs for most modalities. We support increased federal funding for the SUD block grant as well as a study from the State and the Administrative Service Organization and KDADS, or a third party, to determine reimbursement rates that should be increased.
- We encourage the State and the Administrative Service Organization to consider increased funding rates.

800 SW Jackson St., Suite 1100 • Topeka, KS 66612
(p) 785.730.3209 • (e) bhakansas1@gmail.com

- Peer mentor certification and training is a powerful service system that should be expanded and added in as a tool to achieve outcomes.
- We support continued focus of resources and incentivize treatment to integrate SUD and mental health service provision, increase peer supports, and expand supported housing and employment services.
- Block grant funded clients have significant co-occurring challenges that impact their ability to sustain a recovery lifestyle. Uninsured Kansans have limited resources and SUD treatment providers who choose to engage in integrated service models often purchase these services or create them internally in order to offer clients the best opportunity for successful treatment outcomes. We support changes to the current block grant rate structure. Increased rates or expanded billing options would support the following interventions (not an all-inclusive list):
    - Mental health services, to include medication evaluation and medication management.
    - Family therapy
    - Psychiatric services,
    - Purchasing medications prescribed by medical providers, including those medications used in Medication Assisted Treatment

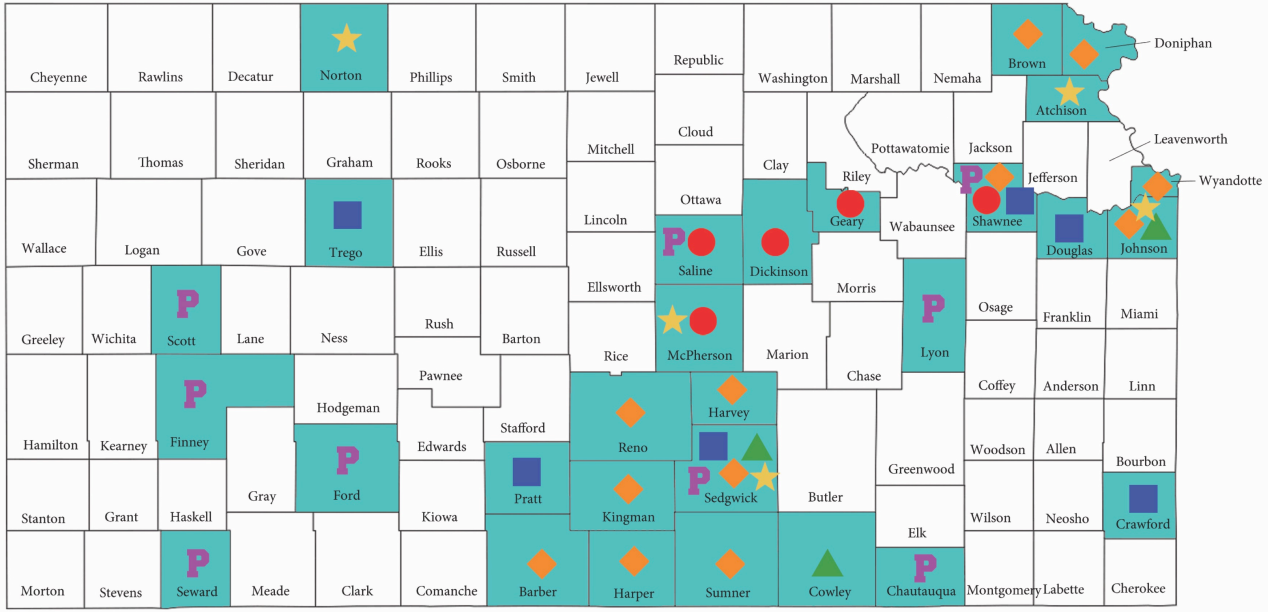
We appreciate the opportunity to provide support for the State of Kansas to secure these funds that are vital to providing SUD treatment services. Our system works and the Kansas Department for Aging and Disability Services has re-established a positive and constructive relationship with providers to better deliver Block Grant funded services to consumers. Thank you for your leadership in procuring and preserving these vital funds

Respectfully,



Stuart J. Little, Ph.D., President
Behavioral Health Association of Kansas

Behavioral Health Association of Kansas Member Service Locations*



*Physical locations serve consumers in a broader geographic region, particularly residential programs.

Mirror, Inc.
130 East Fifth Street
Newton, KS 67114

(316) 283-6743
Barth Hague, CEO

Preferred Family Healthcare
900 East Laharpe
Kirksville, MO 63501

(660) 665-1962
Michael Schwend, CEO

CKF Addiction Treatment
1805 South Ohio
Salina, KS 67401

(785) 833-5378
Shane Hudson, CEO

DCCCA
3312 Clinton Parkway
Lawrence, KS 66047

(785) 841-4138
Lori Alvarado, CEO

Valley Hope Association
103 S. Wabash Ave.
Norton, KS 67654

(785) 877-5111
Pat George, CEO

BHAK Public Policy Network

Ashby House: Saline

CKF Addiction Treatment: Dickinson, Geary, McPherson, Saline, Shawnee

City on a Hill: Finney, Scott, Seward, Chautauqua

Corner House: Lyon

DCCCA: Crawford, Douglas, Pratt, Sedgwick, Shawnee, Trego

Higher Ground: Sedgwick

Mirror, Inc.: Barber, Brown, Doniphan, Harper, Harvey, Johnson, Kingman, Sedgwick, Shawnee, Sumner, Reno, Wyandotte

New Chance: Ford

New Dawn: Shawnee

Preferred Family Healthcare: Cowley, Johnson, Sedgwick

Sims-Kemper: Shawnee

Valley Hope Association: Norton, Atchison, Johnson, Sedgwick, McPherson

800 SW Jackson St., Ste. 1100
Topeka, KS 66612
Stuart J. Little, Ph.D.
(785) 730-3209

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From: Cissy McKinzie [KDADS]
Sent: Thursday, August 29, 2019 1:54 PM
To: Diana Marsh [KDADS]
Subject: FW: Block Grant Public Comment

Diana,

Could you please add to the public comment, please.

Thank you,

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Andrew Brown [KDADS] <Andrew.Brown@ks.gov>
Sent: Thursday, August 29, 2019 12:38 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: FW: Block Grant Public Comment

FYI

Andy Brown
Commissioner of Behavioral Health Services
Kansas Department of Aging and Disability Services
503 S Kansas Ave
Topeka, KS 66603
Phone: (785) 291-3359
Fax: (785) 296-0256

Visit Our Website: www.kdads.ks.gov

From: Doug Ballou <doug@blue-window.org>
Sent: Thursday, August 29, 2019 12:19 PM
To: Andrew Brown [KDADS] <Andrew.Brown@ks.gov>
Cc: doug@blue-window.org; leighanne@blue-window.org; jenn@blue-window.org
Subject: Block Grant Public Comment

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.
Thank you for the time to meet last week and introducing me to Deputy Secretary DeBoer.

Only this morning was I able to review the DRAFT Block Grant Application –all 563 pages of it --and consider the relevance of our recent research, Assessment, strategic framework, primary prevention

program recommendations, and related conversations with you.

As you suggested it may be more practical to consider all that in context of the 2021-22 Application particularly given the looming deadline.

But our sense of urgency in addressing the magnitude of behavioral health risk and its associated implications on Kansas' mental wellness and economic vitality compels us to offer a few suggestions and recommendations. Hopefully your consideration of these concepts will be a pretense for our role in your strategic planning; and your support for new primary prevention models that could plausibly be planned and piloted during this Block Grant period.

1. Definition of Sub-Populations

In both the Evidence Based Workgroup narrative and description of Priority #4, we would recommend expanding or modifying the definitions of "sub-populations" to include Selective Risk groups based on vulnerable personality types, psychographics and traits, Developmental Asset Inventories/Deficits, and predictive insights revealed from the Synthesis® Clusters. These segmentation methodologies have been validated to be significantly more predictive of risk, are more efficient in isolating at-risk subgroups, and have associated Evidence Based Strategies that can be implemented.

Inversely, the targeted populations cited—simple demographics, LGBT and Rural-- while likely to fall into the re-defined segments, are myopic and discount who are the largest at-risk populations.

2. The Application cites Young Adults as a targeted population but the present apparatus and programs may fail to actually address them specifically. A focused workplace strategy, or one targeted to other young adult affinities, could fill that gap and coincide with our private-sector partnership activities.

3. Strategic Planning

The BG Application is a reflection of a labyrinth of councils, committees, subcommittees and workgroups, mandated and otherwise. A concerted effort is needed, perhaps at the Council level, to bring greater focus, clarity, continuity, integration and accountability to a unified collective effort. (What does a proportionate and coordinated response look like?) Outcome Indicators are cited (page 159), however, the year-over-year improvement objectives are so vague or modest as to assure a growing population of those exhibiting risky behavior and consequently incurring the unsustainable cost of intervention and treatment. It is noteworthy in the Primary Prevention Planning section (page 127) there are no indicators checked for timelines, roles, and responsibilities.

A goal of the Data Workgroup should also be more than data collection and integrity but analysis and interpretation that give guidance and continuity that transcend the web of stakeholders and operating groups.

4. Budget Request

Premature and as presumptuous as it may seem, our Testimony to Secretary Howard alluded to a project proposal, incapsulated below, that encompasses Information Dissemination, Education, and Alternatives in a manner that leverages new segmentation methodologies and student engagement practices that promise exponentially improved outcomes in terms of problem alcohol use, illicit drug use, sexual activity, and violence. Anecdotally, in one state we consulted, school officials reported marked improvements in test scores, truancy, and discipline. A pilot implementation is envisioned for the Wichita Public School District that meets criteria described in "Non-Direct Services/System Development" and includes Information

Systems, Training & Education, and Partnerships & Community Outreach. The latter will include private-sector financial support that is integral to the project, enhances its sustainability, and lessens the cost burden on public financing. (This might also be the catalyst for a strong Wichita-based coalition.)

We would be pleased to share a proforma/prospectus on the approach generally and the Wichita project if KDADS wants to take it into account in the 2020-21 Block Grant Application for planning and/or implementation.

5. You reported someone's interest in learning more about Cluster Based Planning. The application of that data set and analysis falls into planning of services for individuals with co-occurring disorders, wrap-around facilitation, and System of Care capacity planning and training. If learning more about those consulting services is relevant to your Block Grant Application we can arrange a briefing, or convene in October.

Regrettably, a scarcity time since we last met precluded more thoughtful or comprehensive comment but I did want to weigh in and express our interest in working with you and Deputy Secretary DeBoer to facilitate and forge a business case and actionable Behavioral Health Strategy that yields significant and meaningful outcomes for Kansans.

Respectfully,

Doug Ballou

Dream. Commit. Change.

Doug Ballou
BlueWindow - www.blue-window.org
doug@blue-window.org | P: 816.719.4315 | F: 816.599.2174
Connect with us on LinkedIn, Facebook or Twitter - @BlueWinKC

8.26.2019

Re: Public comment regarding the Kansas block grant funding for MAT services

Dear Sir/Madam,

I am writing to comment on the state of Kansas block grant funds that are utilized for Medication Assisted Treatment (MAT) services. Specifically, in the attached document it states that the state of Kansas has purchased Methadone with block grant funds. The state of Kansas has paid a minimal amount of block grant funds for the use of MAT services (using methadone treatment) in the state of Kansas. Only approximately 30 patients are being serviced at one clinic located in Wichita, KS. There are approximately 2000-2500 patients in the state of KS that are in MAT services and many more that need access to MAT services but cannot afford the treatment. This block grant funding is underserving the MAT population in Kansas by not providing the access to care for people in need and who want treatment but cannot afford the treatment and/or who do not have health insurance to cover the treatment. The overdose deaths will continue to rise in the state of Kansas without increasing the access to care of people in need of MAT treatment using Kansas block grant funds.

Thank you for your attention to this matter.

Sincerely,

Michelle McGraw

Behavioral Health Group Regional Director

From: Cissy McKinzie [KDADS]
Sent: Thursday, August 22, 2019 4:46 PM
To: Diana Marsh [KDADS]; KDADS BHS
Subject: RE: Block grant application available for comment

Diana,

Could you keep this with the BG App public comment, please? I just returned a call to Charity and spoke to her about the Federal Block Grant requirements and invited her to respond if she would like to provide any feedback.

Cissy McKinzie
Block Grant/SUD Program Manager
SOTA
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services (KDADS)
503 S. Kansas Ave.
Topeka, KS 66603
Phone: (785) 296-4079
Fax: (785) 296-0256
Tamberly.McKinzie@ks.gov

Visit our web site: http://www.kdads.ks.gov/

From: Charity Kossin <charity.kisaliferecovery@gmail.com>
Sent: Thursday, August 22, 2019 6:13 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: Block grant application available for comment

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.
Hello, can you help me understand what this is for?

Thanks!

--
Charity Kossin, LMAC
Executive Director

KISA Life Recovery
865 St. Highway 99
Sedan Ks, 67361
620-710-5058
www.kisaliferecovery.com

Important: This email and any attachments may contain confidential information subject to protection under the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164). If you or your organization is a "Covered Entity" under the above mentioned regulations, you are obligated to treat such information in a manner consistent with the regulations. If this email was sent to you in error you are prohibited from utilizing or disseminating this email or any attachments. Please

immediately delete it from your computer and any servers or other locations where it might be stored and email charity.kisaliferecovery@gmail.com or call Charity Kossin at 620-710-5058 advising that you have done so. We appreciate your cooperation.

From: Michelle Voth <mvoth@parstopeka.com>
Sent: Thursday, August 29, 2019 4:52 PM
To: KDADS BHS
Subject: Substance Abuse Block Grant Comments

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Comments on Draft Block Grant

KDADS is entering the 5th year of a prevention redesign. While the draft block grant references that coalitions are being evaluated regarding their deliverables and progress towards local outcomes, there is no mention of a comprehensive plan or comprehensive evaluation based on the IOM categories and higher risk population as well as geographic areas. It would seem that a comprehensive evaluation of the system redesign would be desired to assess at a high level the impact and reach of populations being served through the current system. There is no reference to how the prevention redesign has benefitted 105 counties in four years, or what percentage of the population is being served currently. Using the SPF process from a statewide perspective moving forward would seem to be an appropriate way of determining the successes/gaps and advantages/disadvantages of the system.

Also is it common for block grant plans to name contractors that will be used in the future? Additionally, an assessment of the prevention workshop would be appropriate in the future as when the system was redesigned, there was a huge loss of Certified Prevention Professional in the state.

I also did not find any discussion of how KDADS is coordinating with other state agencies, specifically Children and Families, to address selective and indicated youth needs. The data and discussion of treatment services underscores there are unmet needs.

Recommendations:

1) based on the history of SAMHSA's investment in KS prevention, there needs to be an intensive and historical analysis of the CTC data including the KU community change findings if KDAD plans to address sub-state and diverse population needs;

2) KS needs a robust prevention plan based on historical and current data with a clear and measurable evaluation strategy;

3) After four years there needs to be evaluation results for the redesign that goes beyond a philosophical discussion and addresses measurable benefits across the 105 counties;

4) There needs to be measurable results and a deeper understanding of how capacity building funds have and/or will strengthen communities to plan and prevent SUD and interrelated risk across the lifespan. KS has applied SPF steps to prevention planning for 25 years so how has the redesign strengthened capacity across 105 counties and for higher risk populations and geographical areas;

5) How is KDAD planning to fulfill their goal of addressing prevention across the lifespan and measure results?

Thank you for the opportunity to comment.

Michelle M. Voth, MPA
Executive Director
Prevention and Recovery Services
2209 SW 29th Street
Topeka, KS 66611
w. 785-266-8666
f. 785-266-3833
www.parstopeka.com

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dr. Jane Adams	Youth/adolescent representative (or member from an organization serving young people)	Keys for Networking	3926 SW 6th St. Topeka KS, 66607 PH: 785-233-8732	jadams@keys.org
Charles Bartlett	State Employees	Kansas Department for Aging and Disability Services	503 S. Kansas Avenue Topeka KS, 66603 PH: 785-368-6391	charles.bartlett@ks.gov
Denise Baynham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7701 Armstrong Ave. Kansas City KS, 66112 PH: 913-689-8192	baynhamdenise@yahoo.com
Ethan Bickelhaupt	Others (Advocates who are not State employees or providers)	Osawatomie State Hospital	2702 Olde Creek Court Leavenworth KS, 66049 PH: 312-610-9636	ethan.bickelhaupt@ks.gov
Cherie Bledsoe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Kansas Consumer Advisory Council for Adult Mental Health, Inc.	7528 Troupe Avenue Kansas City KS, 66102 PH: 913-787-3507	cheriedbledsoe@sbcglobal.net
Randall Bowman	State Employees	Kansas Department of Corrections	714 SW Jackson, Ste. 300 Topeka KS, 66603 PH: 785-296-4213	randall.bowman@ks.gov
Jacob Box	Parents of children with SED/SUD		1518 SW 28th St. Topeka KS, 66611 PH: 320-310-9036	jacob.box82@gmail.com
Wes Cole	State Employees	Osawatomie State Hospital	937 Walnut Osawatomie KS, 66064 PH: 913-755-3655	scole@micoks.net
Robbin Cole	Providers	Pawnee Mental Health Services	2500 Meade Circle Manhattan KS, 66502	robbin.cole@pawnee.org
Hope Cooper	State Employees	Kansas Department of Corrections	714 SW Jackson Topeka KS, 66603 PH: 785-296-1387	Hope.Cooper@ks.gov
			1717 SW Stone Crest	

Dr. James Costello	Others (Advocates who are not State employees or providers)		Drive Topeka KS, 66615 PH: 785-273-1495	jcostello@emporia.edu
Ric Dalke	Providers	Iroquois Center for Human Development, Inc.	901 Lyle Avenue Garden City KS, 67846	ricdalke@irqcenter.com
Sandra Dixon	Providers	DCCCA	1808 Golden Rain Dr. Lawrence KS, 66044 PH: 785-843-9262	sdixon@dccca.org
Mark Dodd	Representatives from Federally Recognized Tribes		3519 SW MacVicar Ave. Topeka KS, 66611 PH: 785-368-6203	doddmark1@gmail.com
Al Dorsey	State Employees	Kansas Housing Resources Corporation	611 S. Jackson Ave. Ste. 300 Topeka KS, 66603 PH: 785-296-2262	adorsey@kshousingcorp.org
Kristin Feeback	Family Members of Individuals in Recovery (to include family members of adults with SMI)			kfeeback@kumc.edu
Victor Fitz	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 316-390-3406	victor@sackansas.org
Koleen Garrison	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			koleengarrison@kansascac.org
Brenda Groves	Parents of children with SED/SUD			bgroves@kfmc.org
Dr. Patrick Hall	Family Members of Individuals in Recovery (to include family members of adults with SMI)		807 Valley Vista Norton KS, 67654	phall@valleyhope.org
Julie Hays	Parents of children with SED/SUD		2336 Avenue T Geneseo KS, 67444 PH: 785-472-7026	hayshollow@gmail.com
Patricia Long	State Employees	Kansas Department of Children and Families	555 S. Kansas Ave. Topeka KS, 66612 PH: 785-296-5254	patricia.long@ks.gov
Christina Mayer	Providers	DCCCA	101 Peach Street Eudora KS, 66025 PH: 785-766-1498	cmayer@dccca.org
Stephanie Salisbury	Family Members of Individuals in Recovery (to include family members of adults with SMI)		500 E. Maple Coldwater KS, 67029 PH: 785-580-8698	stephaniesalisbury@outlook.com
Kirk Schottler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		17991 R. Road Mayetta KS, 66509	kschott54@hotmail.com
Fran Seymour-Hunter	State Employees	Kansas Dept of Health and Environment	900 SW Jackson, Ste. 900 Topeka KS, 66612 PH: 785-296-2212	Fran.Seymour-Hunter@ks.gov

Rodney Shepherd	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1 South Washington St. Emporia KS, 66801 PH: 620-344-1158	rodneys@cornerhouseinc.org
Deann Shinkle Mitchell	Parents of children with SED/SUD		15985 S. Clairborne Olathe KS, 66067	deannmitchell15@aol.com
Peg Spencer	State Employees	Kansas Rehabilitation Services	555 S. Kansas Ave. Topeka KS, 66612 PH: 785-368-8214	margaret.spencer@ks.gov
Guy Steier	Others (Advocates who are not State employees or providers)	District Court Judge	636 Grand Avenue Clyde KS, 66938	judges@12d.org
Christine Thompson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3692 Stewart Farm Rd. Wamego KS, 66547	C.L.Thompson2018@gmail.com
Dr. Sherrie Vaughn	Others (Advocates who are not State employees or providers)	NAMI Kansas	501 Jackson Street Topeka KS, 66603 PH: 800-539-2660	info@namikansas.org

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Required State Agency Representatives
State Vocational Rehabilitation Agency - Peg Spencer
State Criminal Justice Agency - Randy Bowman
State Housing Agency - Al Dorsey
State Social Services Agency - Patricia Long
State Health (MH) Agency - Charles Bartlett
Kansas generally has a Council representative for education, but the representative for the Kansas State Department of Education is currently vacant and not yet been refilled.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**33**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	4	
Vacancies (Individuals and Family Members)	1	
Others (Advocates who are not State employees or providers)	4	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	**20**	**60.61%**
State Employees	8	
Providers	4	
Vacancies	1	
Total State Employees & Providers	**13**	**39.39%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**6**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Some members of the Kansas Governor's Behavioral Health Services Planning Council (GBHSPC) fulfill more than one role based on the subject matter due to their life experience and/or racial/ethnicity diversity.

Persons in recovery from or providing treatment for or advocating for SUD services = 5
Total individuals in Recovery, Family Members & Others = 25

Providers = 6
Total State Employees & Providers = 15

Youth/adolescent representative (or member from an organization serving young people) = 2

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://www.kdads.ks.gov/commissions/behavioral-health/substance-abuse-and-mental-health-services-administration-block-grant

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

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Footnotes:

Public Comment can be found in the attachment to section 21. State Planning/Advisory Council and Input on the Mental Health/SABG Application