Kansas

UNIFORM APPLICATION
FY 2022/2023 Only Application
Behavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 08/22/2022 3:11:03 PM)

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

Plan Year
Start Year 2023
End Year 2024

State DUNS Number
Number 878195098
Expiration Date

I. State Agency to be the 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 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
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

Revision Date  8/22/2022 3:10:49 PM

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: 03/02/2022 Expires: 03/31/2025

Footnotes:
Kansas does not have a Third Party Administrator for the MHBG

Co-Contact Person Responsible for Application Submission:
Jamie Wallen
Mental Health Program Manager
Kansas Department for Aging and Disability Services
Phone: 785-296-2518
Fax: 785-296-0256
E-mail: jamie.wallen@ks.gov
## State Information

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

**Fiscal Year 2023**

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

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awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is
the case, you will be notified.

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds
sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project
described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized
representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish
a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the
appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit
systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit
System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights
Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education
Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c)
Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for
Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real
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whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real
property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities
of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C.
§276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards
for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of
1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood
insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental
quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b)
notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood
hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management
program developed under the 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).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

b. 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)**


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

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

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


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


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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


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: __________________________________________

Title: Secretary Date Signed: 07/19/2022

mm/dd/yyyy

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

Footnotes:
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)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Laura Howard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Secretary</td>
</tr>
<tr>
<td>Organization</td>
<td>Kansas Department for Aging and Disability Services</td>
</tr>
</tbody>
</table>

Signature:  

Date: 7/19/2022

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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

March 15, 2021

To whom it may concern,

I, Secretary Laura Howard of the Kansas Department for Aging and Disability Services, do hereby delegate to Commissioner Andrew Brown of the Kansas Department for Aging and Disability Services, authority to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the U.S. Department of Health and Human Services, and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment Block Grant (including the Annual Synar Report) and the Community Mental Health Services Block Grant until such times as this delegation of authority is rescinded.

Sincerely,

Laura Howard  
Secretary  
Kansas Department for Aging and Disability Services  
503 S. Kansas Ave  
Topeka, Kansas 66603
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 for Aging and Disability Services

Signature:  
Date:

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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.
Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal year 2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding. Table 2 addresses funds to be expended during the 12-month period of July 1, 2022, through June 30, 2023. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP Supplemental funds. Please use these columns to capture how much the state plans to expend over a 12-month period (7/1/22-6/30/23). Please document the use of COVID-19 Relief Supplemental and ARP Supplemental funds in the footnotes.

**Planning Period Start Date: 7/1/2022**  
**Planning Period End Date: 6/30/2023**

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
<th>H. COVID-19 Relief Funds (MHBG)(^a)</th>
<th>I. COVID-19 Relief Funds (SABG)(^a)</th>
<th>J. ARP Funds (MHBG)(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
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<tr>
<td>b. All Other</td>
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<tr>
<td>2. Primary Prevention</td>
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<tr>
<td>a. Substance Abuse Primary Prevention</td>
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<tr>
<td>b. Mental Health Primary Prevention(^c)</td>
<td></td>
<td></td>
<td></td>
<td>$162,311.00</td>
<td>$1,246,277.00</td>
<td></td>
<td>$603,970.00</td>
<td></td>
<td>$603,554.00</td>
<td>$1,079,100.00</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)(^d)</td>
<td></td>
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<td></td>
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<tr>
<td>4. Tuberculosis Services</td>
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<tr>
<td>5. Early Intervention Services for HIV</td>
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<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td>$520,492.58</td>
<td>$0.00</td>
<td>$100,536,615.00</td>
<td></td>
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<tr>
<td>7. Other 24-Hour Care</td>
<td></td>
<td></td>
<td>$63,977,091.53</td>
<td></td>
<td>$27,946,084.39</td>
<td></td>
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</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td>$4,831,760.00</td>
<td>$119,379,508.87</td>
<td>$1,996,050.13</td>
<td>$57,945,287.23</td>
<td></td>
<td>$4,828,434.00</td>
<td>$8,303,425.00</td>
<td></td>
</tr>
<tr>
<td>9. Administration (excluding program/provider level)(^e) MHBG and SABG must be reported separately</td>
<td></td>
<td></td>
<td></td>
<td>$301,985.00</td>
<td>$139,824.20</td>
<td>$3,455.75</td>
<td>$178,307.00</td>
<td>$301,777.00</td>
<td>$521,251.00</td>
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</tr>
<tr>
<td>10. Crisis Services (5 percent set-aside)(^f)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$301,985.00</td>
<td>$521,251.00</td>
</tr>
<tr>
<td>11. Total</td>
<td></td>
<td></td>
<td>$520,492.58</td>
<td>$119,379,508.87</td>
<td>$1,996,050.13</td>
<td>$57,945,287.23</td>
<td>$4,828,434.00</td>
<td>$8,303,425.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2022 – June 30, 2023, for most states.

\(^b\) The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 - September 30, 2025, which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2022 – June 30, 2023, for most states.

\(^c\) While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

\(^d\) Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

\(^e\) Per statute, Administrative expenditures cannot exceed 5 percent of the fiscal year award

\(^f\) Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

**Footnotes:**

Table 2 for the projected SFY 2023 expenses has actuals based off of SFY 2021 due to a need to gather Medicaid encounter data that we anticipate will not be compiled until after the submission due date.
## Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, or ARP funds expended for each activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 Block Grant</th>
<th>FFY 2022 COVID Funds</th>
<th>FFY 2022 ARP Funds</th>
<th>FFY 2023 Block Grant</th>
<th>FFY 2023 COVID Funds</th>
<th>FFY 2023 ARP Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td>$767,744.00</td>
<td>$0.00</td>
<td>$258,640.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td>$21,907.00</td>
<td>$576,627.00</td>
<td>$17,525.00</td>
<td>$691,952.00</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
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<tr>
<td>7. Training and Education</td>
<td></td>
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<tr>
<td><strong>8. Total</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$789,651.00</strong></td>
<td><strong>$576,627.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$276,165.00</strong></td>
<td><strong>$691,952.00</strong></td>
</tr>
</tbody>
</table>

1 The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the “standard” SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

2 The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the “standard” MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

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Printed: 8/22/2022 3:11 PM - Kansas - OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025
Environmental Factors and Plan

15. Crisis Services - Required MHBG, Requested SABG

SAMHSA is directed by Congress through the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260], to set aside 5 percent of the MHBG allocation for each state to support evidence-based crisis systems. The appropriation bill includes the following budget language that outlines the new 5 percent set-aside:

Furthermore, the Committee directs a new five percent set-aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.

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-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources.

SAMHSA recently developed Crisis Services: Meeting Needs, Saving Lives, which includes National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit as well as other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with SMI or children with SED. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.


1. Briefly narrate your state’s crisis system. Include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

   Kansas has hired a Director of Crisis Services to support development of crisis care services. Within this department, a 988 Coordinator and Mobile Crisis Response Coordinator have also been hired to support these efforts.

   The FCC designated 988 as the dialing code for a national suicide prevention and mental health crisis hotline. 988 went live in Kansas on July 16, 2022. To respond to 988 calls, Kansas has 3 NSPL Certified Call Centers (one more to be certified by September). These call centers are averaging approximately 79% in-state answer rates. With the addition of the 4th call center, Kansas hopes to achieve a

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

   a) The Exploration stage: is the stage when states identify their communities’s needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

   b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

   c) Initial Implementation stage: occurs when the state has the three-core crisis services in place and agencies begin to put into practice the SAMHSA guidelines.

   d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.

   e) Program Sustainability stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

   1. Someone to talk to: Crisis Call Capacity

      a. Number of locally based crisis call Centers in state

         i. In the Suicide lifeline network

         ii. Not in the suicide lifeline network

      b. Number of Crisis Call Centers with follow up protocols in place

      c. Percent of 911 calls that are coded as MH related
2. **Someone to respond:** Number of communities that have mobile behavior health crisis capacity
   a. Independent of first responder structures (police, paramedic, fire)
   b. Integrated with first responder structures (police, paramedic, fire)
   c. Number that employ peers

3. **Place to go**
   a. Number of Emergency Departments
   b. Number of Emergency Departments that operate a specialized behavior health component
   c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hour units that can diagnose and stabilize individuals in crisis)

   a. Check one box for each row indicating state’s stage of implementation

<table>
<thead>
<tr>
<th>Exploration</th>
<th>Planning</th>
<th>Installation</th>
<th>Early Implementation Available to less than 25% of people in state</th>
<th>Middle Implementation Available to about 50% of people in state</th>
<th>Majority Implementation Available to at least 75% of people in state</th>
<th>Program Sustainment</th>
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<tbody>
<tr>
<td>Someone to talk to</td>
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<td>Someone to respond</td>
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</tbody>
</table>

b. Briefly explain your stages of implementation selections here.

   **Someone to talk to:** We have 3 National Suicide Prevention Lifeline (NSPL) Certified call centers and 1 that should be certified by September.

   **Someone to respond:** We have 9 Certified Community Behavioral Health Clinics (CCBHCs) who are provisionally certified and will be able to provide 24/7 mobile crisis response. We have 16 mobile crisis teams across the state in various Community Mental Health Center (CMHC) catchment areas. We are working with our CMHCs to expand their teams and hoping to receive the SAMHSA grant to

3. **Based on SAMHSA’s National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.**

   Kansas is following SAMHSA’s National Guidelines for Behavioral Health Crisis Care closely in the development of our system. Kansas is working toward a no-wrong-door integrated system of care to include all the core elements. Kansas continues to support the efforts of the existing 3 988 call centers and is open to expansion of these centers to ensure access to care for all Kansans. Expansion of CCBHCs is an essential element for ensuring Kansans have someone who is able to respond to them in their time of crisis, in person and in a timely manner. The continued development of CSUs and CICs will allow for a safe place for Kansans to go when they find themselves in need of these services. Kansas is committed to ensuring the inclusion and promotion of peer support throughout the

4. **Briefly describe the proposed/planned activities utilizing the 5 percent set aside.**

   Kansas has hired a Director of Crisis Services to support development of crisis care services. Within this department, a 988 Coordinator and Mobile Crisis Response Coordinator have also been hired to support these efforts. These coordinator positions work to expand and enhance crisis services across the state to develop a robust crisis continuum of care.

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**Footnotes:**

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025
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, 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, 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.

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.


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?

   Governor’s Behavioral Health Service Planning Council (GBHSPC) Prevention Subcommittee
   The Prevention Subcommittee serves as a broad voice for behavioral health to provide feedback and guidance related to KDADS BHS prevention initiatives. The group developed and is currently updating the Kansas Behavioral Health Prevention Plan a statewide plan to address behavioral health prevention. Several workgroups exist within the Subcommittee. In 2019, Kansas created the Evidence-Based Strategies Workgroup (EBSW) whose purpose is to support Kansans through promoting the use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services. Following the Center for Substance Abuse Prevention’s (CSAP’s)/Substance Abuse Mental Health Services Administration’s (SAMHSA’s) criteria of evidence-based, the workgroup developed an EBS Matrix of effective and comprehensive prevention strategies as a resource to prevention stakeholders. This matrix offers a blend of environmental strategies and curricula-based prevention education programs that allow coalitions to 1) Distinguishing proven programs from those without evaluated effectiveness, 2) Comparing program costs and benefits to calculate return on investment, 3) Prioritize funds, 3) Help implement and expand proven approaches, 4) Sustain support for evidence-based policymaking.

   Kansas Citizen’s Committee on Alcohol and Other Drug Abuse (KCC)
   The Kansas Citizen’s Committee on Alcohol and Other Drug Abuse is another 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 Behavioral 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.

   The Kansas Citizen’s Committee also functions 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.
   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.

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 behavioral health consumers, family members of behavioral health consumers, behavioral 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’ behavioral 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 are 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 8) Service Members Veterans and Families 9) Evidence-Based Practices 10) Aging and 11) Problem Gambling.

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 2022-2023 Block Grant Application and provided written feedback to the State.

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 also functions 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.

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 2020-2021 goals for work they considered many possible topics and areas of inquiry and research including workforce concerns, impact of COVID, gaps in services, data needs and gaps, child and caregiver engagement, and coordination of our work with other subcommittees and groups. Ultimately, three topics were selected for goal focus: Behavioral Health Telehealth, Behavioral Health Impact and Learning from COVID, and Racial Disparities in Behavioral Health. They have also committed to continuing the role as the advisory group for the KS Kids Map project. Using these topics as a guide, they developed the following goals for work during the 2020-2021 (state fiscal) year:
- 1) BEHAVIORAL HEALTH TELEHEALTH: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.
- 2) BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID: The impact of COVID has affected children and families differently. A closer look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.
- 3) RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas. a. Request and review state data to determine if there are racial disparities in access to care. Based on findings,
there could be recommendations around outreach, stigma reduction efforts, etc.
b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.
4) KSKidsMAP Project: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

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.

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.

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.

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.

Kansas consists of 105 counties with population density classifications in Kansas, by County, for 2019 as illustrated in the map from the Kansas University Institute for Policy & Social Research: (http://www.ipsr.ku.edu/ksdata/ksah/population/popden2.pdf).

Service Members Veterans and Families (SMVF) Subcommittee
The SMVF 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.

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 was established, the goal was to expand this prevention/education effort to other cities in the state.

Prevention Subcommittee
The Prevention Subcommittee 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 across the lifespan. The Prevention Subcommittee will serve as the Advisory Council for Kansas Behavioral Health Prevention Initiatives and will provide feedback and guidance to the Governor’s Behavioral Health Services Planning Council. In FY2021, the Subcommittee has focused on increasing Youth Voice in its monthly meetings and has invited content specialists to increase Subcommittee awareness and education on Zero Suicide, SBIRT, and a health promotion campaign for men.

The Subcommittee is currently making updates to the Kansas Behavioral Health Prevention Plan. The Subcommittee uses the Strategic Prevention Framework (SFP) to guide the data-driven selection of behavioral health priorities for the State using the comprehensive Kansas Behavioral Health Profile.
A workgroup of the Prevention Subcommittee recently completed updates to the Kansas Suicide Prevention Plan (2021-2025). The Evidence-Based Strategies Workgroup has also developed a EBS Matrix of strategies to assist stakeholder in selecting appropriate prevention strategies.

FY2022 recommendations are to:
1) improve shared access to data resources among state agencies and planning council subcommittees,
2) provide better coordination of efforts and care transitions of behavioral health services, and
3) allocate resources to prioritized areas of need including:
   a) additional prevention strategy implementation.
   b) continue funding for the implementation of 988.
   c) hiring a centralized epidemiologist to compile behavioral health needs assessment data gathered by all State Departments.

New GBHSPC Subcommittees
The GBHSPC approved forming three new subcommittees for Aging, Evidence-Based Practices and Problem Gambling:

Aging subcommittee
This subcommittee was identified and met for the very first time about a week prior to COVID-19 announcements. The participants looked at prior recommendations from the previous committee and determined most are still relevant. The main themes that were discussed at this meeting were about the following:
• The concern with the growth of the aging population in the next 15-20 years and the impact that will have on needs, services
• Rate of substance abuse is relatively high among this population
• May be difficult to place those in NFMH's and jails and particularly those with medical issues
• Rate of suicide is relatively high for this population
• Lack of workforce specialized in working with this population
• Mobility and accessibility to care issues
• Direct correlation between substance abuse, mental health and problem gambling

At this time, the committee has not met since this initial meeting. The final report for the Aging Committee in 2013 made the following statement: The Aging Subcommittee is comprised of a diverse membership throughout the state. Each member is invested in improving mental health services to older adults in the state of Kansas. The subcommittee was started in 2004 when a small group of providers and consumers recognized that older adults with mental health issues were being underserved. Consequences observed were high rates of suicide among older men, premature nursing facility admissions, and higher utilization of medical services. The aging subcommittee was formed to represent older adults on these issues and communicate recommendations to the Governor. The aging subcommittee has representation from consumers, mental health providers, Kansas Department of Aging and Disability Services, aging providers, legislative advocates, faith-based organizations, and educational institutions.

Evidence-Based Practices subcommittee
The Evidence Based Practices (EBP) Subcommittee goal is to provide a framework
• for learning from other Council Subcommittee representatives, state stakeholders, providers, consumers, and family members for which EBPs or other measurement-based modes of care are creating positive outcomes for consumers
• for sustainable technical assistance to providers so they can deliver the best practices (evidence-based practices with fidelity) chosen by the consumer
• for providers to become efficient and effective in person-centered, value-based care provision
• for providers in measuring the value of care provision from the standpoint of structure, process, and impact of care provision
• Managed Care Organizations (MCO) support of training and fidelity review for their provider network as required by their contracts

The framework for the best practices (evidence-based practice training and fidelity) plan will align with SAMHSA’s 2019-2023 Strategic Plan and Federal Block Cooperative agreements across various programs and projects such as the Department of Corrections, Systems of Care, Supportive Employment, Substance Use Disorder, Opioid Response and other funding initiatives. EBP Subcommittee membership will also include Council Subcommittee representatives (Kansas Citizen’s Committee, Children’s, Housing and Homelessness, Justice Involved Youth and Adult, Kansas Citizen’s Committee on Alcohol and Other Drug Use, Prevention, Rural and Frontier, Suicide Prevention, Service Members Veterans and Families, Vocational, Aging and Problem Gambling), and State agencies (Kansas Department of Aging and Disability Services, Kansas Department of Health and Environment, Kansas Housing Resources Corporation).

Problem Gambling
This committee is in the process of being formed and a draft charter is being developed.

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

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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.

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Footnotes:
GOVERNOR’S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL

CHILDREN’S SUBCOMMITTEE

PRESENTED TO

Wes Cole, Chair
Governor’s Behavioral Health Services Planning Council

Laura Howard, Secretary
Kansas Department for Aging and Disability Services
& Kansas Department for Children and Families

Laura Kelly, Governor
State of Kansas

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INTRODUCTION

There is an endless list of possible areas of inquiry and research as we consider the behavioral health of children and their families from a holistic continuum of care perspective, which includes primary prevention efforts through targeted interventions for those with identified concerns. As the subcommittee worked to finish last year’s work, report, and set goals, we were in the middle of the COVID pandemic and adjusting how we as individuals lived, continued our professional work, and completed the work of this subcommittee. We considered many possible topics and areas of inquiry and research including workforce concerns, impact of COVID, gaps in services, data needs and gaps, child and caregiver engagement, and coordination of our work with other subcommittees and groups.

Ultimately, we selected three topics: BEHAVIORAL HEALTH TELEHEALTH, BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID, and RACIAL DISPARITIES IN BEHAVIORAL HEALTH. We also committed to continuing our role as the advisory group for the KS Kids Map project. Using those topics as our guide we developed the following goals for our work during the 2020-2021 (state fiscal) year:

1) BEHAVIORAL HEALTH TELEHEALTH: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.

2) BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID: The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.

3) RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.
   a. Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.
   b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.

4) KSKidsMAP Project: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

This subcommittee often discusses the difficulty in having meaningful child and caregiver engagement on and with this subcommittee. We often feel disconnected from those we are ultimately making recommendations to benefit. The quote below, although it has a focus on adults and youth, is a great summary of the sentiment of our subcommittee.
“A great way to understand how to support people in the present is to invest in {asking and listening to} what people say works for them. The consumer/peer support movement has long known these issues.

Mental health resources are too complicated and often defeating, whether you are first reaching for help or have been in the system for decades. This is if there are even resources at all.

Treatment and system goals are not always aligned with the things that actually matter to people. Measures narrowly focused on diagnosis and symptom reduction can often miss what is most important to people.

We expect people to build their lives around mental health resources, as opposed to building mental health resources around people’s lives. People should have access to resources as part of their daily lives and barriers to people’s participation, whether at work or school, should be removed.

If we want to improve mental health, we need to listen to the people who most understand the system and can identify the gaps because it is their needs that are not being met.”

- Kelly Davis
  Associate Vice President of Peer and Youth Advocacy at Mental Health America

The quote above certainly highlights and encourages us to acknowledge the weakness of this subcommittee in inviting and supporting meaningful engagement with children, youth, and families. Stating this in this report will hopefully drive a focus next year and beyond to improve meaningful engagement of children and caregivers so that “our” work truly becomes the work of not just professionals doing what we think and believe is best but is driven by children, youth, and families. We invite you to connect with us and provide your feedback and voice to this effort.

Thank you for taking time to review the report and consider our recommendations. If you have questions, please contact subcommittee members or the Governor’s Behavioral Health Services Planning Council.
**SUMMARY OF RECOMMENDATIONS**

The children’s subcommittee chose three topics to focus on this year and continues to serve as the advisory group for the KSKidsMAP Project. Below are the goals we set for this year and the summary of recommendations for each of those goals.

1) **BEHAVIORAL HEALTH TELEHEALTH**: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.

**Recommendations:**
- Support investments in digital infrastructure to increase access to Telehealth.
- Support providers in the provision of Telehealth with specific populations, situations, and appropriate use within the continuum of care, including to youth in crisis or awaiting placement.
- Ensure inclusive and equitable access to telehealth services, irrespective of provider codes, site, or diagnosis.

2) **BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID**: The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.

**Recommendations:**
- Public education campaign about the effects of isolation and loneliness including the brain science behind it.
- Equip educators, school districts, and early childhood professionals to participate in preventative, family supportive strategies to intervene in child maltreatment and not just reporters of child maltreatment. The state should support and fund efforts to equip teachers with the knowledge, tools, and resources they need.
- Support and expand peer groups and the connection they provide in mitigating the effects of isolation. We hear several examples of how peer groups were effective in combatting isolation during the pandemic.
- Promote and invest in peer support and/or other locally driven communities and support groups where people take care of each other.
- Consolidate COVID response and resource information in a central location where people can easily find it.
- Medicaid Expansion would address many of the safety net issues.
• Support and/or fund specialized training for clinicians in dealing with depression and anxiety
• Support and/or fund ways for providers to meaningfully engage with parents
• Support and/or fund expanded treatment for very young children.

Several recommendations from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature align with or support our recommendation (see Resources & Links section at the end of this report), specifically:
• Community Engagement Recommendation 3.1 Crisis Intervention Centers. Utilize state funds to support the expansion of crisis centers around the state.
• Community Engagement Recommendation 3.4 Community-Based Liaison. Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and cooccurring conditions.
• Prevention and Education Recommendation 4.2 Early Intervention. Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment, and treatment.
• Prevention and Education Recommendation 4.4 Behavioral Health Prevention. Increase state funds for behavioral health prevention efforts (e.g., SUD prevention, suicide prevention).

3) RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.
   a. Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.
   b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.

Recommendations:
• All state agencies should prioritize improved data systems to collect and report on service data reported with racial disparities and equity in mind.
  o Support providers in providing data into those new data systems
  o Engage stakeholders, especially trusted local community leaders, providers and families, in building data systems.
• Hire a dedicated position to coordinate and provide accountability.
• One recommendation from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature aligns with or supports our recommendations specifically: Data Systems Recommendation 7.5 Cross-Agency Data (SI): 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.

4) **KSKidsMAP Project**: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

• Make pediatric primary care workforce development opportunities (i.e., training, technical assistance) widely available. These efforts will ensure gap-filling treatment services in mental health shortage areas are high-quality services that follow mental health best practices.

• Fully fund a statewide child psychiatry access program (e.g., KSKidsMAP) to lead these activities. Funding the KSKidsMAP Expert Team would allow the psychiatry access program services to continue beyond the lifespan of the federal grant award (June 2023). Options to explore should include:
  o Use of Medicaid Administrative match allowed for provider training activities
  o Managed Care Organization and/or commercial insurance
  o State general funds line item
  o Blended/braided funding across state agencies (e.g., KDADS, KDHE)

• Revise payment policies within managed care to ensure appropriate payments are available. Policies should apply to both direct mental health services in primary care and for physician-to-physician consultations.

• Fund initiatives that enhance the number of highly trained professionals, including child and adolescent psychiatrists and child psychologists. KSKidsMAP, and similar programs, require teams with the highest levels of training and expertise – board certified child and adolescent psychiatrists and psychologists. KU’s Department of Psychiatry and Behavioral Sciences trains general psychiatrists and child psychologists in accredited community-based programs. Community partnerships have been established that could support a two-year focused child and adolescent psychiatry fellowship training program, given appropriate financial resources.

• One recommendation from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature aligns with or support our recommendations specifically: Treatment and Recovery Recommendation 5.3 Frontline Capacity. Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.
HIGHLIGHTS OF PROGRESS

Our role is to make recommendations regarding improvements to behavioral health services for Kansas children and their families. Our work often focuses on “what’s wrong” or “not working right.” We realize that we need to model as a subcommittee the strengths-based approach we hope the state supports and Kansas providers use when working with children and their families. With that goal in mind, we are highlighting some of the positive work we know happened and is happening in Kansas this past year.

• The Kansas Legislature, through the Special Committee on Kansas Mental Health Modernization and Reform, has worked to understand and make recommendations regarding the Mental Health system in Kansas. We are hopeful about increased focus on improvements in mental health for Kansans.

• KDADS has worked for several years, including this year, to improve the wait time and waiting list for PRTF beds. This has included working with providers to increase the number of available beds and new specialty beds. We also appreciate KDADS promise of continued work on this.

• Members of the subcommittee have personally seen the impact that state-level multidisciplinary team meetings have had in difficult cases. Specifically, we wish to thank Gary Henault and Joe Winslow and their dedication to participating in MDT meetings for difficult cases that are referred to them. We would encourage others to do the same, and perhaps encourage the state to put more resources (dedicated staff time) into these types of activities.

• We are seeing evidence of a positive culture shift within and between state agencies: state personnel are approachable, staff are listening to providers, and as a result we see better partnerships and collaboration. This has resulted in system improvements to minimize silos and fragmentation. For example, DCF has invested in the creation of and hiring of a Director of Medicaid and Children’s Mental Health, state agencies are sharing updates and data that they have available.

• KDADS is leading progress on review of direct provider training and manuals.

• The state was commitment and dedicated work on the Federal mandate.

• We continue to be amazed by the learning and the progress that has been made with the HRSA funded KSKidsMAP project. Specifically, we have seen great success in improving skills and abilities of pediatricians and other primary care clinicians in meeting behavioral health needs of children and families, and we look forward to seeing continued growth and sustained support of this project.

• The Psychotropic medication workgroup has made progress in a short period of time.
• KDADS’s swift response to new disaster relief grant funding provided free training to parents and professionals.
• We are also encouraged by the work to initiate mobile crisis response.
• The work of the School Mental Health Initiative continued this year, increasing partnerships. Availability and accessibility of services has increased through these collaborative efforts and has helped leverage knowledge capacity of professionals.
• Community Mental Health Centers are working with the state on innovative and new ways to meet the needs of children and families.
• The state has supported continued access to telehealth, with reasonable recommendations in place.
2020-2021 GOALS & ACCOMPLISHMENTS

Goal #1 - BEHAVIORAL HEALTH TELEHEALTH: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.

We used information from professionals and the agencies those professionals represent on this subcommittee to inform the following summary of information related to this goal.

Benefits of Telehealth:
- More frequent meetings
- Better attendance at scheduled meetings
- Improved access for clients and providers
- Safer environment, without exposure to COVID and other illness
- Potential reduction in stigma

Limitations/Barriers of Telehealth:
- Many providers went to 100% Telehealth, losing in-person human interaction.
- Participants cannot see the non-verbal communication (i.e., wringing hands, balled up fists)
- Provider is not able to use other senses to assess client (i.e., client smelling like alcohol or other substances).
- Tough to keep attention of young children, can only use talk therapy and not play therapy.
- Confidentiality of sessions is difficult to ensure people are in the car or in public places like stores, or if they are in a private location there may be other people in the room.
- Privacy may not be easy to ensure, in certain home situations
- Tough or maybe impossible to thoroughly assess to make some diagnoses via Telehealth (e.g., autism)
- Access to technology due to cost or lack of availability in some areas does not make Telehealth an option for some providers and families.
- Some families are uncomfortable with or fearful of technology

Systemic Issues:
- Reimbursement rate to the clinician was less for Telehealth prior to the COVID pandemic
- Limitation in origination sites prior to the COVID pandemic
- Could not access across state boundaries prior to the pandemic
- Professionals from other states providing care to clients in our state and hospital settings during the COVID pandemic, but without awareness of local resources or the ability to liaise with local professionals
- Telehealth should be a tool to use, but not the only tool
- Technical problems resulting in missed sessions or leaving a session
- Cyber security concerns
- Increases in fraud cases
In summary, Telehealth is an appropriate and effective treatment option for some populations and situations, however it is not a replacement for person-to-person contact. Telehealth makes observation of non-verbal cues at the best challenging, if not impossible. Telehealth is a great resource for reaching rural and frontier areas where transportation barriers and access to providers may be a challenge. It is also a good resource for clients who may miss appointments or otherwise have a history of failing to attend appointments. It must be noted, that although Telehealth has resulted in fewer missed appointments for many, the appointment duration is often shorter, resulting in the need for more frequent appointments and adjusting the work to more frequent and shorter appointments. Adults and young adults have a higher success rate with compliance; however, adolescents and small children are extremely difficult to keep engaged and working.

Even with the best of technology, there can still be digital connectivity issues, and there is always the option available to clients to turn off their camera or leave sessions when the conversation becomes difficult.

There is also a concern and need to monitor the use of Telehealth as there is a push for nationwide Telehealth and an increase in practitioners providing care from outside of the state. Although this may be a temporary solution to the lack of providers and increase access initially, it does not solve workforce or other access/barriers to in-person behavioral health treatment and services for our state.

Recommendations:
- Support investments in digital infrastructure to increase access to Telehealth.
- Support providers in the provision of Telehealth with specific populations, situations, and appropriate use within the continuum of care, including to youth in crisis or awaiting placement.
- Ensure inclusive and equitable access to telehealth services, irrespective of provider codes, site, or diagnosis.
Goal #2: BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID: The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.

Safety Net – One of the issues that became very apparent during the pandemic was the need for a secure and adequate safety net in our communities. Due to the pandemic, many people became dependent on their community’s safety net for survival. This includes things like:

- Food
- Housing/safety
- Access to health care
- Human connection
- Financial assistance/employment

Providers and subcommittee members have reported several instances of children literally disappearing from everyone’s radar. Isolation is a strong predictor of child maltreatment and the impact of loneliness on people’s well-being has worsened during the pandemic. Schools that serve as the safety net for many children were unavailable. When thinking about the basic needs and higher-level brain functions, like learning, making sure people’s basic needs are taken care of must come before other needs can be addressed. These overlapping situations increase our concerns for the behavioral health of Kansans, especially children and their families.

Clinical Resources – In retrospect, we now know what behavioral health issues would become prominent for children and caregivers during the pandemic. We should bolster the system by addressing issues such as specialized training for clinicians in dealing with depression and anxiety, ways to meaningfully engage with parents and continuing to expand ways to treat very young children.

Recommendations:
- Public education campaign about the effects of isolation and loneliness including the brain science behind it.
- Equip educators, school districts, and early childhood professionals to participate in preventative, family supportive strategies to intervene in child maltreatment and not just reporters of child maltreatment. The state should support and fund efforts to equip teachers with the knowledge, tools, and resources they need.
- Support and expand peer groups and the connection they provide in mitigating the effects of isolation. We heard several examples of how peer groups were effective in combatting isolation during the pandemic.
- Promote and invest in peer support and/or other locally driven communities and support groups where people take care of each other.
• Consolidating COVID response and resource information in a central location where people can easily find it.
• Medicaid Expansion would address many of the safety net issues.
• Support and/or fund specialized training for clinicians in dealing with depression and anxiety
• Support and/or fund ways for providers to meaningfully engage with parents
• Support and/or fund expanded treat very young children.

Several recommendations from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature align with or support our recommendation (see Resources & Links section at the end of this report), specifically:
• Community Engagement Recommendation 3.1 Crisis Intervention Centers. Utilize state funds to support the expansion of crisis centers around the state.
• Community Engagement Recommendation 3.4 Community-Based Liaison. Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and cooccurring conditions.
• Prevention and Education Recommendation 4.2 Early Intervention. Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment, and treatment.
• Prevention and Education Recommendation 4.4 Behavioral Health Prevention. Increase state funds for behavioral health prevention efforts (e.g., SUD prevention, suicide prevention).
Goal #3 - RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.

a) Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.

b) Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.

Staff from KDHE presented data available in Kansas regarding racial disparities and equity. Data sources included:

1. National Violent Death Report System (NVDRS): State-based surveillance system that gathers comprehensive information to fully characterize incidents
2. Kansas Hospital Association (KHA) discharge databases: includes data on emergency department visits (EDV) and hospitalizations
3. Kansas Communities That Care (KCTC) Student Survey: 6th, 8th, 10th, 12th grades
   - [http://kctcdata.org/](http://kctcdata.org/)
4. Kansas Youth Risk Behavior Survey (YRBS): 9th, 10th, 11th, 12th grades
   - [https://yrbs-explorer.services.cdc.gov/#/](https://yrbs-explorer.services.cdc.gov/#/)

Although there is data available it often has challenges or limitations due to not being collected at all or small sample sizes limiting the ability to draw conclusions or generalize. We are left with many questions and possible next steps.

- Identify and share statewide (and other) reports on mental health service utilization
  - KDADS and MCOs for Medicaid population
  - Association of CMHC
  - BSRB for percentage of providers by race
- Identify trends or gaps with services and provider availability based on data gathered
- Identify what is the Culturally and Linguistically Appropriate Services (CLAS) Program data points and identify if there is any participation in CLAS by any Kansas state agency.
- Then ask for current measures monitored and if any reports exist to review population served/ included.

Recommendation:

- All state agencies should prioritize improved data systems to collect and report on service data reported with racial disparities and equity in mind.
  - Support providers in providing data into those new data systems
  - Engage stakeholders, especially trusted local community leaders, providers and families, in building data systems.
- Hire a dedicated position to coordinate and provide accountability.
• One recommendation from *The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature* align with or support our recommendations specifically: Data Systems Recommendation 7.5 Cross-Agency Data (SI): 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.
**Workgroup #4 - KSKidsMAP Project:** Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

Throughout the year meetings were used to provide us updates on the project and KDHE staff used meeting time via breakout sessions to review data and collect feedback on the data, planned activities, and next steps.

**KSKidsMAP Summary:**
In an effort to address the Mental Health Professional Shortage Areas, specifically child and adolescent psychiatrists and psychologists, and the under-identification of children and adolescents with behavioral disorders, HRSA administers cooperative agreements for *Pediatric Mental Health Care Access Programs*. The Kansas program, KSKidsMAP, is a partnership between KDHE’s Bureau of Family Health and KUSM-Wichita Departments of Pediatrics and Psychiatry and Behavioral Sciences. HRSA funding ($445,000 annually) and 20% ($89,000) non-federal match will support KSKidsMAP from July 2019 through June 2023.

The shortage in mental health professionals, and other factors, including accessibility and lack of stigma, means many families seek treatment in the primary care setting. KSKidsMAP partners with pediatric primary care physicians and clinicians (PCPs) to expand their scope of practice to integrate mental health care. To achieve this, KSKidsMAP established a pediatric mental health team that includes two board-certified child and adolescent psychiatrists, a board-certified child and adolescent psychologist, a board-certified pediatrician, and a licensed social worker/care coordinator. The team offers support via toll-free consultation line, an ongoing TeleECHO Clinic, and PCP wellness activities.

From July 1, 2019 to March 31, 2021, KSKidsMAP has accomplished the following:
- Enrollment of 105 PCPs who serve patients in 59/105 (56%) Kansas counties
- Received 193 calls or emails to the consultation line encompassing 248 inquiries
  - PCPs can contact the consultation line for more than one reason at a time
  - Case consultations are the most requested KSKidsMAP service (28.6%) followed by requests for practitioner toolkits (21.4%)
  - Of the enrolled PCPs, 66.7% have utilized the consultation line
- Trained 73 PCPs through the KSKidsMAP TeleECHO Clinic

**Children's Subcommittee as KSKidsMAP Advisory Council:**
Most meetings focused on strategies for sustainability beyond the lifespan of the grant (June 2023). KSKidsMAP is currently working on an infographic and an impact paper to highlight the importance of the project. The Children’s Subcommittee will assist by providing feedback and sharing ideas for important information to include (e.g., system cost savings). Once finalized, both resources could be used when initiating sustainability discussions with key stakeholders.

The Children’s Subcommittee has identified the following sustainability ideas: use of Medicaid admin funds to support training/workforce development, MCOs, commercial insurance, SGF
line item, and blended/braided funding from state agencies (e.g., KDHE, KDADS). There was also a Frontline Provider recommendation included in the Mental Health Modernization and Reform Committee’s Report furthering supporting the need to sustain the program.

Recommendations:
The following recommendations are proposed to promote policy, programs, and systems which support access to psychiatric care for Kansas youth:

- Make pediatric primary care workforce development opportunities (i.e., training, technical assistance) widely available. These efforts will ensure gap-filling treatment services in mental health shortage areas are high-quality services that follow mental health best practices.
  - Fully fund a statewide child psychiatry access program (e.g., KSKidsMAP) to lead these activities. Funding the KSKidsMAP Expert Team would allow the psychiatry access program services to continue beyond the lifespan of the federal grant award (June 2023). Options to explore should include:
    - Use of Medicaid Administrative match allowed for provider training activities
    - Managed Care Organization and/or commercial insurance
    - State general funds line item
    - Blended/braided funding across state agencies (e.g., KDADS, KDHE)

- Revise payment policies within managed care to ensure appropriate payments are available. Policies should apply to both direct mental health services in primary care and for physician-to-physician consultations.
  - Fund initiatives that enhance the number of highly trained professionals, including child and adolescent psychiatrists and child psychologists. KSKidsMAP, and similar programs, require teams with the highest levels of training and expertise – board certified child and adolescent psychiatrists and psychologists. KU’s Department of Psychiatry and Behavioral Sciences trains general psychiatrists and child psychologists in accredited community-based programs. Community partnerships have been established that could support a two-year focused child and adolescent psychiatry fellowship training program, given appropriate financial resources.

One recommendation from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature align with or support our recommendations specifically: Treatment and Recovery Recommendation 5.3 Frontline Capacity. Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.
Other Recommendations
Throughout the year we received updates and had many discussions which resulted sometimes in follow-up and/or sharing of information. As a result, we identified other recommendations that do not fall within our identified goals for the year. These recommendations are summarized here.

- Continued focus on improvements to parent engagement (information, resources, training, supports, services, etc.) throughout the continuum of care. Information provided to parents should be accessible, clear, timely, and accurate. A greater focus on parent engagement and information about resources is vital to prevention, early intervention, and successful service provision.
- State agencies should continue collaborating to identifying gaps in the continuum of care. Some possible areas of focus include:
  - consider looking into the lack of resources and services for youth who experience sexual reactive disorders.
  - continue to work on PRTF waiting lists
  - consider looking at children who need more than a PRTF but are not eligible for long term care
  - consider the IDD population, especially those with dual diagnosis mental health and IDD.
  - Consider the need for more foster homes, especially specialized or therapeutic foster homes
- We recommend fully funding the IDD Waiver.
- Allow an exception for children who are at risk and may not have health equity due to telehealth and issues due to COVID treatment limitations for children. Or at least have a conversation about why or why not to have exceptions for meeting CAFAS requirements due to extenuating circumstances.
- ACEs screenings should not be used unless it is to inform services and treatment and in coordination with a resiliency and/or strengths-based perspective.
- The state should add partial hospitalization and intensive outpatient services to the state plan – and look at lessons learned from the PRTF Demonstration project as they do so.
- Support for recommendations from the Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature:
  - Treatment and Recovery Recommendation 5.1 Psychiatric Residential Treatment Facilities. Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools.
  - Community Engagement Recommendation 3.3: Foster Homes: The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth.
- Workforce Recommendation 1.4: Workforce Investment Plan: The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include:
  - Develop a career ladder for clinicians, such as through the development of an associate’s-level practitioner role and
  - Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency.

- System Transformation Recommendation 9.5 Family Psychotherapy. Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility.
2021 - 2022 Goals

Goal 1: Children with Dual Diagnoses

Explore* and identify the need and gaps in services for Dually Diagnosed children (IDD/MH; ASD/BH) including workforce issues such as lack of training and availability of providers, funding, system involvement and limits.

*Clarification of the role of CMHCs, CDDOs, consider recommendations from the Special Committee on Mental Health Modernization and Reform.

Goal 2: KSKidsMAP

- Continue to serve as the advisory group for the KSKidsMAP Project
- Make progress on the recommendation to sustain the project by continuing to research and identifying opportunities or actions for the committee or others to take to sustain the project.

Goal 3: Continuum of Care & Parent and Community Engagement

Explore how Community Mental Health Centers, Federally Qualified Health Centers, Psychiatric Residential Treatment Facilities, Qualified Residential Treatment Program are engaging the community to educate and collaborate with primary care providers, caregivers and parents, schools, and other agencies.

Note about this goal: we are concerned about making recommendation regarding prevention to raise the awareness and information available to parents before behavioral health needs are present to increase early access to services and supports. We are also interested in what gets and keeps parents engaged in treatment and care of their child.
RESOURCES & LINKS


• “Education and Mental Health During COVID-19,” Infographic from the National Federation of Families, https://files.constantcontact.com/fa3e9a0a001/fc8696d3-443a-41f8-b8c9-0bf682a9ac59.pdf (Last accessed July 7, 2021)

# Appendix: Children’s Subcommittee Charter

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<td><strong>Subcommittee Name:</strong></td>
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<td><strong>Vision:</strong></td>
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| |  ▪ *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.

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March 13, 2017

Page 1
- **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.\(^{iv}\)

### Intensive supports/intervention:
for children and their families who are in crisis or at risk

“Individual”

### Targeted & Preventative supports/intervention:
for community, providers, staff, children and their families, etc.
with identified needs, risks, etc.

“Targeted Individuals & groups”

### Preventative & Universal Supports/Intervention:
for everyone (state, community, agency, school, etc.)

“Statewide-Communitywide-Agencywide-School Wide”
GBHSPC Children's Subcommittee Charter

**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

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### GBHSPC Approval

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**Charter Effective Date:** 05/08/2017

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2. [https://gucchditcenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf](https://gucchditcenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf)
### APPENDIX: CHILDREN’S SUBCOMMITTEE MEMBERS

- **Erick Vaughn**  
  *Chair*, LMSW, Executive Director, Douglas County CASA
- **Rachel Brown**  
  *Chair-Elect*, MBBS, KU Dept of Psychiatry and Behavioral Sciences, Professor and Chair, Residency Program Director
- **Nancy Crago**  
  *Past-Chair*, LSCSW, Director of Psychosocial Rehabilitation, Family Service and Guidance Center
- **Laura Hattrup**  
  *Secretary*, LSCSW, State Trainer, Kansas Technical Assistance System Network
- **Amanda Aquila-Gonzalez**  
  Kansas Department for Health & Environment, KSKidsMAP
- **Annemarie Arensberg**  
  CEO at Lake Mary Center
- **Anthony Bryan**  
  Director of Risk Management and Corporate Compliance at Family Service and Guidance Center
- **Ashley Grill**  
  *GBHSPC Liaison*
- **Brenda Grove**  
  *Parent Representative*, GBHSPC
- **Brian Dempsey**  
  Attorney at Kansas Department of Education
- **Charlene Jostes**  
  Parent & Affiliate Development Specialist at NAMI Kansas
- **Charlie Bartlett**  
  *KDADS Liaison*
- **Chelle Kemper**  
  Special Education Director
- **Debra Garcia**  
  *KDADS Liaison*, Kansas Department for Aging and Disabilities Services, Children’s Community & Inpatient Program Manager
- **Gary Henault**  
  *KDADS Liaison*, Kansas Department for Aging and Disabilities Services, Director of Youth Services
- **Gianna Gariglietti**  
  President at Lakemary
- **Jeff Butrick**  
  Service Manager at Kansas Department of Corrections-Juvenile Services
- **Kellie Hans-Reid**  
  Foster Care Coordinator, Aetna Better Health of Kansas
- **Kelsee Torrez**  
  Maternal & Child Health Behavioral Health Consultant, KDHE
- **Kevin Kufeldt**  
  LCPC, Program Manager, ACT Residential Treatment, Johnson County Mental Health
- **Laura Nichols**  
  Assistant Principal at Topeka West High School
- **Melinda Kline**  
  Prevention and Protection Services Deputy Director, DCF
- **Natalie Sollo**  
  Director of Ambulatory Division, KUMC Pediatrics
- **Pamela Cornwell**  
  Saint Francis Community Services
- **Rick Gaskill**  
  Executive Director, Sumner Mental Health Center
- **Sandra Berg**  
  Executive Director, UnitedHealth Group
- **Sherri Luthe**  
  *Parent Representative*, Recovery and Resiliency Manager at OptumHealth Division of United Health Care
ACKNOWLEDGEMENTS
This report was prepared by KSKidsMAP staff: Amanda Aguila Gonzalez, MPH; Rachel Brown, MBBS; Kari Harris, MD; Nicole Klaus, PhD; Polly Freeman, LBSW MSW; Cari Schmidt, PhD; Ashley Hervey, Med; and Kelsee Torrez, MPA with contributions from the Kansas Governor’s Behavioral Health Services Planning Council’s Children’s Subcommittee.

STATEMENT OF NEED
Mental disorders among children and adolescents age 0 to 21 years (hence, youth) are on the rise across the country. In Kansas, one in five youth meet criteria for a diagnosis, and more than 35,000 are severely impaired as a result. The COVID-19 pandemic has impacted youth who are at risk due to developmental age, educational status, economic underprivilege or pre-existing mental disorders.

Many youth identified as at risk or diagnosed with a mental disorder as defined by Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5), receive no treatment. Those who receive treatment often experience long waits to access care. Waiting lists to see a mental health professional can be three months to a year. Just over 10% of U.S youth receive any treatment from a mental health professional, far fewer than the number living with a mental disorder.

Youth who do not receive effective treatment for their mental disorders are significantly disadvantaged compared to their healthy peers. Mental disorders interfere with the ability to participate in age appropriate academic and social activities. Youth with mental disorders have lower grades and are less likely to graduate high school or to be college or work ready. Without effective management and follow up of their disorders, prognosis in adult life is worse. Delayed diagnosis and inadequate treatment

4 Kaiser Family Foundation (KFF). (2018). Percent of Children (ages 3-17) Who Receive Any Treatment or Counseling from a Mental Health Professional. Retrieved from https://www.kff.org/other/state-indicator/child-access-to-mental-health-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22location%22,%22sort%22:%22asc%22%7D.  
lead to increased disability and poorer functioning in adulthood with higher likelihood of un/under employment, incarceration, and higher health care costs for both mental and physical health.\textsuperscript{11} The life expectancy of adults with mental disorders, including anxiety and depression, is significantly shortened.\textsuperscript{12}

The financial costs of untreated mental disorders are also significant. In 2009, the National Research Council and the Institute of Medicine estimated the total cost of mental, emotional, and behavioral services to be close to $250 billion a year, including lost productivity, criminal behavior, and cost of health services.\textsuperscript{13} This is likely an underestimate as the Kaiser Family Foundation has reported a 3% increase in the cost per case to treat mental disorders between 2000 and 2012.\textsuperscript{14}

Along with rising mental and behavioral health problems in youth, there is a national shortage of mental health professionals, especially those with the greatest expertise, child and adolescent psychiatrists and psychologists.\textsuperscript{15} Kansas needs more than 400 child and adolescent psychiatrists to support the population but currently has approximately 60, the majority of whom work in the northeast region of the state.\textsuperscript{16}

There is a chasm between the number of youths needing treatment and the availability of child and adolescent psychiatrists and psychologists and other professionals with expertise in evidence-based treatment for mental disorders. This shortage means many families seek treatment in the primary care setting. Primary care physicians and clinicians (PCPs), especially pediatricians, family physicians, physician assistants and nurse practitioners, are being called on to manage the mental disorders of youth.

PCPs play an important role in the overall health and wellbeing of youth. PCPs see patients from birth through adolescence and into adult life. Because of their role in a child’s life, PCPs are uniquely positioned to implement psychosocial screenings, provide assessments, diagnose, and treat less complicated mental disorders themselves. Professional organizations, such as the American Academy of Pediatrics (AAP), are recommending psychosocial screening and assessment for mental disorders be integrated into the pediatric workflow,\textsuperscript{17} and a number of other policy and position papers support these initiatives.\textsuperscript{18} In addition, recommendation 5.3 of the Special Committee on Mental Health Modernization and Reform report to the 2021 Kansas Legislature specifically addresses the need to

\begin{thebibliography}{99}
\end{thebibliography}
increase the capacity of frontline health care providers to offer services to those with behavioral health needs.¹⁹

Unfortunately, most PCPs have little training in pediatric psychiatric care. While screening is recommended universally and easily implemented in primary care, thorough assessment, diagnosis, and treatment of mental disorders in youth are an entirely different matter. The training of pediatricians and family physicians includes little education in how to evaluate youth presenting with emotional and behavioral problems that may be the symptoms of mental disorders. The training of nurse practitioners and physician assistants is even more limited. As such, many children presenting in primary care go undiagnosed, untreated and without services and accommodations that would benefit them.

In response to the combination of increased need and specialty shortage, a number of states have developed models of care to provide ongoing education and support for PCPs as they expand their ability to take care of youth with mental disorders. These models include Pediatric Mental Healthcare Access (PMHCA) programs also referred to as Child Psychiatry Access Programs; Kansas’ KSKidsMAP is an example. The program’s impact and growth since 2019 have been significant; by empowering PCPs to provide pediatric psychiatric care in their own clinics, access for youth to this limited resource is improved. The program will be described in detail below.

CURRENT EFFORTS

Integrated Care Models

The shortage in pediatric mental and behavioral health experts is not exclusive to Kansas. Many clinics have used practice models that integrate primary and mental health care to improve patient outcomes and satisfaction at a lower cost by addressing common behavioral health problems (e.g., depression, anxiety, attention deficit hyperactivity disorder). PMHCA programs support integrated care practice models by offering training and consultations to PCPs. Programs like KSKidsMAP work to improve the expertise of PCPs in assessing, diagnosing, treating, and referring youth with mental disorders. By empowering PCPs to provide mental health care in their own clinics, access to care for youth is improved. PMHCAs programs increase PCPs’ ability to provide mental health care as part of overall comprehensive health care to their patients and are valued by PCPs as an extension of primary care.²⁰

KSKidsMAP Program

KSKidsMAP is a partnership between the Kansas Department of Health and Environment (KDHE) and the University of Kansas School of Medicine-Wichita, Departments of Pediatrics and Psychiatry and Behavioral Sciences. Established in 2019, KSKidsMAP partners with PCPs to expand their scope of practice to integrate mental health care. The program relies on the availability of highly trained mental health professionals and a pediatric primary care liaison to provide advice on screening, accurate diagnostic and assessment tools and practices, and evidence-based treatments and resources.

The professionals who make up the KSKidsMAP Pediatric Mental Health Team (PMHT) include:

- Two board-certified child and adolescent psychiatrists
- Board-certified child and adolescent psychologist

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- Board-certified pediatrician with experience in adolescent medicine and mental health
- Licensed Social Worker Care Coordinator

KSKidsMAP works directly with the PCP, providing tailored resources to ensure confidence in delivering evidence-based mental health care to youth in their practice. KSKidsMAP has multiple program components led by their team, including an ongoing TeleECHO Clinic, a Consultation Line, and wellness resources (Figure 1), to support the PCP who is managing youth with mental disorders.

Figure 1. Expert Support for the Primary Care Clinician Working in Pediatric Mental Health

KSKidsMAP offers multidisciplinary expertise through the KSKidsMAP Consultation Line and KSKidsMAP TeleECHO Clinic. These two components of KSKidsMAP allow PCPs to have an ongoing telementoring relationship with experts as they manage patients. In addition, the TeleECHO Clinic provides ongoing learning through a community of PCPs who can share expertise with and learn from each other. This concept is fundamental to the program because it allows the entire KSKidsMAP network to learn from a single case, thereby moving knowledge (not patients), and disseminating best practices throughout the community. As PCPs participate in KSKidsMAP, their skills and confidence expand, and they are able to manage patients more effectively in their practices with similar conditions.

KSKidsMAP Physicians and Clinicians
Since inception (December 2019 - April 2021), a total of 115 PCPs have enrolled in KSKidsMAP (Table 1). Participating PCPs indicated serving patients in 60 (57%) of 105 Kansas counties (Figure 2).
Table 1. KSKidsMAP Network

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<tr>
<th>Physician/clinician Type</th>
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<tr>
<td>Physician</td>
<td>70</td>
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<td>Nurse Practitioner</td>
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<tr>
<td>Registered Nurse</td>
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<td>(2.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>(2.6%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>115</td>
<td>(100.0%)</td>
</tr>
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</table>

Of the PCPs enrolled, 66.7% (n=70) have utilized the Consultation Line and 69.5% (n=73) have been trained through the KSKidsMAP TeleECHO Clinic.

Figure 2. Counties served by KSKidsMAP physicians and clinicians’ (Heat Map)

*Note: Circles with red and yellow marks denote high numbers in the given area

KSKidsMAP Consultation Line
An enrolled PCP may contact the KSKidsMAP Consultation Line by phone or email to connect with the Social Work Care Coordinator. Inquiries by the PCP can be patient-related or personal-wellness centered. The Care Coordinator gathers information regarding the PCP’s specific need and responds to requests for patient- and wellness-focused resources and referrals. She consults with the wider Pediatric Mental Health Team for specific patient related questions. Case consultations are offered within 72 hours of the first inquiry. After a videoconference, the PCP receives a summary of the case with written recommendations and a tailored list of resources.

Between December 2019 and April 2021, KSKidsMAP supported care for pediatric patients across Kansas with a total of 222 contacts regarding 292 specific inquiries. Case consultation (29.1%, n=85) is the most requested KSKidsMAP support service, followed by mental health toolkits/website resources (22.9%, n=67). Other inquiries include requests for mental health resources for referral (18.5%, n=54),
community resources (10.3%, n=30), telehealth resources (0.3%, n=1), and physician wellness resources (18.8%, n=55).

Of the total consultation inquiries (N=292), 61.6% (n=180) requested assistance addressing specific mental disorders. Of these, 27.2% (n=49) indicated a focus on attention deficit hyperactivity disorder, followed by anxiety (23.3%, n=42), depression (13.9%, n=25), and autism spectrum disorder (13.9%, n=25).

**TeleECHO Clinic**

Launched in April 2020, the KSKidsMAP TeleECHO Clinic is an ongoing virtual clinic that meets twice a month for case consultation and didactic learning on youth mental health needs in primary care settings. The TeleECHO Clinic offers a platform for PCPs to share de-identified cases and receive input and support from other PCPs and the KSKidsMAP Team. Case-related feedback from the TeleECHO Clinic is summarized and packaged with additional recommendations from the Team, toolkits, and local resources. These case recommendations are made available to all TeleECHO Clinic participants. Approximately 10-15 PCPs attend each session.

Brief didactics are also included in the TeleECHO Clinics. Thus far, PCPs have received education on screening, diagnosis, and treatment for depression, anxiety, and attention deficit hyperactivity disorder. PCPs have also received education on pharmacologic and non-pharmacologic interventions for sleep, monitoring, follow up, and when to refer for additional mental health services. Lastly, physician wellness, and COVID-19 implications for mental health and returning to school have also been explored through TeleECHO Clinic education.

**Physician and Clinician Wellness**

Integrating mental health care and providing support for youth with mental disorders can increase the stress PCPs experience. In addition to integrating wellness concepts and resources in the KSKidsMAP TeleECHO didactics and Consultation Line supports, the KSKidsMAP program has partnered with programs to offer wellness sessions for enrolled PCPs and to support development of a wellness culture within their clinics.

**Other KSKidsMAP activities**

During the first 22-months of the program, the KSKidsMAP team has conducted a multisite quality improvement project to increase adolescent depression screening during well visits, developed policies and procedures for clinical recommendations, created a statewide database for mental health resources and toolkits, and developed and broadly distributed a quarterly newsletter. In addition, participating PCPs have received continuing medical education credits and maintenance of certification credits required for licensure and board certification.

**KSKidsMAP Participant Highlights**

PCPs who utilized the Consultation Line and/or participated in the TeleECHO Clinic provided positive feedback regarding the benefit of resources and discussion in increasing their ability to treat youth within their own practices. During the TeleECHO Clinic discussion one physician from a rural practice shared,

"KSKidsMAP provides the extension of care of a pediatric medical home with the psychiatric expertise to provide the best mental health care to children under one roof."

KSKidsMAP Impact Paper, July 2021
Another physician said,

"KSKidsMAP fills a long-standing void in pediatric care as the prevalence of mental health is increasing with the changing social structure dynamics of modern times. The program helps to manage complicated [psychiatric illnesses and other mental and behavioral health problems] in children, since most pediatricians do not have the support of a mental health team in their realm of pediatric practice. During all these years in practice, we could not get the help which is currently being provided by the team in KSKidsMAP."

SUSTAINABILITY
KSKidsMAP is one of many programs across the nation working to increase access to pediatric mental health care by building capacity in primary care. These programs have shown success on the large scale but all face challenges with sustained funding. Kansas is no different. KSKidsMAP is in year two of a 4-year HRSA grant that expires in June 2023. Beyond 2023, the future of KSKidsMAP, and access to care for youth currently benefiting from the program, is uncertain. Pediatric mental health care takes time and effort beyond typical pediatric health care; KSKidsMAP needs financial support for infrastructure and for the dedicated time of the expert Pediatric Mental Health Team. Without funding, the program will not survive beyond the grant period, and the opportunity to educate and support PCPs in providing quality care to youth suffering from mental disorders will be lost.

Other PMHCA programs across the country have been partially successful in addressing the financial sustainability barrier. The most successful initiatives rely on the engagement of legislators and on partnerships with state health departments and Medicaid leadership. Examples include implementing billing codes for physician-to-physician consultation reimbursement (North Carolina Psychiatry Access Line) or obtaining state budget allocation for program funding (Missouri Child Psychiatry Access Project). Maryland Behavioral Health Integration in Pediatric Primary Care is funded through both state line items and federal funding. Specifically, Maryland’s Department of Health Behavioral Administration funds the consultation line, training, social work co-location, and resource and referral networks, while HRSA funds care coordination, ECHO clinics, telepsychiatry and tele-counseling services. Other options for sustainability include private sector support, community foundation support, and improved reimbursement for interprofessional collaboration around specific patient needs.

RECOMMENDATIONS
The following recommendations are proposed to promote policy, programs, and systems which support access to psychiatric care for Kansas youth:

1. Make pediatric primary care workforce development opportunities (i.e., training, technical assistance) widely available. These efforts will ensure gap-filling treatment services in mental health shortage areas are high-quality services that follow mental health best practices.
   a. Fully fund a statewide child psychiatry access program (e.g., KSKidsMAP) to lead these activities. Funding the KSKidsMAP Expert Team would allow the psychiatry access program services to continue beyond the lifespan of the federal grant award (June 2023). Options to explore should include:
      - Use of Medicaid Administrative match allowed for provider training activities
      - Managed Care Organization and/or commercial insurance
      - State general funds line item
- Blended/braided funding across state agencies (e.g., KDADS, KDHE)
  
b. Revise payment policies within managed care to ensure appropriate payments are available. Policies should apply to both direct mental health services in primary care and for physician-to-physician consultations.

2. **Fund initiatives that enhance the number of highly trained professionals, including child and adolescent psychiatrists and child psychologists.** KSKidsMAP, and similar programs, require teams with the highest levels of training and expertise – board certified child and adolescent psychiatrists and psychologists. KU’s Department of Psychiatry and Behavioral Sciences trains general psychiatrists and child psychologists in accredited community-based programs. Community partnerships have been established that could support a two-year focused child and adolescent psychiatry fellowship training program, given appropriate financial resources.

**CONCLUSION**

More than 20% of Kansas youth experience mental disorders and there is a grave shortage of specialists to care for them. KSKidsMAP is one effective solution. The program decreases barriers to mental health care access in Kansas because it builds capacity in primary care, allowing more youth to receive quality mental health care closer to home and by the PCP with whom they already have a trusting relationship. Youth and families are spared long wait times to see mental health experts and long drives to access this specialty care. In addition, by decreasing long-distance appointments, youth are able to remain in school and parents at work, thus benefiting the economy. By supporting PCPs to manage less complex mental disorders in primary care, this model also allows experts in child and adolescent psychiatry and psychology to see youth with more complex mental disorders. With more than 100 enrolled PCPs from over half of Kansas counties, KSKidsMAP has indirectly reached 3,400 children, adolescents, and their families in Kansas over the first 22 months of the program. The KSKidsMAP network continues to grow as does the comfort, knowledge, and skills of the PCPs who participate in the program.
Governor’s Behavioral Health Services Planning Council  
Evidence Based Practices Subcommittee Behavioral Health  
September 2021 Annual Report

**Background:** The Evidence Based Practice (EBP) subcommittee restarted in April of 2021 after the anticipated passage of the Senate Substitute for House Bill 2208 which establishes a new model for providing behavioral health services – the Certified Community Behavioral Health Clinic (CCBHC). The Substance Abuse and Mental Health Services Administration (SAMHSA) sets the guidelines for CCBHCs and requires the use of Evidence Based Practices (EBP) in CCBHCs. As stated in SAMHSA’s Strategic Plan for FY 2019-2023, SAMHSA is committed to advancing the use of science – in the form of data; research and evaluation; and evidence-based policies, programs, and practices – to improve the lives of Americans living with substance use disorders and mental illness, as well as their families.

The EBP Subcommittee was established to enable agency collaboration and education of evidence-based practices. Using previous EBP experience and work to inform current practice and through collaboration among multiple partners, the Subcommittee will develop a sustainable framework to strengthen and expand access for all Kansans. The EBP Subcommittee will serve as a broad, representative voice as it relates to practices for a broad range of behavioral health issues.

**Membership:** Composition of the Subcommittee must represent diversity within the State. The Subcommittee will make it a priority to elevate voices of the historically marginalized populations, paying attention to both organizational representation and diversity of experience. Members of the workgroup must have a stake in behavioral health.

**Philosophical approach /lens:** The EBP Subcommittee created a space where consumer experience and voice are elevated and prioritized at all levels of implementation in an ongoing process. The perspective is intentionally shifted to privilege the experience of the individuals we serve.

The EBP Subcommittee will approach the framework in a way that builds equity and partnership with all communities and populations implementing EBP’s.

The EBP Subcommittee will utilize Implementation Science (defined in the excerpt below) as the framework for providing the resources, tools, training etc. to be available for all Behavioral Health Agencies (to include CMHC and SUD providers) to effectively implement evidence-based practices. The framework will include consideration of barriers to success and modifications to successful rural and frontier sites and sustainable evaluation processes.

“Implementation science is defined as the study of factors that influence the full and effective use of innovations in practice the goal of implementation science is not to answer factual questions about what is, but to determine what is required (mission driven)”  
(Fixsen & Van Dyke, 2019)

Innovative research and evidence-based practices are typically lost if not methodically installed using implementation science processes and tools (Fixsen et al., 2005). Implementation science maximizes the effectiveness of innovations with collaborative implementer partnerships and contextual fidelity measures, achieving authentic sustainable socially significant outcomes. State, regional, and organization Implementation Teams, trained on use of implementation science processes and tools, could then carefully identify, and navigate factors which facilitate or impede the effective use and sustainability of innovations (Fixsen & Van Dyke, 2019).
Goal: Provide a framework
- For learning from other Council Subcommittee representatives, state stakeholders, providers, consumers, and family members for which EBPs or other measurement-based modes of care are creating positive outcomes for consumers.
- For sustainable technical assistance to providers so they can deliver the best practices (evidence-based practices with fidelity) chosen by the consumer in collaboration with the provider.
- To equip providers to deliver efficient, effective, person-centered, value-based care.
- For providers in measuring the value of care provision from the standpoint of structure, process, cost-effectiveness, and impact of care provision; and Managed Care Organizations (MCO) support of training and quality review that leads to fidelity for their provider network as required by their contracts.

Accomplishments:
- Created the EBP Charter;
- Established a full inclusive membership, leadership team, and membership expectations;
- Held bi-monthly full subcommittee meetings;
- Held bi-monthly leadership subcommittee meetings;
- Partnered with Mid-America Mental Health Technology Transfer Center (MHTTC) -
  - Utilized MHTTC to explore best practices used in other states in order to be most efficient in developing the framework.
- Leveraged previous subcommittee resources that have been provided to illustrate how past work helped us move forward to truly provide the structural support for the current vision;
  - Prevention matrix
  - Vocational subcommittee
  - Housing homeless
  - KCCC (Kansas Citizens Committee on alcohol and drugs)
  - Rural and Frontier
- Partnered with Matt Enyart from The Kansas Institute for Positive, Healthy and Inclusive Communities to explore Implementation Science and how that supports our framework.

Plans: EBP Subcommittee plans to
- Utilize information from the 2021 EBP survey for CMHC and for SUD Providers completed;
- Utilize the Individualized Placement and Support survey to inform decision making around readiness for statewide implementation of the Evidence Based Practice of Supported Employment implementation and sustainability including modifications for rural and frontier CMHCs;
- Partner with KDADS to utilize ongoing Technical Assistance (TA) around common practices or themes that flow throughout all the EBPs as provided by the MHTTC with consideration of access to EBP’s for a broad population;
- Develop the approach to Evidence Based Practice and Practice Based Evidence that utilizes the framework features and phases of implementation science;
- Create a toolbox that can be used for all providers;
- Define fidelity with quality as the indicator with specific consideration to modifications as appropriate for agency environment/circumstances (e.g., Rural and Frontier, workforce capacity);
- Utilize HRSA data and other reports available on workforce capacity in developing recommendations and acquiring TA; and
• Partner with KDADS to sustainability plans of EBP’s.

Additional resources

The Charter for the EBP Subcommittee can be accessed by double clicking on the icon above.

The full EBP Subcommittee Membership can be accessed by double clicking on the icon of the PDF.
Governor’s Behavioral Health Services Planning Council
Subcommittee on Housing and Homelessness
2021 Annual Report
September 2021

Presented to:
Wes Cole, Chairperson, Governor’s Behavioral Health Services Planning Council
Secretary Laura Howard, Kansas Department for Aging and Disability Services
Laura Kelly, 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

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<th>MEMBER</th>
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<th>POPULATION DENSITY*</th>
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<td>Aetna Better Heath of Kansas</td>
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<td>Melissa Bogart-Starkey, Erin Olson and Sarah Hussain</td>
<td>Kansas Department for Aging &amp; Disability Services, Behavioral Health Services Subcommittee Staff Support</td>
<td></td>
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List of Outstanding Accomplishments/Milestones Achieved During FY 2020

1. Funding shared with communities through the Continuum of Care (CoC) HUD NOFA funding competition or the state of Kansas supported communities through the following funding allocations:
   - KS-502 – Wichita/Sedgwick County CoC - $2,849,774
   - KS-503 – Topeka/Shawnee County CoC - $1,775,569
   - KS-505 - Overland Park, Shawnee/Johnson County CoC $768,911
   - KS-507- Kansas Balance of State CoC - $2,695,262

   **Kansas total CoC HUD allocated funding: $8,089,516**

   The four active Kansas CoC’s addressing homelessness (excluding Wyandotte that is encompassed within the Kansas City, Missouri CoC) actively coordinate care, extend community support and share barriers and challenges through bi-monthly peer to peer CoC coordination calls. These calls highlight specific community challenges such as:
   - COVID response
   - Availability of affordable housing and rent burden for tenants
   - Shelter funding allocation, planning and coordination of efforts
   - CoC to CoC transfer plans and coordination of services
   - The four CoC’s coordinated and worked directly with Kansas Department for Aging and Disability Services to ensure that each local community health departments had the resources, personnel, volunteers, and other necessary supports to oversee COVID testing, vaccinations and other programming and needs to respond to the COVID pandemic.

   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. The Subcommittee’s statewide representatives are also involved in either a supporting and/or funding role.

   In addition to funding for households who are homeless, many CMHC/communities are actively involved in the response to COVID 19 and are now providing homeless prevention services for households affected by COVID 19. Homeless prevention funds are being distributed by local and state governments along with private foundations. Kansas Statewide Homeless Coalition, for the Kansas Balance of State, applied for and was awarded over $2,000,000 to provide COVID shelter programming for those who were homeless and needed shelter, those who became homeless because of the financial impact of COVID and those who needed shelter for recovery from COVID.

   United Community Services coordinated with Johnson County, Kansas municipalities to provide a hotel shelter which secured 145 bed nights and assisted with distribution of CARES Act funding through the United Way of Greater Kansas City. Safe Parking Spaces were also set aside in collaboration with the City of Shawnee and the Johnson County Sheriff’s Office. This provided 10 parking spots for the homeless population living in their vehicles. This also allowed those sheltering in their vehicles access to restroom facilities, hygiene items and overall safety.
Through partnership with the Johnson County Housing Authority, Johnson County Mental Health Center was given 10 homeless “set aside” vouchers. Had 90% occupancy, getting ready to be 100%.

2. Kansas Department of Aging and Disability Services and Kansas Housing Resources Corporation partnered to distribute $500,000 in Emergency Solutions Grant CARES dollars to Community Mental Health Centers around the state of Kansas. This allowed CMHC’s to apply for funds for Rapid Re-housing, Homeless Prevention, Street Outreach and Shelter. These dollars are targeted to the homeless population in Kansas.

3. Community responses to the COVID-19 pandemic:
   In 2020 and 2021 our communities were faced with unprecedented needs. People experiencing homelessness found it more difficult to get into homeless shelters or to access resources. During this time, unique partnerships were formed to meet the needs of the people experiencing homelessness. During the subcommittee meetings, we highlighted these partnerships to educate committee members of the resources. Below are four examples of the resources created during this pandemic.

   • The Human Services Department within Johnson County Government used CARES Act dollars to provide a safe place for people to stay who were homeless and not able to get into the Project 10/20 cold weather shelter. They served approximately 145 individuals including many children during the Pandemic.
   • The Woody Park city sanctioned camp program in Douglas County was operated from November 2020 until March 2021. To provide this service, funding was used to install utility services on a designated property, purchase tents and camping supplies, and purchase latrine, laundry, and shower trailers for use at the site.
   • The City of Wichita partnered with Humankind Ministries to purchase the 316 Hotel with $4.2M in CDBG-CARES and ESG-CARES funds. In January 2021, the property was opened as an expanded emergency shelter for women. The property is being completely rehabilitated, converting the hotel rooms into studio apartments adding, kitchenettes and updated fixtures. In September 2021 the property, renamed The Studios at Humankind, will open as permanent supportive housing for persons coming from homelessness.
   • Valeo Behavioral Health Care, Topeka Rescue Mission, Shawnee County Health Department, Stormont Vail Health and the Topeka Police Department has formed the Mobile Access Partnership. MAP is a unique partnership that creates a mobile continuum of social, health and behavioral health services to the unsheltered homeless and those living in poverty. MAP inspires hope by providing a comprehensive response that focuses on the social determinants of health and their impact on overall health and well-being.

4. SSI/SSDI Outreach, Access, and Recovery (SOAR) is a SAMHSA endorsed approach for helping states increase access and re-connection to mainstream benefits for people who are experiencing homelessness or at risk of homelessness through strategic planning, training, and technical assistance. Nationally, SOAR has developed into a best practice for assisting eligible individuals with accessing Social Security disability programs. SOAR-trained caseworkers assist eligible individuals with submitting successful SSI/SSDI applications that are approved quickly and without going through a lengthy appeals process. In 2009, the Kansas Department of Social and Rehabilitation Services (KDADS) led an effort to expand SOAR across Kansas.
Through these efforts, the Kansas SOAR program has expanded to all CMHC’s, a variety of other community agencies, state mental health hospitals, the Department of Children and Family Services, and the Kansas Department of Corrections. With the implementation of SOAR in Kansas, a collaboration has developed between KDADS, KDHE, SOAR trained caseworkers, the Social Security Administration, Kansas Disability Determination Services, and the SOAR TA Center. Through this collaboration, the SOAR program in Kansas has become an effective model for helping eligible individuals access and re-connect to the Social Security Administration, and Title 19 Medicaid disability benefits.

**2021 SOAR outcomes report for Kansas:**

- 118 SOAR applications were submitted
- 91 received favorable determinations
- The approval rate for the state of KS increased 7% from the previous year to 77%
- Although the nation’s numbers have suffered due to the pandemic, Kansas has adapted to the challenges and risen to be a top 10 state.

*final report not yet released at the time this report was finished.*

One positive change is the expectation that SOAR-trained caseworkers also assist individuals with applying for Medicaid in conjunction with the SSI/SSDI application. This will help vulnerable adults across Kansas have access to mainstream benefits necessary to help them in their path towards recovery. The subcommittee applauds KDADS’ continued efforts to improve the SOAR program. Another positive change is adding language in the CMHC contracts that require all CMHCs to have a certified SOAR trained case worker.

**This Year’s Achievements:**

- Commissioner Brown found a way to allow additional use of Basecamp with the purpose of connecting all SOAR caseworkers and supervisors to a centralized training forum.
- Local leads have begun hosting quarterly statewide meetings with the purpose of providing teachings covering all aspects of the SOAR process, Q&A sessions, and bringing in guest speakers from agencies like SSA and DDS as well as teams from KDHE PMDT.
- SOAR-specific Medicaid process changes have drastically reduced the time it takes to get critical medical coverage for those who are being served by SOAR caseworkers.
- Agency-to-agency training has been carried out by Four County Mental Health Center and Crosswinds Counseling and Wellness to assist agencies around the state with (re)establishing SOAR programs.
- Kansas received recognition from the SAMHSA SOAR TA Center for becoming one of the top ten states in the nation and one of the few to improve during the pandemic. Kansas SOAR TA Liaison writes “I think the work you all are doing to hold regular meetings and provide more support to caseworkers, along with strong communication in Basecamp has been a huge contributing factor to the increased approval rate.”
5. On July 1, 2019, the State of Kansas opened four per diem codes to “enhance community supportive services” for high-risk behavioral health consumers experiencing homelessness. The per diem codes reimburse providers for the provision of intensive support services needed to improve independent living skills. Due to the slow adoption of the OCI codes, KDADS solicited feedback from various stakeholders, including the three KanCare Managed Care Organizations and the Subcommittee on Housing and Homelessness on potential barriers for implementing the codes. In response to the request from KDADS, the Subcommittee on Housing and Homelessness developed a goal in 2020 to explore the barriers for the OCI codes and to look at opportunities to expand the utilization of the codes.

The workgroup developed four objectives to accomplish its goal:
   1. Research/recommend a Housing First fidelity scale
   2. Advertise successes to CMHCS /SUD providers to help expand the use of the codes
   3. Identify and gather information from last needs assessment
   4. Change language in the OCI policy to eliminate/reduce misinterpretations.

In order to alleviate misinterpretation of the OCI policy, the Subcommittee on Housing and Homelessness and the Managed Care Organizations have provided feedback to KDADS on the OCI policy. These changes have been sent to the Commissioner for further follow up with KDHE.
Recommendaçons for KDADS
for FY 2022

1. Affordable Housing allocations and oversight

Kansas communities have not been immune to the housing crisis that has spread through the nation. It is imperative that affordable and low-income housing is identified, secured, and made available to individuals and families in crisis. The current availability of rental units is limited, and especially for those who are in households identified as extremely low income (ELI), those whose incomes are at or below the poverty guideline or 30% of their area median income. To achieve this, it is essential that:

- Oversight and limits be placed on development and use of housing and rental units that have been historically used for low-income households.
- Affordable housing protections must be put in place to reduce developers buying low-cost, affordable properties, doing high-end renovations, and increasing rents by over 400%, displacing low-income residents and reducing the availability in these communities of low-income housing.

Effects of the rent moratorium

Although the intent of the rent moratorium was to address and overcome financial hardships for renters directly related to COVID caused financial strains, the opposite long-term affect is becoming apparent. Though the moratorium has successfully stayed or delayed many evictions, it ultimately has caused a distrust between landlords and municipalities and landlords and renters to create even more stringent rental guidelines and requirements.

To address this immediately and to reduce the continued damage with landlords it is necessary to:

- Create direct marketing and incentives for landlords are needed along with intentional aggressive campaigns to repair these relationships and create a network of landlords willing to work with low-income residents.
- Provide oversight and limits through affordability measures to address the amount of rental-cost burden that is permitted on a statewide level. HUD defines rental cost-burden as those “who pay more than 30% of their income for housing” and may “have difficulty affording necessities such as food, clothing transportation, and medical care.”
- Ensure that day, night and long-term shelters are available to communities. Currently most communities are required to share one shelter across a 100 mile or greater radius. Without emergency or day shelters, there is limited access to engage those who are homeless or who have recently become homeless. Day shelters must be equipped to assist with basic needs, food, medicine and medical care and access to assistance.

Rationale:

Safe, affordable housing leads to improved mental and physical health, reduced health care costs and an improved quality of life. Cost burdened households and/or people experiencing homelessness often have higher health care costs or increased contact with emergency services. They often must choose between paying their housing costs and paying for food or healthcare. It is imperative that affordable housing and low-income housing is identified and made available to individuals and families in crisis. Additionally, it is imperative steps are taken to mitigate the distrust between landlords and the tenants.
2. Evidence Based Practices and Fidelity Reviews:
   The Governor’s Behavioral Health Services Planning Council’s Subcommittee on Housing and Homelessness recommends the state of Kansas work to change its strategy for (a) engaging service providers to increase the use and implementation of Evidence Based Practices (EBP’s) and (b) administering the associated fidelity standards and review processes. Explicitly, the committee advises the state to develop and implement a strategy and administrative process of partnership, rather than one of oversight. From this new perspective, state officials and staff would seek to partner with providers to increase the use/implementation of Evidence Based Practices (EBP’s) and the quality of associated service provision across the state. This will explicitly require that state staff view and treat the associated fidelity models and scales as a tool for quality improvement, and the fidelity review as a quality improvement process, rather than a pass/fail regulatory assessment that triggers punitive measures. In this model, the fidelity review is administered as a partnership between state staff and service providers who work as a team to evaluate performance (based on fidelity standards), and work to develop and implement strategies to achieve the outcome of service quality improvement over time (measured by increased fidelity scores in subsequent assessments). This shift will help address a culture of discouragement and reluctance on behalf of service providers to adopt and implement (EBP’s) for fear of resulting punitive actions due to assessed low fidelity/performance. This will also require the state to develop explicit language, literature, and training for staff to develop the skills of partnering, as opposed to regulating, and explicitly communicate this shift in strategy with service providers. Fidelity review teams would also serve as a resource for service agencies to utilize and contact for assistance in improving service quality. Additionally, the state must work to make the requisite resources available for agencies operating and implementing EBP’s to successfully operate and provide a given EBP. For example, agencies who seek to implement the Pathways Housing First EBP and fidelity standards must have resources to provide expeditious housing access and provision, and to provide sufficient supportive services staffing to meet the level of need in the region. Additionally, the committee advises the state to partner with the university system to enhance and expedite the implementation of this strategy and approach and stand up the associated fidelity review and service quality improvement teams. And the committee advises the state to include the Pathways Housing First model as a priority EBP and fidelity and quality improvement team.

Rationale:
Evidence-based practices are models that have been studied and proven successful. Even though evidenced-based practices have demonstrated good outcomes, several providers have been reluctant to adopt them. One of the barriers is the State’s approach for oversight of the EBP implementation. Service providers may be discouraged or reluctant to adopt an EBP out of fear of punitive actions due to assessed low fidelity. In order to expand the use of EBPS, the State must change their strategy from oversight to partnership. The fidelity review team would serve as a resource to the provider for assistance in improving fidelity. Additionally, the state needs to work to make resources available for the successful implementation of the EBPS.

3. Develop Integrated Statewide Data Platform
As in 2020, the Subcommittee on Housing and Homelessness recommends departments of the state work together to create an Integrated Statewide Data Platform. The Subcommittee on Housing and Homelessness participated in conversations with representatives from other states in the region
and their KDADS equivalents. These conversations suggest that data platform improvement and integration is feasible. This would open funding streams for the state of Kansas, provide data quickly when applying for grants as a state and for individual sites, allow easy access to answer questions from the public and/or legislature, and support cross-system communication and efficiency. As we learned during COVID 19 with the unemployment system, the infrastructure of our state data platforms are outdated and unable to keep the pace of modern data needs.

The GBHSPC’s Subcommittee on Housing and Homelessness recommends:

- KDADS, in partnership with other state departments, hire a consultant to provide Kansas technical assistance on how to move forward with developing this integrated data platform.
- KDADS ensures standardization of data collection so information can be compared statewide.
- KDADS allocate dollars for technology improvements for the state agencies so that data can be collected and used in a meaningful way.

Rationale:
Developing an integrated statewide data platform could open additional funding opportunities for the state of Kansas and/or providers and could allow easy access to statewide data when responding to the public and/or legislature inquiries. The integrated statewide data platform would improve cross-system communication and efficiency.

4. Continue the Supported Housing Program
The GBHSPC Subcommittee on Housing and Homelessness recommends that KDADS continue to support the funding of Supported Housing Funds to assist those experiencing Severe and Persistent Mental Illness (SPMI), Serious Mental Illness (SMI) and/or Serious Mental Illness with co-occurring disorder, or youth who have a serious emotional disturbance (SED) aged 18-21, in obtaining or maintaining housing in the community as they are integral to the work being done by the housing specialists.

The total amount of Supported Housing Funds has been $535,000 for the past several fiscal years. This fund reimbursed this volume of requests per corresponding fiscal year:

- FY2018: 744
- FY2019: 907
- FY2020: 855

The Supported Housing Fund also contributed $9520.20 in FY2021 to the Topeka Housing First Project (Tent City Project) as this project was prolonged due to the COVID Pandemic.

The GBHSPC Subcommittee on Housing and Homelessness recommends that KDADS add an additional $50,000 to the Supported Housing Fund. The increase in funding would support a risk mitigation function which has been a growing problem/concern for CMHC Housing Specialists and community landlords. The additional funding would be used to reimburse landlords, up to $1000, for repairs due to damages caused by consumers.

Rationale:
The Supported Housing Fund (SHF) program provides affordable housing linked to services for low-income, homeless or potentially homeless people with Serious Mental Illness (SMI) and/or Serious
Mental Illness with co-occurring disorder, or youth who have a serious emotional disturbance (SED) aged 18-21. The goal is to provide persons with SMI the help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives. The Supported Housing program supports eligible individuals 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.

5. **Expand and Enhance SOAR Services**
   The GBHSPC’s Subcommittee on Housing and Homelessness applauds KDADS efforts to advance the provision of SOAR (SSI/SSDI Outreach, Access, and Recovery) Program services 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 persons eligible for Social Security disability benefits are receiving them, the GBHSPC’s Subcommittee on Housing and Homelessness recommends that:

   **New/Continued Goals:**
   - KDADS create and maintain a full-time position in KDADS dedicated to SOAR. This position would be the SOAR State Lead and would be responsible for coordinating SOAR activities and training across Kansas.
   - KDADS continues to explore resources to support the provision of SOAR in smaller communities, including resources to help fund SOAR activities. a. Goal partially met, continued efforts, still in process.
   - Funding be made available for the purpose of sending Kansas SOAR Local leads to YTI Online WIP-CTM training to become a Work Incentive Practitioner.
   - KDADS continue to fund Base Camp to support communication and training for all certified SOAR specialist in the state.

   **Rationale:**
   For people with behavioral health disorders, receiving SSI/SSDI and Title 19 Medicaid 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. A myth often believed is that those who are on disability can no longer work. With the goal of training SOAR Leads to also be Work Incentive Planners or Benefit Specialists, agencies can work to dispel this myth while assisting those who are disabled on their path to recovery by taking steps towards employment without losing the benefits that are difficult to obtain. As the Behavioral Health System in Kansas is moving toward the CCBHC program model, the need for Certified Benefit Specialists is increasing. The committee would like to ensure that all of our SOAR local leads are given the opportunity to advance their knowledge by attending the C-WICK training offered through Cornell University. The cost of this program would be $1,525.00 for each local lead—so the committee is asking that KDADS allocate $7,000.00 for this expense and begin working on integrating Benefits Specialist into the ACT and IPS supported employment teams within the State of Kansas.

6. **Comprehensive, State Wide, Housing and Homelessness Plan/Strategy**
   The Governor’s Behavioral Health Counsel Subcommittee on Housing and Homelessness recommends the State of Kansas engage in utilizing the recently completed KHRC housing market...
study to expeditiously develop a comprehensive, statewide homeless and housing strategic plan. This strategy should address immediate and short term, as well as long term needs. This strategy should seek to work with each region in the state (frontier, rural, urban, and mixed), to expeditiously develop/create a spectrum of quality, accessible, affordable housing stock to meet the various local needs for affordable housing. For example, a spectrum of housing options should include: robust, damage resistant, eviction proof permanent supportive housing for SPMI households who cannot maintain market based housing; master leasing programs to provide expedited access for households who have barriers to accessing market rate housing on their own; permanently dedicated income based housing for set, low income households, including more robust, accessible, and numerous rental subsidy programs; risk mitigation funding to incentivize landlords to rent with higher risk households; low income home ownership programs; low income rent to own options.

A comprehensive plan should also include strategies and priorities for addressing housing cost inflation in respect to slower increases in median income for the various state regions. It should also include strategies for homeless prevention and upstream interventions and acknowledge, as well as address the relationship between housing stability and socio-economic inequities and include strategies for overcoming these inequities.

Rationale:
Creating a comprehensive housing and homelessness plan will ensure individuals and families will have access to affordable housing that meets their unique needs. It is critical the State of Kansas develop a comprehensive plan to develop a spectrum of housing options. This plan should include strategies for homeless prevention and address socio-economic inequities.

7. Transitions from State Institutions to the Community
Consumers transitioning from state funded institutions (correctional facilities, state mental health hospitals, etc.) back to the community often face multiple barriers. The Subcommittee on Housing and Homelessness recommends KDADS work with the subcommittee to explore these barriers and solutions for resolving them.

Examples of barriers for people discharging from institutions:
- Individuals who have resided in institution for multiple months must reapply for their disability payments and Medicaid. The process of getting their payments and insurance reinstated could take several days up to several weeks. This can lead to individuals discharging from institutions without income and without insurance coverage. Not only does this impact their ability to secure safe and decent housing, it creates delays in receiving needed supportive services. This situation is exacerbated when the individuals have a criminal history. People with felonies are often excluded from low income housing projects.

- The Kansas Continua of Care communities receive funding from HUD to provide resources for people experiencing homelessness. People seeking assistance must go through the CoC’s coordinated entry system and be added to the By Name List. Applicants on the By Name list are prioritized according to the results of the coordinated entry assessment. Resources are distributed according to this list. In some communities, only people who are sleeping outdoors or in a homeless shelter are prioritized enough to receive help. This process can exclude consumers discharging from institutions since they may not be considered homeless or are considered a low priority on the By Name list.
• There has been a large amount of funding distributed across the state to help people who have been financially impacted by COVID including funds to help people with rent and utility assistance. The funding is targeted to individuals who have experienced a financial hardship due to COVID. Consumers discharging from institutions may not be eligible for the COVID relief funds as they are not able to demonstrate a financial hardship caused by COVID.

• Service providers across Kansas have experienced a staff shortage. The staff shortages can impact the consumer’s ability to access needed services in a timely manner. The staff shortages have also impacted supportive housing programs. Housing providers are not able to accept as many residents due to staff shortages. Transitional housing programs that offer short term housing coupled with supportive services also struggle with reimbursement rates for the services. The current rates often do not fully pay for the staffing levels needed in the housing program.

• Rural communities often lack transitional housing programs and other needed resources. The lack of resources and transitional housing programs in rural communities leads to people being discharged to these larger cities so that they can access resources.

Recommendations:
1. The Subcommittee on Housing and Homelessness applauds KDADS for the funding awarded to the Bridge pilot projects. The subcommittee recommends KDADS allocate a permanent funding stream for the original Bridge pilot projects as well as funding to develop new projects throughout Kansas.
2. The subcommittee requests support from KDADS to gather data on discharges from state funded institutions for the last five years. The subcommittee would like to analyze the discharge data to look for trends on discharges.
3. Kansas needs alternate funding streams for transitional housing programs and services. The subcommittee recommends KDADS explore additional funding streams to provide these needed resources.
4. Over the last several years there have been multiple task forces / committees that formed to examine the current infrastructure in Kansas and to make recommendations for improvement. Examples of these committees is the Adult Continuum of Care committee, NFMH workgroup and the Mental Health Task Force. The subcommittee requests KDADS publish a report summarizing the recommendations from these committees including progress made toward the recommendations.
5. The subcommittee requests KDADS examine current policy and procedures for reinstating disability payments and Medicaid coverage for people exiting state institutions to look for opportunities to reduce gaps in coverage.
6. The subcommittee plans to develop a training for community mental health centers and community housing providers on HUD terminology. This training will reduce misconceptions or misunderstanding of eligibility criteria for HUD funded programs.

Rationale:
It is important for individuals with behavioral health disorders who are transitioning from state institutions to community housing to have access to affordable housing coupled supportive services. Having no income or medical coverage creates a barrier for these individuals to access the supportive housing that is needed. Delays in funding and medical coverage are system level barriers that should be addressed by the State of Kansas. The federal housing and homelessness
resources have specific definitions and/or processes that can be a barrier for individuals transitioning out of the state institutions. Education and advocacy is needed to help open these resources for individuals transitioning out of state institutions.

8. Workforce Development, Academic Credentialing & Peer Expertise Utilization:
The Governor’s Behavioral Health Services Planning Council’s Subcommittee on Housing and Homelessness recommends leveraging collaborative partnerships with existing platforms, state colleges and universities to develop strategies that will enhance economic viability by expanding employment possibilities for people who have lived experience of homelessness and providing workforce training that will build capacity to overcome labor shortages.

Through internships, mentoring, technologically accessible and applied learning opportunities, academic programming will:

- clearly delineate a career path for homelessness focused service roles, specializations, and technical certifications for cross-discipline or intersectional fields of study
- provide "basic" training, including terminology and eligibility criteria, for professionals and organizations engaged in providing services to people experiencing homelessness
- improve employability and employment outcomes for people with disabilities and co-occurring conditions
- both increase the number of workers available to fill employment demands and strengthen the skills of these employees in addressing homelessness

Rationale:
Peer mentoring certifications already exist for mental health and substance use disorder specialists and could be emulated to extend the expertise of individuals who have experienced homelessness, as well. Similarly, the technology used to deliver SOAR certification to caseworkers also exemplifies a successful delivery model and demonstrates the need for practical education across intersecting disciplines. The Try-Out Employment model in Southeast Kansas has also met with measurable success. Furthermore, according to the “The Challenge to Compete Kansas Workforce 2020” Report (updated August 2021) “social assistance” roles are “among the largest private sector industries [in which] employment growth was concentrated,” “even at full staff, Vocational Rehabilitation only has capacity to serve about five percent of working-age Kansans with disabilities,” and “find[ing] specialized partners in rural areas is much more difficult.”

Subcommittee on Housing and Homelessness Goals

1. The Subcommittee will create a guide to help people experiencing homelessness access services/resources. The guide will provide information on agencies that can be contacted in most Kansas counties for assistance. It will also provide tips and guidance for how to access assistance.

2. Recruit and sustain a diverse membership including persons with lived experience

3. The Subcommittee will work with the Governor’s Behavioral Health Planning Council to move forward the integrated data platform statewide.

4. The Subcommittee will assist KDADS in developing a fund distribution plan to allocate dollars for the second round of CARES Act as it relates to housing needs in Kansas.

5. The Subcommittee will develop a training on federal housing programs that will include an overview of eligibility criteria and other program specific terminology.

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.

For further questions please contact:

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Simon Messmer-Vice Chair
GOVERNOR’S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL UPDATE

JUSTICE INVOLVED YOUTH AND ADULTS – SUBCOMMITTEE REPORT

2021

Report presented to:
Governor’s Behavioral Health Services Planning Council

Prepared by:

Bill Persinger, Co-Chair
Dr. Sherrie Vaughn, Ed. D., Co-Chair
Charles Bartlett, KDADS, Liaison to GBHSPC
INTRODUCTION

The interface between the behavioral 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

Charles Bartlett, *KDADS, Liaison to GBHSPC*
Jennifer Beery, *DCF*
Mike Brouwer, *Douglas County Sheriff’s Office*
Ashley Brown, *DCF*
Gary Bunting, *Under Sheriff, Douglas County*
Harold Casey, *Executive Director, Substance Abuse Center of KS*
Andrea Clark, *KDADS, Liaison to JIYA Subcomittee*
Bill Cochran, *Chief, Topeka Police Department*
Wes Cole, *GBHSPC Liaison*
Dale Coleman, *Under Sheriff, Ford County*
Hope Cooper, *Deputy Secretary, KDOC*
Letitia Ferwalt, *Johnson County DA’s office*
Mike Fonkert, *Kansas Appleseed*
Jessica Harvey, *Consumer*
Jeffrey Herrig, *Sheriff, Jefferson County*
Jason Hess, *Executive Director, Heartland RADAC*
Jennifer Hornback, *Principal, Hazel Grove Elementary, KCK*
Sandy Horton, *Kansas Sheriff’s Association*
J Ted Jester, *Johnson County Department of Corrections*
Ed Klumpp, *Local law enforcement*
Brandi Lane, *Johnson County Mental Health*
Dantia MacDonald, *Consumer*
Bill Persinger, *Executive Director, Valeo Behavioral Health*
Michelle Pickert,
Usha Reddi, *Honorable Mayor, Manhattan, KS*
Dr. Sherrie Vaughn, Ed. D., *Executive Director, NAMI Kansas*
Susan Wallace, *Family Member*
SUBCOMMITTEE AND WORKGROUP SUMMARIES

JIYA SUMMARY INTRODUCTION

In the FY20 JIYA Report, the JIYA subcommittee adopted the following FY2021 Tasks:

- JIYA members to serve on the Kansas Stepping Up Technical Assistance Center Oversight Committee
- Continue to follow the Kansas Criminal Justice Reform Commission (KCJRC) and various subcommittees; anticipating working with KDADS and/or KDOC where possible on policy development and programs based on recommendations for reform
- Assist KDADS with any short-term projects or tasks needed in support of the statewide plan referenced in this report, the aforementioned “top priorities and recommendations”, or on any other ad hoc basis deemed necessary

In response to the FY21 Tasks, the JIYA subcommittee and its members have been actively involved serving on the Kansas Stepping Up Technical Assistance Center Oversight Committee, following the Kansas Criminal Justice Reform Commission, working closely with KDADS and/or KDOC where possible on policy development and programs, and assisting KDADS with short-term projects or tasks as needed to support the statewide plan delivered to the Legislative Division of Post Audit in May of 2020. In FY21, under Audra Goldsmith’s leadership, the Kansas Stepping Up Technical Assistance Center has been implemented and has gained significant traction across the state of Kansas, adding Shawnee County, Ellis County, and Crawford County to its service network. Additionally, NAMI Kansas has actively engaged the Stepping Up Initiative through its awarded SAMHSA grant (Statewide Consumer Network) to engage consumers and bring their voice to the community decision tables concerning the Stepping Up Initiative.

Additionally, the JIYA subcommittee members have engaged various statewide taskforces, committees, and workgroups discussions on mental health issues related to youth and adult justice systems in Kansas. The JIYA subcommittee recognizes that these discussions, topics, and issues raised about systems of care specific to behavioral health and how these behavioral issues connect to the justice systems for youth and adults are transformational in nature. In response to these various discussions, topics, and issues, the JIYA recommends the following priorities that can aid in these transformational issues and initiatives.

TOP PRIORITIES & RECOMMENDATIONS:

Immediate

1. Support the implementation and funding for 988.
2. Support development and implementation for **Behavioral Health Jail Liaison** positions in all CMHCs.

3. Support the role of **peer support** in the arenas of behavioral health and criminal justice, such as peer support services within correctional settings.

4. Convene the **Competency to Stand Trial** Evaluation and Restoration Statewide Workgroup to address the legal challenges, delay, and system capacity issues.

**Longer-Term**

1. Support behavioral health and juvenile and adult criminal justice system **collaborations** (per CCBHC standards).

2. Support the study, and implementation of, **best practices** where the public behavioral healthcare system and the criminal justice system intersect, keeping in mind the principle of “scalability” of programming/services adaptable to frontier, rural, and urban regions/counties.

3. Continue support of the **Stepping-Up Initiative**.

4. Support discussion on planning for, and implementation of, **specialty courts** (mental health courts and drug courts).

5. Support the **Zero Suicide Kansas Project**, including prevention/intervention strategies between state and local systems.

6. Support discussion on planning for, and implementation of, **Assisted Outpatient Treatment** (AOT).

7. **Support city and county** level innovations and services, including support for learning and information sharing statewide.

**FY 2022 TASKS**

- JIYA members will continue to serve on the Kansas Stepping Up Technical Assistance Center Oversight Committee

- Continue to follow the Kansas Criminal Justice Reform Commission (KCJRC) and various subcommittees; anticipating working with KDADS and/or KDOC where possible on policy development and programs based on recommendations for reform

- Assist KDADS with any short-term projects or tasks needed in support of the statewide plan referenced in this report, the aforementioned “top priorities and recommendations”, or on any other ad hoc basis deemed necessary

**SUMMARY**
In summary, the JIYA Subcommittee, 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. A continuing role and mission of the JIYA should be to monitor the work of other groups and make sure that important issues show up in their work. Also, our JIYA role should continue to be to encourage communication and coordination of the work of the various groups, as well as being a sort of clearinghouse and a resource to the KDADS Secretary and her team as they build policy.
Governor’s Behavioral Health Services Planning Council
Kansas Citizens’ Committee on Alcohol and Other Drug Abuse (KCC)
Annual Report, August 2021

Presented to:
Wes Cole, Chairperson, Governor’s Behavioral Health Services Planning Council
Laura Howard, Secretary, Kansas Department of Aging and Disability Services
Laura Kelly, 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:

<table>
<thead>
<tr>
<th>Member</th>
<th>Representing</th>
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</thead>
<tbody>
<tr>
<td>Krista Machado</td>
<td>Prevention</td>
</tr>
<tr>
<td>Ana Woodburn</td>
<td>Prevention</td>
</tr>
<tr>
<td>Dana Schwartz</td>
<td>Prevention</td>
</tr>
<tr>
<td>Daniel Warren, Chair</td>
<td>Treatment</td>
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<tr>
<td>Shane Hudson</td>
<td>Treatment</td>
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<tr>
<td>Sara Jackson, Chair Elect</td>
<td>Treatment</td>
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<tr>
<td>Brad Sloan</td>
<td>Citizens</td>
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<tr>
<td>Al Dorsey</td>
<td>Citizens</td>
</tr>
<tr>
<td>Nancy Jo Kepple, Past Chair</td>
<td>Citizens</td>
</tr>
<tr>
<td>Jamie Felton</td>
<td>Citizens</td>
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<tr>
<td>Ngoc Vuong, Recorder</td>
<td>Citizens</td>
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<tr>
<td>Josh Klamm</td>
<td>Law Enforcement</td>
</tr>
<tr>
<td>Victor Fitz</td>
<td>GBHSPC Liaison</td>
</tr>
<tr>
<td>Kayla Waters</td>
<td>Higher Education</td>
</tr>
<tr>
<td>Ethan Bickelhaupt</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Tina Abney</td>
<td>Child Protective Services</td>
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<tr>
<td>Megan Bradshaw</td>
<td>Juvenile Justice Authority</td>
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<tr>
<td>Lindsie Ford</td>
<td>Domestic Violence/Sexual Assault Advocate</td>
</tr>
<tr>
<td>Becky Woodward</td>
<td>Discretionary</td>
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<tr>
<td>Diana Marsh</td>
<td>KDADS/KCC Support Staff</td>
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Executive Summary

2020 Report Review

The Kansas Citizens’ Committee on Alcohol and Other Drug Abuse (KCC) generates this annual report to provide behavioral health recommendations for the State of Kansas. Each report focuses on a number of topics that deserve special attention. Last year’s report was the first during the COVID-19 pandemic, and many of the recommendations were acted upon. We recognize the State continuing to prioritize remote treatment options during the pandemic, increasing block grant reimbursements, and for focusing on access to medication-assisted treatment (MAT). We are aware of ongoing efforts regarding one of our other recommendations, allocating funding from opioid litigation settlements, which we advise strongly to adhere to guidance from Legal Action Center. One principal recommendation from 2020, of which we are not aware of progress, was establishing a marijuana advisory committee; we are concerned that the State will be delayed in preparing for marijuana policy changes and will also fail to benefit from other states’ successes and missteps.

2021 Report Preview

In addition to the unresolved recommendations above, we highlight the top five priority areas that have come to our attention during the 2020-2021 Fiscal Year:

1) Eliminating behavioral health deserts by increasing the number and distribution of Crisis Stabilization Centers (p3-4)
2) Increasing the workforce pipeline while also addressing regulatory barriers to treatment that have arisen due to the Workforce Crisis (p4)
3) Expanding prevention efforts for all adolescents by implementing pilot School-Based Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs (p5)
4) Collecting data and changing committee representation to address Substance Use Health Disparities and Equity (p6-7)
5) Helping people who use drugs to experience fewer complications, including overdose, hepatitis C, and HIV, by supporting Harm Reduction Practices (p7-8)

These recommendations reflect the changing nature of substance use, with illicit drugs more commonly including lethal quantities of fentanyl. They also focus on populations with historically limited access to behavioral services, including various marginalized communities, rural Kansans, and non-treatment-seeking individuals. In some cases, our recommendations are specific and immediately actionable; for others, we recognize we are at the starting point of a long process.

2022 Goals

We plan to ask for outside presenters, from Kansas and beyond, to provide more information about the complicated relationship of the criminal justice and behavioral health systems. We will also gain information about health disparities in the behavioral health domain, which is essential in identifying and advocating for populations that are poorly served by our current treatment options.

In conclusion, we appreciate your commitment to Kansas and we hope you find this report useful.
Detailed Report

Crisis Stabilization Centers and Behavioral Health Deserts

Behavioral health systems serve people with behavioral health conditions and support a wide variety of specialized services, which can be delivered in a range of care settings, including Crisis Stabilization Centers (CSCs). The behavioral health system in Kansas itself is in crisis, according to the Kansas Mental Health Task Force. Kansas had already been identified by Mental Health America as a state with a higher prevalence of mental illness and lower rates of access to care before COVID-19 further amplified mental health and substance use needs. We recommend Kansas increase funding for CSCs to serve the non-insured and underinsured, especially in rural and frontier areas of the State.

CSCs specialize in providing a safe and secure environment for individuals experiencing a mental health or substance use-related crisis, in a less restrictive setting than hospitals, which are primarily designed to address non-behavioral health needs. Most CSCs are non-profit and utilize a combination of behavioral health professionals as well as trained volunteers. CSCs are often described as a “core element” of behavioral health crisis systems, as they serve individuals who need a higher level of care than the traditional outpatient community setting. Many times, a person who is having what appears to be a mental health crisis is in fact suffering a substance use-related crisis, and vice-versa. For this reason, CSCs include both mental health and substance-related crisis services.

According to a Rural and Frontier Subcommittee report, the primary difference between rural and urban Kansas is not in prevalence of mental illness and substance use, but rather in the accessibility of treatment and attitudes toward these issues. “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.” Kansas has 8 approved CSCs serving 43 out of 105 counties in the State of Kansas, including 2 under construction serving Douglas County and Leavenworth/Atchison/Jefferson counties. Kansans in southwest, southeast, and northwest parts of the state do not have proximity to CSCs; those in the northwesternmost areas must drive nearly 200 miles to access a CSC.

Beyond addressing rural health disparities, increasing CSC access unburdens emergency departments, which do not usually have the specially trained professionals and peers to address mental health crises. Treatment at CSCs also costs far less than emergency departments. In a one-year cost avoidance study, Wichita State University estimated that treatment at the Sedgwick County Community Crisis Center saved community agencies, including hospitals and emergency transport, nearly three million dollars.

Improving access is important, as is improving quality and sustainability. In that light, Kansas should commit to providing reimbursement for all substance use services provided at CSCs, including level 3.2 social detoxification and level 3.7 medical detoxification. Kansas should also provide incentives and training to CSCs interested in providing medical detoxification, as this is a level of care that is largely unavailable to Kansans without commercial insurance.

It is important to provide rural and frontier residents the same high-quality behavioral health services that are readily available to residents in urban areas. It is understood that gaps in services exist in all systems. An increase in funding for CSCs would help fill the gap and eliminate the current “Behavioral Health Deserts” in the State of Kansas.
Workforce Crisis

In Kansas and across the nation, insufficient staffing is resulting in poorer services, increased professional burnout, and administrative strain. Kansas behavioral health agencies are using effective approaches to prevention and treatment, but doing so requires adequately trained staff with manageable workloads. We recommend the following:

- We are encouraged by the State supporting the essential role of people with lived experience by expanding training and certification of peer recovery support providers. We recommend further enhancing support by extending Medicaid coverage for peer support services across all payors.

- Kansas has seen an overall increase in counties with buprenorphine-waivered providers, from 20 in 2018 to 43 in 2021. Despite the increase, nearly 60% of counties still do not have a buprenorphine prescriber. Furthermore, it is unknown how many of the waivered providers are actively prescribing buprenorphine, meaning that access, especially in select rural areas, may be tenuous. We recommend the State pursue two possible solutions to increase access to treatment:
  - To address rural disparities, the State should continue to provide funds to train local providers to prescribe buprenorphine. The State should also provide rural SUD treatment providers with technical assistance to establish telemedicine buprenorphine services, as well as connecting rural providers with clinics in urban areas that may be willing to provide remote buprenorphine prescribing services.
  - For urban areas, opioid treatment programs (OTPs or “methadone clinics”) provide the majority of OUD treatment. State regulations limit access to medications at OTPs based on the counselor-patient ratio, blocking life-saving medication treatment for hundreds of patients. This shortage coincides with the highly lethal opioid fentanyl contributing to a 20% increase in Kansas drug overdose deaths from 2019 to 2020. We recommend the state reevaluate treatment-limiting caps for all SUD providers, not just OTPs, given the worsening workforce crisis and rapid increase in overdose deaths in the state. We also recommend the State reconsider licensure requirements for all SUD providers, not just OTPs, allowing any Behavioral Sciences Regulatory Board licensee to provide SUD treatment consistent with their training.

- Telemedicine, with video, can be an effective tool to allow individuals to access treatment. We recommend the State address televideo barriers by providing digital devices directly to treatment recipients or community partners like health departments or local physician offices. We also recommend the State standardize and publicize training for professionals on best practices for telemedicine SUD treatment, ensuring reliable and competent adoption of this critical tool.

- We recommend that the state use SB 283 to improve salary and benefits for licensed substance use professionals, similar to recent supplements provided for hospital nurses.

- We encourage the State develop its own student loan repayment program for substance use professionals. Requirements for current federal programs are stringent, and they are tied to the agency the individual works for. We recommend a repayment program that is based on the qualification of the individual.
School-based Screening, Brief Intervention, and Referral to Treatment (SBIRT)

According to Kansas Communities That Care (KCTC) data, most rates of substance use among school-aged adolescents have steadily decreased in Kansas over the last 10 years, with 2021 showing the most significant decreases since monitoring began. Risk perception with illicit substance use has remained high among this group as well. While some problem behaviors and risk factors have seen steady improvement, the 2021 KCTC shows some are actively worsening: symptoms of depression, use of vaping, and cannabis risk perception. This data shows new vulnerabilities that need to be addressed.

KDADS’ proposed 2022-2023 SAPT Block Grant application prioritizes reductions in adolescent use of marijuana, alcohol, and vaping, with implementation primarily via community coalitions. A primary challenge in developing a statewide strategy for addressing underage substance use is finding ways to reach youths, especially those who are most at-risk. Assessments among justice-involved youth in Kansas who are adjudicated of a crime demonstrate that 62% are at moderate or high risk in the substance use domain. These youth are not only likely to be consistent users of illicit drugs, but also that using is having a negative impact on the youth’s physical or social functioning.

SBIRT is one approach to intervening early. SBIRT is an evidence-based model used for screening, secondary prevention (early detection of risky or hazardous substance use), early intervention, and treatment for people who have hazardous substance use within health care settings. Two decades of evidence demonstrates SBIRT’s effectiveness for hazardous alcohol, illicit drug, and tobacco use, as well as depression and trauma/anxiety disorders. There is comprehensive evidence for effectiveness of brief intervention and treatments for alcohol misuse, tobacco use, and depression; there is growing but inconsistent evidence for effectiveness of brief intervention/treatment for illicit drug misuse. Unfortunately, uptake of SBIRT in primary care has been low in Kansas, and further, many at-risk youths may not have regular exposure to these clinical settings.

Prevention and early intervention are critical to our success at addressing substance use in adolescents. Once adolescents develop more severe substance use disorders, Kansas has limited options. Olathe has Kansas’s only inpatient treatment facility, with just 10 beds. With limited capacity for this level of treatment, adolescents and their families deal with long waits, significant travel requirements, and difficulty integrating family into treatment.

Because of increasing adolescent risk factors and limited screening and treatment in other settings, we recommend School-Based SBIRT Programs. Research shows that “school health clinics are over 21 times more likely to elicit visits for behavioral health issues than are general community health clinics, particularly for minority and other “hard to reach” adolescents (Jusczak, Melinkovich, & Kaplan, 2003)”. Initiating school-based SBIRT specifically in pilot sites will provide early detection of issues with confidentiality, reimbursement, opt-in vs opt-out, and locating treatment partners in the local community. Pilots should include at least one rural and one urban school. Integrating this pilot with other school-based healthcare initiatives is critical. The KCC identified existing Kansas resources already exploring SBIRT initiatives; given the scope of the project, KDADS, KDHE, and other State entities should participate in planning and implementation to rapidly address real or potential barriers.

In order to more effectively monitor substance use in adolescents, we also recommend returning the KCTC to an opt-out model, instead of its current opt-in method. Limited participation reduces accuracy of KCTC data. Without accurate local data, we will not be able to determine if there is any effect from school-based SBIRT pilots.
SUBSTANCE USE HEALTH DISPARITIES AND EQUITY

The Center for Disease and Control (CDC) states that health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Social determinates of health (SDOH) are conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. SDOH can include economic and job security, safe housing, availability of treatment services, healthcare access and quality, social community and context, food access, education access and quality, neighborhood and built environment, generational trauma and poverty. Constructing health equity requires policy makers, program developers, treatment providers and the health systems to begin understanding “the specific and collective needs of individuals and the entire community.” (Ortiz and Hernandez, 2019)

Behavioral Health, Mental Health, and Substance Use Disorder Disparity Data for Kansas

The numbers in the chart below reflect populations and identified subpopulations in Kansas. Mental Health Block Grant and Substance Abuse Block Grant Population and Services Reports provided the estimates by race, ethnicity and gender. The disparate populations are identified in the table and narrative below the table.

<table>
<thead>
<tr>
<th></th>
<th>U.S. Census 2019 Estimates</th>
<th>Mental Health Estimates*</th>
<th>SUD Estimates**</th>
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<tr>
<td><strong>Kansas Population</strong></td>
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<tr>
<td>By Race</td>
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<tr>
<td>White (non-Hispanic)</td>
<td>75.4%</td>
<td>76.74%</td>
<td>75.65%</td>
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<tr>
<td>African American</td>
<td>6.1%</td>
<td>8.18%</td>
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<td>American Indian/Alaska Native</td>
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<td>Asian</td>
<td>3.2%</td>
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<td>Native Hawaiian/Other Pacific Islander</td>
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<td>.22%</td>
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<tr>
<td>Other (other races, two or more races, unknown, etc.)***</td>
<td>3.1%</td>
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<tr>
<td>Ethnicity</td>
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<td>Hispanic or Latino</td>
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<tr>
<td>By Gender</td>
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<tr>
<td>Female</td>
<td>50.2%</td>
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<tr>
<td>Male</td>
<td>49.8%</td>
<td>46.61%</td>
<td>60.98%</td>
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</table>

* The Mental Health Block Grant Population and Services report for services during 7/1/2017 to 6/30/2018 was used to estimate percentages of people served in Community Mental Health Services.
** The Substance Abuse Block Grant Population and Services report for services during 7/1/2017 to 6/30/2018 was used to estimate percentages of people served in Substance Use Disorder Services.
***For the Block Grant Reports, this category includes other races not listed, two or more races, and unknown races.

Data Challenges

The recently developed Kansas Substance Use Reporting Solution (KSURS) is a data reporting system that collects admission and discharge data for SAMHSA’s Treatment Episode Data Set and National
Outcome Measures, which are required of all treatment programs receiving public funding. Agencies which only provide drug and alcohol assessments and referrals, but not treatment, are not required to enter data into KSURS.

Agencies that do not receive public funds are also not required to collect data for submission to the State. Data collection for substance use and mental health care is not a current priority and the current data collection system. KSURS is collecting data sets that are not sufficient in gathering information that is needed to measure health disparities in Kansas.

**Recommendations**

We recommend that the following measures be adopted to begin to understand and address the health disparities and equity within our state:

- Increase data collection efforts through the utilization of an Electronic Health Record (EHR) system by various state agencies to institute data tracking methods and consolidate data about services being offered to and utilized by marginalized communities throughout Kansas. Submit requests to have data tracking methods to monitor race, ethnicity, socio-economic status, sex, disability status, sexual orientation, gender identity, and residential location of those being served that can be reported without revealing patients’ personally identifying information. These data should also be collected about populations receiving medication-assisted treatment.

- Increase diversity in the membership of the Kansas Citizens’ Committee on Alcohol and Other Drug Abuse subcommittee to facilitate a better understanding of the effects of racial disparities across Kansas, while we are building capacity around data collection. Efforts should be made to target members of community-based programs that traditionally intersect with marginalized communities, such as Big Brothers/Big Sisters, Boys and Girls club, local faith-based organizations, etc. Having diverse voices from the community and individuals with lived experience will provide insight into barriers that exist to limit access to services.

- Commission a committee to review state-wide public health disparities in connection to mental health and substance use disorder services.

**Harm Reduction**

Increases in drug overdose deaths and bloodborne viral infections (hepatitis C and HIV primarily) in Kansas warrant cost-effective strategies that save lives, promote public health and safety, and address structural stigma and barriers to care. **Harm Reduction** is a set of practical, evidence-based strategies aimed at reducing negative consequences associated with substance use and ensuring that individuals with SUD receive the care and support they need. We recommend the following strategies to address the administrative and legislative roadblocks to effective, evidence-based SUD and overdose prevention:

- **911 Good Samaritan Law (GSL):** In a drug overdose, lives are lost when bystanders fear that calling for medical assistance would lead to arrest and prosecution. Due to the high prevalence of drug overdoses not reported to first responders, most states have enacted GSLs that provide legal protection for individuals who call 911 in the event of a drug overdose. Kansas has not enacted a GSL. We recommend a comprehensive 911 GSL for drug overdoses along with adequate funding programs that increase awareness and understanding among first responders, health care professionals, and the general public.
• **Fentanyl contamination testing:** Increases in drug overdose deaths have been primarily attributed to illicitly manufactured synthetic opioids like fentanyl. Fentanyl test strips (FTS) screen drugs for lethal concentrations of fentanyl, promoting safer and more-informed decision-making about substance use. FTS are currently considered paraphernalia in Kansas and are therefore not legally accessible. An amendment to HB 2277, which passed the KS House of Representatives, would have decriminalized FTS; however, it did not pass the Kansas Senate. We recommend removal of barriers to legal use of FTS as well as implementation of community-based training and distribution of FTS.

• **Increased access, training, and utilization of naloxone:** Naloxone, an FDA-approved treatment to reverse an opioid overdose, has little to no side effects or potential for misuse. It has been instrumental in efforts to reduce opioid overdose deaths. While naloxone has been available for years via prescription, direct distribution to those at risk for overdose, their family members, and first responders is the most effective strategy. We recommend requiring first responders to receive naloxone training, funding direct distribution of naloxone, and requiring pharmacies to participate in dispensing without prescription. In order to sustainably improve access to naloxone at the time of hospital discharge, we also recommend legislation similar to Colorado HB20-1065, which requires insurers to reimburse hospitals for the cost of the naloxone.

• **Facilitation of syringe services programs (SSPs) and syringe disposal sites:** Kansas is suffering the consequences of the national HIV, hepatitis C, and overdose syndemic. The Kansas Opioid Vulnerability Assessment in 2020 showed that rural and frontier communities may be more at risk from these consequences of injection drug use. Syringe service programs (SSPs) reduce these harms by providing access to both sterile syringes and proper disposal of used syringes. SSPs also serve as a linkage to SUD treatment services. The same paraphernalia laws in Kansas that prohibit legal possession of FTS also prohibit dispensing and possessing sterile needles, syringes, and other injection equipment. We recommend changing state law so that SSPs can operate and people who use drugs can properly dispose of used injection equipment.

• **Increased access to and utilization of medication-assisted treatment (MAT) in disenfranchised, underserved populations:** MAT, primarily for opioid and alcohol use disorder, combines medication with psychotherapy to improve outcomes for individuals with SUD. For opioid use disorder, MAT reduces illicit opioid use, overdoses, and involvement in the criminal legal system; improves retention in treatment; and ensures pathways to long-term recovery. The need for MAT is especially evident considering high rates of SUD among justice-involved individuals, restricted MAT access in correctional facilities, and a major unmet need for MAT in rural/frontier communities and communities of color. We recommend removing institutional barriers to MAT in all incarceration settings and expanding the overall number of MAT providers and programs.

• **Increased screening and surveillance of overdoses:** Overdose Detection Mapping Application Program (ODMAP) allows first responders and coroners to log an overdose in real time into a centralized mapping database. Through real-time accessible data provided by ODMAP, communities are able to adapt to emergent substance trends by implementing or expanding overdose prevention strategies in high overdose areas. ODMAP is already utilized in a few Kansas counties, but the benefits of increasing surveillance of overdoses will be most pronounced when ODMAP is used by multiple agencies and entities across the entire state. We recommend that all counties and the state of Kansas join ODMAP.
Governor’s Behavioral Health Services Planning Council
Prevention Subcommittee 2021 Annual Report

VISION:
To ensure that key representatives and stakeholders are involved in the process 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 engagement, feedback, guidance, and advocacy 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:
Members must have a stake in behavioral health and represent diversity within the State. Subcommittee members will initially commit to serving one, two-year term, but may serve up to two additional two-year terms if desired. The Prevention Subcommittee Charter was amended on 12.03.20 to increase the membership cap from 15 to 20. Thirteen of 15 members were present at the meeting and the vote was unanimous in favor.

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<thead>
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<th>Name</th>
<th>Organization</th>
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<tr>
<td>Stephanie Rhinehart – Liaison</td>
<td>Kansas Department for Aging &amp; Disability Services</td>
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<tr>
<td>Lisa Chaney – Chair</td>
<td>Learning Tree Institute at Greenbush</td>
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<tr>
<td>Callie Dyer – Vice Chair</td>
<td>Finney County Community Health Coalition, dba LiveWell Finney County</td>
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<tr>
<td>Shereen Ellis – Secretary</td>
<td>Aetna Better Health of Kansas</td>
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<tr>
<td>Aonya Barnett</td>
<td>Partners for Wichita</td>
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<tr>
<td>Bailey Blair</td>
<td>Sedgwick County Suicide Prevention Coalition</td>
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<tr>
<td>Holly Bowyer</td>
<td>The Center for Counseling &amp; Consultation</td>
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<td>Vicki Broz</td>
<td>Compass Behavioral Health</td>
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<td>Jan Chandler</td>
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<td>Chad Childs</td>
<td>Wichita State University Community Engagement Institute</td>
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<td>Mary McBride</td>
<td>Parent</td>
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<td>Stephenie Roberts</td>
<td>South Central Kansas Problem Gambling Task Force</td>
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<tr>
<td>Marissa Woodmansee</td>
<td>20th Judicial District Juvenile Services</td>
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SFY21 FOCUS: Collaboration and Coordination

In SFY2021, the Prevention Subcommittee has continued to grow in its strong focus on collaboration built since its inception. We believe that it is important to continue to learn about the work of the other Subcommittees to make progress on behavioral health challenges in Kansas. Prevention can be woven into all Subcommittee areas to reduce the incidence of substance abuse and provide supports for mental illness. The Prevention Subcommittee is made up of members who were also active members of the GBHSPC Rural and Frontier Subcommittee, Service Members, Veterans, and Families Subcommittee, Evidence-Based Strategies Subcommittee, and the Problem Gambling Subcommittee.

In October of 2020 Nancy Jo Kepple, Chair of the Kansas Citizens Committee on Alcohol and Other Drug Abuse (KCC) shared the work of their Subcommittee. The Prevention Subcommittee collaborated with the KCC on goals that aligned related to marijuana legalization and unintended consequences. A shared slide was created and presented at both Subcommittee presentations to KDADS Secretary with a recommendation to establish an expert panel to explore and create awareness around this topic.

In November 2020, The Prevention Subcommittee also hosted a presentation from Shawna Wright, Chair of the Rural and Frontier Subcommittee. The Prevention Subcommittee voted to write a letter of support for the expansion of telehealth options to all Kansans. The increased availability of treatment services virtually could positively impact all seven Behavioral Health Priorities outlined by the Prevention Subcommittee.

Using the Kansas Behavioral Health Profile, the Prevention Subcommittee went through a behavioral health data review and indicator prioritization process in FY2020. In FY2021, the Subcommittee reviewed updated data for the priority areas and while substance use measures are showing improvement, it was determined they were still priorities of focus. Prevention Subcommittee Behavioral Health Priorities include suicide and depression, underage drinking, youth marijuana use and vaping, amphetamine use (all ages), and Family Attachment. Kansas Communities That Care (KCTC) 2021 Student Survey trend data and hot spot maps for these priority areas are available for counties to view on the Kansas Prevention Collaborative website. Behavioral Health Indicator Maps - Kansas Prevention Collaborative The maps help Kansans identify geographical areas of strengths and needs related to the indicators. It also provides information necessary to build awareness and capacity and will make it easier to collaborate with other partners to create more comprehensive plans for prevention and behavioral health services across the state.

The Prevention Subcommittee met every month over the course of the year and continued to support the Evidence-Based Strategies Workgroup, Legislative Event/Advocacy Workgroup, and State Suicide Prevention Plan Workgroup. These groups, with membership and coordination by the Prevention Subcommittee, met as often as needed throughout FY2021. The Subcommittee added three new members in FY2021. A new member Onboarding Workgroup was created to help new members transition into the Prevention Subcommittee work.

The Evidence-Based Strategies Workgroup (EBSW) revised the Kansas Prevention Collaborative Evidence-based Strategies Matrix in FY2021. The Matrix is tools for prevention stakeholders to use to find appropriate prevention strategies with proven effectiveness. For sustainability, the EBSW requested the Kansas Prevention Collaborative and the Training Project Team assume ownership and maintenance of this resource. The Prevention Subcommittee EBSW will continue to meet annually or bi-annually to
review EBS in Kansas and make recommendations on the Matrix content. There will also be Prevention Subcommittee member representation on the GBHSPC Evidence-Based Strategies Subcommittee.

To create awareness of the purpose and work of the Prevention Subcommittee, the Legislative Event/Advocacy Workgroup, with help of Wichita State University Community Engagement Institute (on behalf of the Kansas Prevention Collaborative), developed a short video to share with legislators and stakeholders. GBHSPC Prevention Subcommittee - YouTube The workgroup hosted an hour-long session during Prevention Advocacy week and shared the video and had discussion of our purpose and mission. The Subcommittee was also joined in a regular meeting by a leader from Iowa who shared her expertise about ways to advocate regarding marijuana legislation in Iowa and Nebraska.

Suicide prevention remained a priority of the Prevention Subcommittee in FY2021. In FY2020 a workgroup of the Subcommittee was formed to update the state’s suicide prevention plan. The plan was finalized in FY2021 and can be found on the Kansas Prevention Collaborative website KPC-Suicide-Prevention-Final-3.pdf (kansaspreadeventioncollaborative.org). The plan covers the period of 2021-2025 and will be reviewed annually and updated every five years. One of the first objectives in the plan was to create a statewide suicide prevention coalition. As a result of strengthened collaborations KDADS, KDHE, the Attorney General’s Office, and other partners put in place a process to form a Steering Committee. The Committee created a mission and vision, by-laws, and invited members. The new Kansas Suicide Prevention Coalition (KSPC) will hold their first official meeting in September. The State Suicide Prevention Plan Workgroup will hand off this plan to the KSPC after their first meeting. Several members of the Prevention Subcommittee are on the Steering Committee for this new statewide coalition which will help with the transition.

The Prevention Subcommittee stressed the importance of engaging youth in prevention and ensuring their voice is included in the work of the Subcommittee. This felt particularly important during the pandemic of COVID-19 and the changes that students, schools, and families were experiencing. While the Subcommittee discussed the desire to have youth members, the difficulty of membership due to the meeting format and school schedules led to discussion of inclusion of youth as Subcommittee guests. As a starting point, the Subcommittee added a Youth Voice section to our regular meeting agenda. Throughout the year, our guests included students from STAND Harvey County, Kansas Youth Connect, Teen TALC from Dodge City, and a representative from Rise Up Reno. The Subcommittee also learned about opportunities to expand Youth Leadership in Kansas (YLINK) and received an update from the Kansas Youth Community Change Conference (KYC3).

We asked the groups to address three questions:

1) What prevention work are you doing?
2) What is most concerning right now to you and your friends?
3) What can adults do to help?

While we learned what they were doing in their communities, most of the students said that mental health was their main concern at this time, along with not being able to be with their friends. Adults can help by being supportive and listening without judgement.

Another focus for the Prevention Subcommittee was to ensure that members had opportunities to learn and had a shared understanding of the goals, objectives, and programs discussed in the Subcommittee’s objectives. In May Leslie Hale from KDHE spoke about Zero Suicide and in June individuals from the Massachusetts Department of Public Health shared information about Screening Brief Intervention and Referral to Treatment (SBIRT) and how it can be used in schools.

The Prevention Subcommittee continued progressing in organizational processes, including amending the charter to increase more diverse membership, seeking individuals with lived experience, at-risk
populations, and including student voice for prevention. While COVID required virtual participation, it also allowed easy attendance with no travel restrictions. Three new members were added in FY2021.

PROGRESS on State Fiscal Year 2021 and PREVIOUS YEARS’ GOALS:

FY2021 Goal 1: For efforts to improve shared access to data resources among State agencies and GBHSPC Subcommittees, the Prevention Subcommittee:

1) Supported the KPC by highlighting areas of needed focus and capacity-building for prevention coalitions and task forces (substance abuse, problem gambling, and suicide) priorities based on data.
2) Reviewed progress based on updated Kansas Behavioral Health Profile data for the seven behavioral health prevention priority areas identified by the Prevention Subcommittee. Updated data indicators were provided to KDADS and promoted by and through the Kansas Prevention Collaborative (KPC). Updated trend data for counties participating in the Kansas Communities That Care (KCTC) Student Survey can be found on the KPC website.
3) Finalized and disseminated the new Kansas Suicide Prevention Plan 2021-2025 summarizing data from multiple agencies to provide an understanding of suicide in Kansas and to provide a five-year prevention timeline with goals and objectives.
   a. Incorporated the 2020 Service Members, Veterans, and Families Subcommittee and Kansas Governor’s Challenge Combined Action Plan into the overall Kansas Prevention Suicide Plan.
4) Supported the State Epidemiological Workgroup (SEOW) with utilization of the guidance of this Workgroup and the promotion of the Kansas Behavioral Health Profile.
5) Supported the SEOW access to mental health and substance abuse treatment data to assist in the Kansas Prevention and Mental Health Block Grant planning and applications, and for inclusion in the 2021 Kansas Behavioral Health Profile.
6) Formed a small group to review the New Hampshire Public Use data system and determine if a similar plan should be recommended for Kansas.

FY2021 Goal 2: In elevating awareness and implementation of strategies recommended by EBSW and engage in EBS Subcommittee efforts, the Prevention Subcommittee:

1) Continued to facilitate meetings of the EBSW to promote more use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services.
2) EBSW revised and promoted the Kansas Prevention Collaborative Evidence-Based Strategies Matrix.
3) Continued to identify and update the catalog behavioral health prevention efforts (KDADS-funded and unfunded) occurring across the state.
   a. The EBSW collaborated with the KPC Evaluation Team to develop and administer an online survey of unfunded community coalitions to learn what evidence-based strategies are being implemented in the state. The survey will be administered every six months.
   b. Utilizing the KPC, a second survey asked if previously funded communities have sustained their strategy implementation and coalitions.
4) Included Prevention Subcommittee representation on the larger GBHSPC Evidence-Based Strategies Subcommittee and will work with members to identify the prevention EBS that other Subcommittees are implementing or recommending.
FY2021 Goal 3: In coordinating efforts and care transitions relative to hospitalization, outpatient, recovery, and prevention of future hospitalization, the Prevention Subcommittee:

1) Encouraged the State to better coordinate efforts and care transitions of behavioral health services by encouraging communities and the State to increase healthcare linkages and identify care transition best practices for mental health, substance abuse, and emergency departments across Kansas. The Subcommittee also recommended utilization of enhanced follow-up with clients during crisis and stepping down in levels of care.

2) Continued to recommend modifications to the requirements of SBIRT (Screening, Brief Intervention, and Referral to Treatment) providers for Medicaid-eligible clients. Purposes of encouraging the expansion of these requirements have been to prevent suicide and reduce opioid misuse and other substance abuse.

3) Provided education to Prevention Subcommittee members regarding Screening Brief Intervention and Referral to Treatment (SBIRT) and Zero Suicide framework.

4) Met with Pat Stilen, Co-Director, Mid-America Addiction Technology Transfer Center to explore how SBIRT might be provided in schools. Pat connected the Subcommittee with a presentation from Massachusetts Department of Health staff.

5) Discussed how the Subcommittee could discuss the promotion of Zero Suicide strategies through the new Statewide Suicide Prevention Coalition.

6) Had representation that actively participated in strategic planning with the Zero Suicide Advisory Council.

FY2021 Goal 4: In allocating resources to prioritized areas of need through data-driven decision making, the Prevention Subcommittee:

1) Requested funding allocation from the GBHSPC and KDADS Secretary in the 2020 Prevention Subcommittee Annual Report and presentations for the following:
   a. Centralized epidemiologist.
   c. Full time state Suicide Prevention Coordinator.

2) Supported and promoted the Prevention Subcommittee behavioral health priorities.
   a. Created a video that highlighted the purpose of the GBHSPC Prevention Subcommittee and shared its seven data priorities (suicide, depression, underage drinking, youth marijuana use and vaping, amphetamine use (all ages), and family attachment).
   b. Disseminated the highlighted priority areas on the Kansas Prevention Collaborative website. Interactive maps assist prevention planning with the ability to compare county data with the state or with surrounding counties. County trend data, when available, are shown for each county.

3) Reviewed annual progress data for the seven priority areas. Youth substance use measures showed a reduction, but suicide and depression increased.

4) Requested that a comprehensive statewide approach to suicide prevention with dedicated funding be enacted.

RECOMMENDATIONS AND NEXT STEPS: The Prevention Subcommittee 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 GBHSPC. We ask our policymakers, state, and local leaders, and all those who have a vested interest 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. The Prevention Subcommittee is in the process of updating the Plan and have made it a goal to ensure annual updates to stay current and connected. We recognize this work cannot be completed by any one entity. It takes the collaborative effort of a multitude of agencies and organizations. We ask for your support in promoting our recommendations for next steps in this report and as described in more detail in the upcoming 2022 Kansas Behavioral Health Prevention Plan.

There are many moving parts to the prevention infrastructure and the Prevention Subcommittee continues to identify new partners and leverage resources to make an impact. We will continue to identify populations at high risk to promote equity and inclusion. We will also continue our focus on Youth Voice by inviting students to our monthly Prevention Subcommittee meetings to share the work being promoted in their community and to identify opportunities for coordination at the state level. To maintain our focus, the Subcommittee has also embedded Youth Voice into the FY2022 objectives.

There is a wealth of data available across the various State Agencies. The Prevention Subcommittee recommends the formalization of a process for sharing these data to assist in providing a comprehensive needs assessment. The SEOW has provided the Kansas Behavioral Health Profile to fill this purpose, providing data from all agencies together to monitor behavioral health, review trends, and assist with identifying at-risk subpopulations. However, there is little awareness, and thus little use of the Profile. Sharing of data and resources is needed to prioritize needs and guide capacity-building, planning, implementation, and evaluation of behavioral health services in Kansas. The Profile includes data gaps, and the Subcommittee will work to fill those gaps to further inform State and community needs.

Some of the Prevention Subcommittee 2022 goals remain the same as the prior year but the objectives have been revised. Other goal statements have been added or revised.

**PREVENTION SUBCOMMITTEE SFY 2022 GOALS:**

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Support improved shared access to data resources among State Agencies and GBHSPC Subcommittees</th>
<th>Completion</th>
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</thead>
<tbody>
<tr>
<td>Objective 1.1</td>
<td>Create awareness of the Kansas Behavioral Health Profile by asking the Governor’s Behavioral Health Services Planning Council (GBHSPC) to share and promote the Profile at an All-Subcommittee meeting.</td>
<td>2022</td>
</tr>
<tr>
<td>Objective 1.2</td>
<td>Support the work of the State Epidemiological Outcomes Workgroup (SEOW) to develop a cross-agency Behavioral Health Data Inventory to provide information on data providers, data characteristics, and data availability to assist users in finding behavioral health data of interest.</td>
<td>2025</td>
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<td>Objective 1.3</td>
<td>Recommend the SEOW have access to mental health and substance abuse treatment data for annual inclusion in the Kansas Behavioral Health Profile.</td>
<td>2023</td>
</tr>
<tr>
<td>Objective 1.4</td>
<td>Review New Hampshire Public Use data system and recommend a similar plan in Kansas.</td>
<td>2025</td>
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Goal 2

| Objective 2.1 | Support expansion of SBIRT utilization to youth populations (grades 6-12) to increase early detection of substance misuse and provide greater opportunity for substance use related education. | 2025 |
| Objective 2.2 | Connect Kansas youth and adult prevention efforts for better collaboration in communities. | 2022 |
| Objective 2.3 | Provide leadership and support to regional and local partners by securing and distributing a suicide prevention awareness campaign materials/toolkit. | 2025 |
| Objective 2.4 | Work to secure sustainable resources for initiatives that improve access to behavioral healthcare to support an environment that is amenable to prevention such as 988 and Certified Community Behavioral Health Centers (CCBHCs). | 2023 |

Goal 3

| Objective 3.1 | Review the Kansas Behavioral Health Prevention Plan and assign members or teams to update sections. | August 2021 |
| Objective 3.2 | Include Student Voice section in the Kansas Behavioral Health Prevention Plan to emphasize Kansas youth prevention initiatives (e.g., Kansas Youth Connect, YLINK). | December 2021 |
| Objective 3.3 | Review updates and finalize revisions. | February 2022 |
| Objective 3.4 | Final proofreading and submission for prevention partner feedback. | March 2022 |
| Objective 3.4 | Completion and dissemination of annual Kansas Behavioral Health Prevention Plan. | May 2022 |

Subcommittee Recommendations and Action Items to the GBHSPC and KDADS: The Prevention Subcommittee recommends the following to the GBHSPC and KDADS Administration for action in Kansas this year.

1. **Data-sharing Access (SFY 2022 Goal #1)**
   - Support improved data-sharing among State Agencies and Subcommittees.
   - Better utilize the State Epidemiological Outcomes Workgroup and promote tools like the Kansas Behavioral Health Profile to prioritize State programmatic action based on data priorities identified by this group.
     - We ask that the GBHSPC share and promote the Kansas Behavioral Health Profile at an All-Subcommittee meeting.

2. **Transitions (SFY 2022 Goal #2)**
   - Expand approved providers for SBIRT by changing the language to include community health workers and other health education providers.
   - Consider sustainable resources for initiatives that improve access to behavioral healthcare to support an environment that is amenable to prevention such as 988 and Certified Community Behavioral Health Centers (CCBHCs).

3. **Collaboration**
   - Hold quarterly GBHSPC Subcommittee Chairs’ meetings for increased awareness and opportunities for collaboration.
b. Hold annual All-Subcommittee meetings to identify opportunities for coordination of goal development and alignment.

**Prevention Subcommittee Resource Request of KDADS Secretary:** The following action items, requiring funding allocation, are recommended to the GBHSPC, the Secretary of KDADS, and the Governor of Kansas.

<table>
<thead>
<tr>
<th><strong>Action Items</strong></th>
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<tr>
<td>• Support broader evidence-based universal prevention strategies for community and statewide implementation around Prevention Subcommittee behavioral health priorities (suicide, depression, youth alcohol, marijuana, vaping, family attachment) at $500,000.</td>
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<tr>
<td>• Hire and employ a centralized Epidemiologist to gather, compile, and compare behavioral health needs assessment data from all State Departments and Subcommittees and to support and maintain a Behavioral Health Data Source Inventory at a rate of $80,000 or higher in consideration of fair market rate.</td>
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<tr>
<td>• Continued funding for 988 implementation at FY2021 rate of $3,000,000 or higher.</td>
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Problem gambling is a preventable and treatable public health issue. Kansas casinos are state-owned and operated, consequently Kansas has an increased duty of care to address and prevent gambling-related harms.

Kansas has experienced a renaissance in legalized gambling beginning in 1987 with the launch of the Kansas Lottery, the opening of four tribal casinos in the late 1990s, and the 2007 Kansas Expanded Lottery Act which authorized the Lottery to own and operate gaming in four destination casinos. Boot Hill Casino and Resort was the first casino to open in December 2009, Kansas Star Casino opened in 2011, Hollywood Casino opened in 2012 and Kansas Crossing opened in 2017.

Based on national prevalence rates of problem and pathological gambling, there are an estimated 60,000 problem gamblers (2.8% of the adult population) and 24,400 pathological gamblers (1.14% of the adult population) in Kansas. The 2.8% of the problem gamblers have mild or moderate gambling problems; that is, they do not meet the full diagnostic criteria for gambling addiction but meet one or more of the criteria and are experiencing problems due to their gambling behavior.

Problem gambling is not well understood by the general public, including members of helping professions, parents, gaming industry line employees, and others. Experts in the problem gambling field note significant barriers to successfully implementing programs to mitigate gambling related harm. These include stigma that problem gambling is less harmful than substance abuse and other problem behaviors; perception that children do not gamble, beliefs that problem gambling is a moral weakness rather than a valid psychiatric condition, etc. Therefore, efforts to address problem gambling take on greater importance within the current context of expanding gambling opportunities combined with poor societal awareness of problem gambling and an under-developed system to reduce gambling related harm.

It is difficult to talk about the problem gambling program in Kansas in its current context without providing some history. This is a relatively new program for Kansas Department for Aging and Disability Services (KDADS). From a technical standpoint, the field of problem and pathological gambling (or as now referenced – disordered gambling) is relatively young. Much of the knowledge that does exist about the efforts to address problem gambling is largely outside of the mainstream literature. The United States is predominantly dependent on government reports, personal communications with administrators of other problem gambling programs and services, and particularly dependent on research from the experiences of Canada, Australia, New Zealand, Hong Kong, Germany, the United Kingdom, and others.

So why must we look outside of the U.S to find the bulk of the research? Problem gambling services in the United States are not federally funded, they are publicly funded programs with very limited budgets, and often those limited moneys cannot afford to invest in the cost of research. Those moneys are spent primarily on crisis interventions, treatment, and some public awareness campaigns.
The task of establishing a statewide problem gambling program or service system is challenging at best. The field is young therefore the body of knowledge is limited. But Kansas had the advantage to learn from the successes and missteps of other states. Kansas was positioned to break new ground in the U.S. as the only state to own casinos and it possessed the greatest opportunity to develop the model system to minimize harm caused by gambling.

The Historical Perspective:

The Kansas Legislature passed the Kansas Expanded Lottery Act (KELA) in 2007. This act allows for the state of Kansas to own and operate one destination casino resort (Lottery gaming facility) in each of the four designated gaming zones within the state of Kansas – northeast, southeast, south central and southwest. During the development of KELA, concerns were raised about the negative impact expanded gaming may have on the incidence of problem gambling and other addictive disorders in Kansas and due to these concerns, a provision was included in the act that created the Problem Gambling and Other Addictions Fund (PGOAF). This provision for 2% of lottery gaming facility net revenues is to be paid to the problem gambling and other addictions grant fund established by K.S.A. 79-4805.

K.S.A. 79-4805. Problem gambling and addictions grant fund. (a) There is hereby established in the state treasury the problem gambling and addictions grant fund. All moneys credited to such fund shall be used for the awarding of grants under this section. The state grant program will provide assistance for the direct treatment of persons diagnosed as suffering from pathological gambling and provide funding for research regarding the impact of gambling on residents of Kansas. Research grants awarded under this section may include, but need not be limited to, grants for determining the effectiveness of education and prevention efforts on the prevalence of pathological gambling in Kansas. Moneys in the problem gambling and addictions grant fund may be used to treat alcoholism, drug abuse and other addictive behaviors.

Kansas was proactive in 2007 with KELA, to address through legislation the potential harms resulting from expanded gaming (gambling) by creating the Problem Gambling and Other Addictions Fund. (SRS) KDADS serves as the administrator of this fund. Keep in mind, to date the federal government does not fund problem gambling services of any kind nationwide, so states are entirely dependent upon funding from state sources.

The vision for the Kansas problem gambling program started around the time of KELA. It was a shared vision of the Kansas Coalition on Problem Gambling and other addiction and prevention stakeholders to ensure that anyone impacted by problem gambling was protected by a safety net of services. Starting in 2008, a dedicated position was created at SRS (KDADS) to coordinate problem gambling services which included the helpline, treatment, and targeted workforce development which would primarily build a process for and certification of gambling counselors.

The staff person hired for this position took the vision and began developing a program that would include the following service components building a unique but comprehensive infrastructure for problem gambling services in Kansas:

1. Prevention – a (FTE) gambling specialist would be hired, and a community task force of volunteers would be developed to work in each gaming zone as the casino prepared to open. Both would partner with the casino and the Kansas Coalition on Problem Gambling to provide outreach to the casino market region, raise awareness and provide education about problem and responsible gambling, and the resources available across the state.
These entities would utilize SAMHSA’s (Substance Abuse and Mental Health Services Administration) Strategic Prevention Framework (assessment, capacity building, planning, implementation, and evaluation guided by cultural competence and sustainability) and the CSAPs (Center for Substance Abuse Prevention) Strategies (information dissemination, education, alternatives, environmental, community-based processes, problem identification and referral) as they conduct their community and statewide work.

2. **Public Awareness** – there was a coordinated effort to develop a gambling-specific website, Public Service Announcements, population-specific print materials, billboards, and statewide branding that increased awareness about the Helpline and the availability of treatment for problem gamblers and affected others. Trainings were conducted statewide, regionally and nationally that addressed problem gambling including specific populations (initially the general public, older adults and youth). A statewide alliance of multi-agency leaders was put in place with the mission of collaborating to maximize resources and enact policy, practice and regulations that would address problem gambling in Kansas. (*Stakeholders included Kansas SRS, Kansas Racing and Gaming Commission, Kansas State Gaming Agency, Kansas Lottery, Kansas Coalition on Problem Gambling, Kansas Department of Corrections, Casino Managers, community members, Kansas Certified Gambling Counselors, and Kansas helpline representatives. Community task force members joined as task forces were formed.*).

3. **Workforce Development** – a gambling-specific training and the process for gambling counselor certification was developed and operational by 2007-2008. By early 2013 there were 47 alcohol and drug counselors and/or mental health clinicians who became Kansas Certified Gambling Counselors (KCGC) following 60 hours of gambling specific education. (*Today, we have 30 network counselors - 2 in provisional status, 2 with International Gaming Disorder Certification status and 4 pending IGDC status. We have 14 non-network status counselors.*).

4. **Treatment** – meetings were held with Substance Use Disorder and Mental Health providers and agencies. They were provided education on gambling addiction and they were encouraged to allow staff to become certified as gambling counselors to increase the reach of gambling services. An agreement was initiated with an experienced (out of state) gambling treatment facility to provide the residential treatment component. Outpatient services were provided in Kansas by the KCGCs.

5. **Crisis Intervention and Helpline Services** – a partnership was developed with the Kansas Health Solutions crisis line to ensure a dedicated helpline service for problem gambling was available 24/7/365. Gambling-specific training and data tracking was provided to helpline staff to ensure caller needs were met. That service is now administered by Beacon Health Options.

6. **Research and Evaluation** - three gambling questions were added to the adult BRFSS (Behavioral Risk Factor Surveillance System). Eleven questions were added to the annual Kansas Communities That Care Youth Survey administered to 6th, 8th, 10th and 12th grade. The first Kansas adult gambling attitudes and behaviors survey was conducted in 2012. A second survey was conducted in 2017 after the opening of the fourth state-owned casino.
This infrastructure for a state problem gambling services program was unheard of across the nation. It was a coveted design and discussed frequently at the national level. Three elements within the design made it a unique structure:

- First, the development of a responsible gambling alliance that would pool resources and expertise to address problem gambling through policy, practice and regulation.

- Second, the development of the all-volunteer community task forces that worked in tandem with the local casino on responsible gambling efforts, raising awareness about problem gambling through education and other prevention efforts, and promoting the Helpline number and the availability of treatment.

- Third, the placement of a full-time gambling specialist in each gaming zone. This position would serve in the market region as a representative of SRS (KDADS), to mobilize the community around problem gambling concerns, to partner with the casino, to provide outreach and referral to treatment and services of care, to raise public awareness, to educate stakeholders and businesses in the communities, to help bring stakeholders to the task force table, and to provide technical assistance and grant oversight for the task force. This position would serve as a subject matter expert on state, regional and national problem gambling prevention efforts.

The infrastructure was in place. Each component was being developed simultaneously. During the development of a new program, it requires focused attention on all service components to become a viable and sustainable program. Program funding started at $100,000 in FY2009-10. As the program grew and casino revenue generated additional dollars in the PGAOF, funding began to increase slightly in FY2011-12.

At the time, the three active gaming zones had assigned specialists providing technical assistance and working on special projects based on the needs of their casino market region. An example of this is the relationship that was built with one of the meat packing plants in SW Kansas. Many attempts from the Specialist to “get a foot in the door” led to numerous conversations about responsible and problem gambling.

The plant leadership eventually disclosed concerns that employees were spending their paychecks on gambling at the “new” casino (not able to pay their rent, domestic issues, health issues, work performance issues, etc.). Based on those concerns, the Specialist provided some education on problem gambling to the management team. They continued their discussions over time and eventually welcomed the idea of having the helpline number and print materials available to employees should they need them. More discussions took place which resulted in the plant placing the helpline number and tagline on their digital information boards in the break rooms, in both English and Spanish. Treatment posters were available on their information bulletin boards. Help became more accessible to the employees and a firm relationship was established with the management team. It helped that the Specialist is also Spanish-speaking.

In 2014, events occurred which changed the program. The problem gambling manager resigned. The program was restructured and placed under the prevention manager. The Specialist’s tasks were rewritten placing the problem gambling prevention component under the SUD youth prevention umbrella and the problem gambling treatment component under adult substance
abuse treatment services. With this design change, the Problem Gambling Specialists also assumed SUD youth prevention, mental health promotion and suicide awareness duties in their market region and statewide. Their role as a gambling specialist became less of a priority and their ability to provide technical assistance to the problem gambling task forces and outreach to the casino market regions was diminished significantly. Unfortunately, the special projects were set aside when the additional prevention duties were assigned.

During this same time, the Kansas Responsible Gambling Alliance was dissolved as it was determined no longer beneficial to the new structure. The work with other state agencies around policy, practice and regulation vanished.

Two of the three specialists resigned to take other job offers outside of KDADS. Two SUD prevention staff and the one remaining Problem Gambling Specialist were re-assigned to oversee the four gaming zone task forces and the statewide coalition, along with their duties of SUD youth prevention, mental health promotion and suicide prevention. Understanding the federal funding source for the SUD, MH and suicide prevention grants, and the federal requirements tied to those grants, the problem gambling prevention momentum waned, and the work being done by the task forces with the help of the Specialists was minimized.

One highlight from FY2014-15 was an increase in funding that was dedicated to a problem gambling media campaign. This increased awareness about problem gambling, the helpline call numbers and treatment enrollment numbers increased. Once the campaign ended, those numbers began to decrease and level off. Out of sight, out of mind. Funding also decreased.

In the fall of 2017, another significant change occurred. The prevention manager resigned. The problem gambling certification and treatment coordinator was asked by leadership to manage all problem gambling services. This would include certification, treatment, the Problem Gambling Specialists (prevention), and the task forces. Most of the original design.

The program is still in the process of re-building but it has momentum. It is a staff of three. From FY2015 until currently, funding for the problem gambling program has been consistently less than 10% of the Problem Gambling and Other Addictions Fund and inconsistent with legislative intent. Funding has been insufficient to support the full range of services envisioned when planning began in 2007. The program service infrastructure lacks substantial development resulting in lower treatment seeking rates, fewer problem gambling prevention efforts, limited relevant research specific to gambling and Kansas, and insufficient awareness about problem gambling across communities and statewide. The program is now up against the legalization of sports betting and are already seeing the impact of gaming addiction in the treatment enrollments and calls to the helpline.

The invitation to become a part of the Governor’s Behavioral Health Services Planning Council is timely. Knowing problem gambling is not well understood and considering the current context of expanded gambling opportunities in Kansas combined with an under-developed system to reduce gambling related harm, this is the time to invest in a comprehensive program to protect Kansans and reduce gambling related harms. This is understood by the Governor’s Behavioral Health Services Planning Council and thus a subcommittee specific to problem gambling is now being formed.
The following outlines the purpose, guiding principles, mission, vision, values and membership the sub-committee will use to direct their work. It will be central to their purpose to monitor, review, and evaluate the allocation of funding and adequacy of services within Kansas.

**The Purpose:** Kansas state agencies, private entities, consumers, the statewide problem gambling coalition and problem gambling task forces will partner together to evaluate data and other research to guide policy directed towards reducing problem gambling/gaming and the impact on individual and community health.

**The Guiding Principles:**

**The Vision:** All Kansans will be free from the impact of problem gambling.

**The Mission:** The public health of Kansans will be supported through a comprehensive system of services to address problem gambling and the co-occurrence with other addictions.

**The Values:** (how)

- Adhere to the legislative intent of the Problem Gambling and other Addictions Fund to ensure problem gambling programs receive adequate allocations from the PGAOF to address prevention, treatment, research and evaluation.
- Create a system of care that is customer/community centered, outcome driven and comprised of a highly competent workforce focused on best practices.
- Develop and implement research-based prevention and treatment strategies that address problem gambling and the co-occurrence with other addictions.
- Reduce the impact of problem gambling by providing resources that uphold prevention, treatment and service efficacy.
- Infuse problem gambling language into all behavioral health programs and services

**The Proposed Sub-Committee Membership and Structure:**

The Problem Gambling Sub-Committee shall include representation from prevention, treatment and other behavioral health entities potentially impacted by or who may have a vested interest in the community impact of gambling/gaming. It may also include members of the gambling and/or gaming industry. It will consist of voting members and non-voting members but shall not include more than one voting member from a given group. Groups that may be considered for prevention, treatment, other behavioral health entities, and the gambling/gaming industry may include but are not limited to:

- Kansas Coalition on Problem Gambling
- Consumer of Problem Gambling or Gaming Services
- Beacon Health Options of Kansas
- Behavioral Health Association of Kansas
- Kansas Racing and Gaming Commission
- Kansas Certified Gambling Counselor(s)
- Kansas Citizens Committee on Alcoholism and Other Drug Abuse
- Kansas Association of Addiction Professionals
- Kansas Mental Health Association
- Kansas Peace Officers Association
- Kansas Prevention Collaborative – Suicide Prevention
- Kansas Housing and Credit Counseling
- Kansas Bankers Association

The sub-committee would be delighted to tell you it has accomplished this important work, however it will meet only for the second time September 27th.
Problem gambling is a preventable and treatable public health issue.

Problem gambling is a persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four or more of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired effect.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control gambling.
4. Is often preoccupied with gambling.
5. Often gambles when feeling distressed.
6. After losing money, returns another day to get even (chasing losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job or educational or career opportunity.
9. Relies on others to provide money to mitigate financial situations caused by gambling.
Legalized Gambling in Kansas

• 1987 – Kansas Lottery was launched
• Late 1990’s – 4 Tribal Casinos opened
• 2007 – Kansas Expanded Lottery Act (KELA)
• 2009-2017 4 State-owned destination casinos opened
Prevalence Rates in Kansas

- 60,000 problem gamblers (2.8% of the adult population)
- 24,400 pathological gamblers (1.14% of the adult population)
Historical Perspective

- Kansas Expanded Lottery Act (KELA)
- Problem Gambling and Other Addictions Fund (PGOAF)
- K.S.A. 79-4805
  - 2% of Lottery Gaming Facility net revenues is to be paid to the PGOAF
The Vision for Problem Gambling Services in Kansas

- Prevention
- Public Awareness
- Workforce Development
- Treatment
- Crisis Intervention and Helpline Services
- Research and Evaluation
Problem Gambling Sub-Committee Charter

The Purpose

To evaluate data and other research to guide policy directed toward reducing problem gambling/gaming and the impact on individual and community health.
The Guiding Principles

**Vision**: All Kansans will be free from the impact of problem gambling.

**Mission**: The public health of Kansans will be supported through a comprehensive system of services to address problem gambling and the co-occurrence with other addictions.
The Values

• Adhere to the legislative intent of the PGOAF to ensure problem gambling programs receive adequate allocations to address prevention, treatment, research and evaluation.

• Create a system of care that is customer/community centered, outcome driven and comprised of a highly competent workforce focused on best practices.

• Develop and implement research-based prevention and treatment strategies that address problem gambling and the co-occurrence with other addictions.

• Reduce the impact of problem gambling by providing resources that uphold prevention, treatment and service efficacy.

• Infuse problem gambling language into all behavioral health programs and services.
Governor’s Behavioral Health Services Planning Council
Rural and Frontier Subcommittee

2021 Annual Report

Presented to:

Wes Cole, Chairperson
Governors’ Behavioral Health Services Planning Council (GBHSPC)

Laura Howard, Secretary
Department for Aging and Disability Services (KDADS)

Laura Kelly, Governor

Prepared by:
GBHSPC Rural and Frontier Subcommittee

Shawna Wright, PhD. – FY2021 Chair

Amanda Pfannenstiel, LCP, LCAC- FY2022 Chair

September 15, 2021
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: Please see Appendix A

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 Organizations, Private and State Psychiatric Hospitals, Managed Care Organizations (MCOs), University Partners, and Law Enforcement. A membership list with the Kansas counties they serve is provided in Appendix B.

The Subcommittee meets six times per year, usually during odd numbered months, on the fourth Thursday of the month. Historically, members have been able to participate in person at Compass Behavioral Health Outpatient office in Dodge City, as well as by phone conference or televideo. In response to the COVID-19 pandemic in 2020, the subcommittee transitioned meetings to televideo and will continue to offer this platform for attendance into the future.

FY2021 Goals & Progress

In FY2021, the R/F Subcommittee focused on addressing the following four primary goals. The previous year marked an opportune time to study, research, and advocate for telebehavioral health adoption, implementation, and utilization. The R/F Subcommittee strived to inform telebehavioral health best practices for providers and community members. The R/F Subcommittee anticipated a significant need to address and support suicide prevention initiatives and to increase prevention efforts in rural and frontier communities, particularly in response to the financial, employment, and life challenges rural and frontier communities have faced in response to COVID-19. The R/F Subcommittee advocated to increase behavioral health service accessibility and to support data integration with other subcommittees for the purposes of collaborating around data-driven initiatives to address the specific needs of rural and frontier communities.

The R/F Subcommittee partnered with KU’s Center for Telemedicine & Telehealth (KUCTT) to explore opportunities for funding the Kansas Rural and Frontier Telebehavioral health (KRAFT) Study. The R/F Subcommittee engaged with potential statewide partners to identify grant funding; however, the R/F Subcommittee did not secure funding for the KRAFT study in FY2021. The R/F Subcommittee remains committed to Telebehavioral health research and advocacy as a means of increasing behavioral health equity, accessibility, and best practices in Kansas and is committed to continuing to seek and support opportunities to inform, collaborate, and advocate for advancements in these areas.
Goal 1: Telebehavioral health Study

- The R/F Subcommittee collaborated with researchers at the KU Center for Telemedicine & Telehealth to update the KRAFT Study parameters in response to the nationwide/statewide surge in telebehavioral health activity. Five mental health centers, one substance abuse treatment facility, and the Association of Community Mental Health Centers of Kansas agreed to participate as study partners. The Chair and Co-Chair met with other GBHSPC subcommittees and received support and endorsement for the study.
- The R/F Subcommittee pursued funding through connecting and consulting with foundations in the state and explored allocation of state COVID dollars. Unfortunately, the R/F Subcommittee was unable to secure funding for the KRAFT Study. Given the significant telehealth movement in the state, the aims of the study are outdated. The R/F Subcommittee will not continue to pursue funding for this study but remains dedicated to engaging with partners to study telebehavioral health and other evidence-based practices and how best practices can be informed from the rural and frontier perspective. In particular, the R/F Subcommittee has interest in partnering with mental health centers that are transitioning to the Certified Community Behavioral Health Clinic (CCBHC) model and investigating telehealth and evidence-based approaches to support equitable access to quality behavioral health services.

Goal 2: Suicide Prevention

- The R/F Subcommittee actively sought to include members from the rural, agricultural community and was successful in this endeavor. The R/F Subcommittee is committed to increasing membership of individuals with lived experience and plans to invite Jane Adams to an upcoming meeting for consultation and guidance in this area.
- The R/F Subcommittee reviewed the suicide prevention and consumer engagement approaches of community mental health centers and other rural organizations. The R/F Subcommittee is committed to advancing the High Plains Community Mental Health Center’s (HPMHC) Hope in the Heartland approach and commends this effort to reduce the stigma associated with seeking behavioral health support. HPMCH has also invested in training local law enforcement officers in the Columbia-Suicide Severity Rating Scale (C-SSRS). Other efforts of note include Four County Mental Health Center’s (FCMHC) radio announcements, which identified and normalized the experience of stress particular to rural communities. The Southeast Kansas Mental Health Center (SEKMHC) has developed a #StopTheSpike campaign in response to the anticipated increase in suicide related to the COVID-19 pandemic. This approach empowers local community members to support each other and provides guidance for talking with family members, peers, and co-workers who may be struggling with behavioral health signs and symptoms. Ford County has invested in Crisis Intervention Teams, and the R/F Subcommittee will consider ways to encourage other rural and frontier communities to adopt this approach. Incoming R/F Subcommittee Co-Chair, Monica Kurz actively shared suicide training opportunities for providers throughout the year for dissemination to rural/frontier partners.
- R/F Subcommittee members actively participated in statewide coalitions to represent rural and frontier needs and perspectives related to suicide prevention. Shawna Wright (Chair) and Monica Kurz (Incoming Co-Chair) were members of the Kansas Suicide Prevention Coalition Steering Committee and the Kansas 988 Coalition. Through this
work, the R/F Subcommittee developed a Power Point slide presentation that highlights the needs of rural Kansans through the examination of maps. Shawna Wright is also a member of the Kansas State Epidemiological Outcomes Workgroup and represents the data needs and barriers for rural and frontier communities.

Goal 3: Service Accessibility

- The R/F Subcommittee dedicated resources to advocating for measures to increase workforce availability and behavioral health service access throughout the year.
  - The R/F Subcommittee wrote a letter to the Kansas Behavioral Sciences Regulatory Board in December as the Board considered legislative priorities for the upcoming session. The R/F Subcommittee endorsed the utilization of telesupervision across behavioral health disciplines for professionals requiring supervision for independent licensure.
    - The R/F Subcommittee was pleased with the passage of HB 2208, a bill requested by the Board of the BSRB that includes many helpful statutory changes, including expanded authorization of supervision by televideo, changes to required hours, and other significant modifications to requirements for licensees and aspiring licensees.
    - David Anderson, R/F Subcommittee member serves on the Board of the KS BSRB, and he was instrumental in communicating the needs of rural and frontier behavioral health services providers and with assisting the R/F Subcommittee with understanding BSRB policy and procedures.
    - The R/F Subcommittee will continue to take an active role in supporting telesupervision best practices and will sponsor an educational learning session this year at the Association of Community Mental Health Centers of Kansas Annual Conference.
- The R/F Subcommittee supports HB 2209 Enacting the psychology interjurisdictional compact to provide for interjurisdictional authorization to practice telepsychology and temporary in-person, face-to-face psychology and will continue to advocate for its passage as part of the Subcommittee’s goal to encourage the BSRB to expand reciprocity of behavioral health licenses across state lines.
- The R/F Subcommittee continues to support and advocate for all behavioral health disciplines to maintain COVID-19 waiver changes for reimbursement from federal payors HR945/S286.
- The R/F Subcommittee collaborated with the 2020 Special Committee on Kansas Mental Health Modernization and Reform. Shawna Wright (Chair) worked with the Telehealth workgroup to assist with identifying and organizing State telebehavioral health priorities.
- The R/F Subcommittee invited Audra Goldsmith to share information about Stepping UP, a national initiative to reduce the number of people with mental illnesses in jails. The Subcommittee will continue to pursue collaboration with Stepping Up.
  - Shawna Wright (Chair) was invited to speak on a panel at the postponed 2021 Statewide Behavioral Health Summit. a part of the national initiative from the National Center for State Courts, State Justice Institute, Conference of State Court Administrators, and Conference of Chief Justices on addressing the Court and Community Response to the Issue of Mental Health. Dr. Wright will discuss statewide needs and provide a rural and frontier perspective.
Goal 4: Data Integration across Subcommittees
- The R/F Subcommittee met with two other subcommittees during the FY2021 year and discussed collaboration and data sharing. The Subcommittee has found through direct meetings and membership liaisons that other subcommittees share similar interests. The R/F Subcommittee will continue to explore opportunities for collaboration and data sharing in the upcoming year with a focus on learning how to leverage the Microsoft Teams platform.
- The R/F Subcommittee has adopted the SMART goals approach to assist with measuring outcomes and directing the Subcommittee efforts.

Noteworthy Efforts FY2021
The R/F Subcommittee partners with other service organizations across state to increase access to services. The R/F Subcommittee will continue to share information regarding rural and frontier strengths, needs, and unique issues as well as advocate for solutions to address the behavioral health workforce shortage.
- R/F Subcommittee members actively participate in local and state conversations and initiatives to address this goal.
- Hosted a virtual Legislative Coffee in November of 2020 via Zoom and presented the R/F Subcommittee’s goals and objectives.
- Partner with the State Epidemiological Outcome Workgroup to share data needs for Rural and Frontier areas.
- R/F Subcommittee members serve on a variety of GBHSPC subcommittees to increase communication and collaboration across subcommittees and workgroups (e.g., Ric Dalke- Exec Committee as Vice-Chair; Shawna Wright- Kansas State Epidemiological Outcomes Workgroup, Kansas Suicide Prevention Coalition Steering Committee, Kansas 988 Coalition, Kansas Prescription Drug and Opioid Advisory Committee; Vicki Broz- Prevention Subcommittee; Shereen Ellis- Service Members, Veterans, and Families and Prevention Subcommittees, Monica Kurz – Prevention Subcommittee, Kansas Suicide Prevention Coalition Steering Committee; Debbie Snapp- Homeless and Housing Subcommittee, etc.)
- Collaborated with other subcommittees through the year (e.g., Prevention Subcommittee, Children’s Subcommittee).
- The Subcommittee continues to strive to diversify membership. New memberships include:
  - Mirna Bonilla/K-State Extension
  - Ian Cizerele-Brown/Four County Mental Health Center
  - Pending Member: Audra Goldsmith/Stepping Up

FY2022 Goals
The R/F Subcommittee is committed to addressing and achieving the four following goals in FY2022. The Subcommittee continues to highly value any opportunity to improve behavioral health service access and equity for rural and frontier populations while holding standards for high quality services and client-informed approaches. The R/F Subcommittee will continue to lead efforts to advance telehealth availability and training for rural behavioral health providers.
The Certified Community Behavioral Health Center (CCBHC) is a promising model for all of Kansas, and particularly rural and frontier communities.

Transitioning to the CCBHC model may be more difficult for rural and frontier communities due to their limited resources, particularly in the domain of delivering evidence-based care. Evidence-based approaches are typically researched and developed in urban areas where treatment and intervention studies are highly structured, controlled, and resource-rich. The R/F Subcommittee aspires to collaborate with CCHBCs to explore ways in which evidence-based treatment models can be modified to fit rural and frontier populations and ways in which practice in rural and frontier communities can inform ongoing research.

The R/F Subcommittee will embrace all opportunities to support and develop suicide prevention resources and to contribute to such initiatives by including the rural and frontier perspective and looks forward to continued collaborations with the Kansas Suicide Prevention Coalition, the 988 Coalition, and the mobile crisis initiative. The R/F Subcommittee will continue to prioritize and engage in efforts to increase behavioral health service availability, access, and equity through exploring and supporting workforce issues to increase the number of behavioral health providers who deliver service in rural and frontier communities. The R/F Subcommittee is invested in collaborating with other GBHSPC subcommittees and supports data integration with other subcommittees to adopt data-driven initiatives that address the specific needs of rural and frontier communities.

**Goal 1: Evidence-Based Practices:** The Rural/Frontier Subcommittee will actively seek research/training opportunities for evidence-based practices applicable to the rural/frontier population.

- Objective 1. Identify topic areas pertinent to Rural/Frontier populations. (Telebehavioral health study, Telebehavioral health supervision training, etc.)
- Objective 2. Locate partners with mutual interests (Evidence-based Practices Subcommittee, etc.)
- Objective 3. Pursue 1-2 research/training opportunities.

**Goal 2: Suicide Prevention and Postvention:** The Rural/Frontier Subcommittee will have at least 2-3 members serve on the State Suicide Prevention Coalition, 988 Coalition, and/or Mobile Crisis Initiatives.

- Objective 1. Provide data and input on rural/frontier populations
- Objective 2. Identify ways to increase awareness of available resources and then engage with those resources
- Objective 3. Collaborate with community partners to address any barriers

**Goal 3: Service Accessibility:** The Rural/Frontier Subcommittee will advocate for at least 3 service accessibility issues by July 31, 2022.

- Objective 1. Advocate to BSRB on reciprocity of licenses across state lines
- Objective 2. Advocate for all disciplines to maintain waiver changes for reimbursement from federal payors HR945/S.286, using data when possible
- Objective 3: Support workforce opportunities for behavioral health professions
Goal 4: Data Integration and Information: The Rural/Frontier Subcommittee will collaborate with other GBHSPC subcommittees by utilizing a technology platform to support data sharing.

- Objective 1. Identify current access/use of platform (Microsoft Teams)
- Objective 2. Identify R/F member to take lead on uploading R/F data to platform.
- Objective 3. Explore opportunities to educate other subcommittee members and members of legislature on rural/frontier needs (R/F Maps PowerPoint, Virtual Coffee, etc.)

Recommendations

The R/F Subcommittee recognizes the need for collaboration regarding identified goals and recommendations. The Subcommittee makes the following recommendations with the understanding that the State and the GBHSPC are instrumental in affecting change to support and enhance the goal of behavioral health equity in Kansas. The Subcommittee understands that in order to affect meaningful change across Kansas, we must partner creatively to achieve measurable change.

1) The R/F Subcommittee recommends championing use of telebehavioral health to address barriers through several mechanisms:

   - Include the client/patient home as a recognized originating site (i.e., allow telebehavioral health billing to the home).
     - Include telephone-only telebehavioral health services in all Kansas geographies that have insufficient broadband access.
   - Advocacy for all behavioral health disciplines to maintain waiver changes for reimbursement from federal payors HR945/S.286.

2) The R/F Subcommittee recommends the inclusion of rural and frontier representatives on all State behavioral health initiatives (e.g., Mental Health Modernization, 988 Coalition, Mobile Crisis Initiatives, etc.). Behavioral health policy and decision-making expectedly occurs in the State’s urban centers; however, more than 80% of the State is classified as rural or frontier. Rural and frontier representatives are imperative to strategic planning and implementation given their unique experiences, expertise, and familiarity with local behavioral health resources and barriers.

3) The R/F Subcommittee recommends the passage of HB 2209 Enacting the psychology interjurisdictional compact to provide for interjurisdictional authorization to practice telepsychology and temporary in-person, face-to-face psychology as a means of increasing access to qualified behavioral health professionals and specialty behavioral health care in Kansas.

4) The R/F Subcommittee recommends the dedication of resources to strengthen the continuum of care in R/F areas by increasing the number of available crisis beds for the non-insured and/or underinsured to fill the gap in the western half of the state.
5) The R/F Subcommittee recommends statewide adoption of KDHE’s Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order.

6) The R/F Subcommittee recommends the adoption of a common software platform (e.g., Microsoft Teams) to assist collaboration and communication with other GBHSPC subcommittees and data integration across groups. Further, the R/F Subcommittee recommends that all subcommittees be trained on the utilization and features of a shared software platform.

Summary
The behavioral health needs of Kansans in Rural and Frontier areas are unique and need to be taken into consideration regarding policy development and fiscal issues. 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 accessing the quality behavioral health care Kansas residents in rural and frontier areas need and deserve. The COVID-19 pandemic has had a global impact of the health and well-being of the general population, and individuals living in rural and frontier areas have fewer resources to mitigate the impact of the pandemic. It is noted that even urban areas have struggled to meet workforce demands to address the increasing need for behavioral health services, which increases competition for available behavioral health professionals. 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.

Although the R/F Subcommittee is not dedicating resources to the adoption of the Rural through Urban Continuum, the Subcommittee continues to go on record in the statewide adoption of this definition that is utilized by the Kansas Department of Health and Environment (KDHE). The Subcommittee is agreeable to partnering with and supporting other organizations/committees that support this goal.

The R/F Subcommittee is glad to announce the incoming FY2022 Chair, Amanda Pfannenstiel, the incoming FY2022 Co-Chair, Monica Kurz, and the incoming FY2022 Secretary, Ian Brown.

Appendix A: Rural and Frontier Subcommittee History
Appendix B: County Membership Representation
Appendix A

Rural and Frontier Subcommittee 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 subcommittees 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 2019.
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. Behavioral Health Provider Shortage
4. Increased Suicide Rates

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!
Appendix B
GBHSPC - Rural & Frontier Subcommittee Members
Organization representation(s), county(ies) served, office location(s), & email

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<th>Organization</th>
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<td>20 counties</td>
<td>Ellis</td>
<td><a href="mailto:david.anderson@hpmhc.com">david.anderson@hpmhc.com</a></td>
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<td>KS Dept. for Aging &amp; Disability Behavioral Health Commission</td>
<td>Jefferson</td>
<td><a href="mailto:Charles.Bartlett@kdads.ks.gov">Charles.Bartlett@kdads.ks.gov</a></td>
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<td>Southwest Guidance Center</td>
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* David Anderson – High Plains Mental Health Center (20 counties) / Behavioral Sciences Regulatory Board Member (KS counties) – Ellis david.anderson@hpmhc.com


+ Leslie Bissell – Southwest Guidance Center (4 counties) – Seward ibissell@swguidance.org

? Mirna Bonilla – K-State Research and Extension, mbonillia@ksu.edu

≡ Diann Brosch – Senior Companion Program/Fort Hays State University (15 counties) – Hodgeman dbvillagenurse@yahoo.com

& Vicki Broz – Compass Behavioral Health (13 counties) / Prevention Subcommittee – Ford ybroz@compassbh.org

Dale Coleman – Ford County Law Enforcement (1 county) – Ford dcoleman@fordcounty.net

Ian Cizerele-Brown – Four County Mental Health Center, ibrown@fourcounty.com

† Ric Dalke – Iroquois Center for Human Development, Inc. (4 counties) / GBHSPC Member – Reno RicDalke@irgcenter.com

Shereen Ellis – Aetna (KS counties) / Service Members, Veterans, and Families / Prevention Subcommittee EllisS3@Aetna.com

& Renee Geyer – Compass Behavioral Health (13 counties) – Scott rgeyer@compassbh.org

? Kylee Harrison – K-State Research and Extension – Wild West District, (3 counties) kharrison@ksu.edu

> Scott Kedrowski – Russell Child Development Center (10 counties) – Finney skedrowski@rcdc4kids.org

≡ Monica Kurtz – KS Suicide Prevention Resource Center (KS counties) / GBHSPC Prevention Subcommittee / Prevention Works Steering Committee / KS Prevention Collaborative Conference Planning Committee monica@kansassuicideprevention.org

≡ Jolene Niernberger – Foster Grandparent & Senior Companion Programs / Fort Hays State University (15 counties) – Ellisjniernbe@fhsu.edu

@ Amanda Pfannenstiel – Saint Francis Ministries (75 counties) / KS Assoc. of Masters in Psychology (KS counties) – Ellis Amanda.Pfannenstiel@st-francis.org

Larry Salmons – KS Association of Master’s in Psychology (KS counties) – Hodgeman senatorsalmans@yahoo.com

[ Debbie Snapp – Catholic Charities of Southwest KS (28 counties) – Homeless & Housing Subcommittee / Problem Gambling Task Force / Southwest KS Homeless Coalition (28 counties) – Ford dsnapp@catholiccharitieswks.org

& Lisa Southern – Compass Behavioral Health (13 counties) – Garden City lsouthern@compassbh.org

$ Nicole Tice – Larned State Hospital (61 counties) – Pawnee nicoletice@lsh.ks.gov

Justin White – KVC Hospitals (KS counties), Sedgwick jrwhite@kvc.org

Shawna Wright – KU Center for Telemedicine & Telehealth / Wright Psychological Services (KS counties) / Aging Subcommittee / KansasState Epidemiological Outcomes Workgroup – Neosho swright6@kumc.edu

& Dorothy Ziesch – Compass Behavioral Health Board Member (13 counties) / Silver Haired Legislator (Hodgeman) – Hodgeman dot.ziesch@yahoo.com

KDADS Behavioral Health Commission/KS counties: with office in Shawnee County

Southwest Guidance Center/4 counties: Haskell, Meade, Seward & Stevens; with office in Liberal

Foster Grandparent & Senior Companion Programs/15 counties: Barton, Ellis, Ford, Gove, Graham, Hodgeman, Logan, Ness, Osborne, Pawnee, Phillips, Rooks, Rush, Russell & Trego; with office in Hays

Compass Behavioral Health/13 counties: Ford, Finney, Gray, Greeley, Grant, Hamilton, Hodgeman, Kearny, Lane, Morton, Scott, Stanton & Wichita; 4 offices/Dodge City, Garden City, Scott City & Ulysses

Ford County Law Enforcement (1 county)–Ford

Four County Mental Health Center (4 counties)– Chautauqua, Cowley, Elk, Montgomery, Wilson

Aetna–KS counties

KU Center for Telemedicine & Telehealth/KS counties

K-State Research and Extension- Wild West District/3 counties: Haskell, Seward, and Stevens

The Iroquois Center for Human Development Inc. /4 counties: Comanche, Clark, Edwards & Kiowa; 5 offices/Ashland, Coolwater, Greensburg, Kinsley & Minneola

Russell Child Development Center/19 counties: Clark, Ford, Finney, Gray, Greeley, Grant, Hamilton, Haskell, Hodgeman, Kearney, Lane, Mead, Morton, Ness, Scott, Seward, Stevens, Stanton & Wichita; 4 offices/Dodge City, Garden City, Liberal & Scott City

KS Suicide Prevention Resource Center/KS counties


Catholic Charities of Southwest Kansas/28 counties: Barber, Barton, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Rush, Scott, Seward, Stafford, Stanton, Stevens, Wichita; 3 offices/Dodge City, Garden City & Great Bend

Larned State Hospital, Psychiatric Services Program/61 counties: Barber, Barton, Butler, Cheyenne, Clark, Comanche, Cowley, Decatur, Dickinson, Edwards, Ellis, Ellsworth, Finney, Ford, Gove, Graham, Grant, Gray, Greeley, Hamilton, Harper, Harvey, Haskell, Hodgeman, Kearny, Kingman, Kiowa,
Lane, Lincoln, Logan, Marion, McPherson, Meade, Morton, Ness, Norton, Osborne, Ottawa, Pawnee, Phillips, Pratt, Rawlins, Reno, Rice, Rooks, Rush, Russell, Saline, Scott, Stafford, Stanton, Stevens, Seward, Sheridan, Sherman, Smith, Sumner, Thomas, Trego, Wallace & Wichita; office/Larned State Hospital

KVC Hospitals- (KS counties)
Appendix C

Executive order – For Behavioral Health Care in Rural and Frontier Counties of Kansas

By the Governor’s Behavioral Health Services Planning Council and their Rural and Frontier Subcommittee.

Assuring access and availability of behavioral health and medical care services for all Kansans from border to border;

WHEREAS, K.S.A. 48-925(b) provides that the Governor may issue orders and proclamations which shall have the force and effect of law under subsection (b) of K.S.A 48-924;

WHEREAS there are 105 Kansas counties, of which 36 counties are Frontier, 32 counties are Rural, 21 counties are Densely settled Rural, 10 counties are Semi-urban and 6 counties are Urban;

WHEREAS the majority of the state is rural and frontier and all counties in Kansas should be adequately represented and considered in regard to policy and decision making;

WHEREAS the adoption of this Frontier through Urban Continuum Definition will allow for the clear and consistent definition of each population density and support the inclusion of all Kansans;

NOW, THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby acknowledge the need for a consistent definition of Frontier, Rural, Densely settled Rural, Semi-urban and Urban using the Kansas Department of Health and Environment (KDHE) Continuum definition designations of:

- **Frontier** counties are designated as less than 6 people per square mile.
- **Rural** counties are designated as 6-19.9 people per square mile.
- **Densely settled Rural** counties are designated as 20-39.9 people per square mile.
- **Semi-urban** counties are designated as 40-149.9 people per square mile.
- **Urban** counties are designated as 150+ people per square mile.

AND, FURTHERMORE, state agencies shall use the designation to guide policy development; program and regulation implementation; to determine policy impact on Frontier, Rural, Densely settled Rural, Semi-urban, and Urban areas; and to address issues and develop strategies that take into account both population and geography.

This document shall be filed with the Secretary of State as Executive Order No. x-x and shall become effective immediately.
Submitted by the GBHPC Rural/Frontier Subcommittee

Nicole Tice, GBHPC Rural/Frontier Subcommittee Chair 11/05/2019

For more information contact:

Shawna Wright, PhD, Associate Director, KU Center for Telemedicine & Telehealth; swright6@kumc.edu; 913-588-2257

Amanda Pfannenstiel LCP, LCAC, Clinical Director- Corporate, Saint Francis Ministries; amanda.pfannenstiel@st-francis.org; 785.259.2031

References


Leadership

Shawna Wright, PhD, LP – FY2021 Chair
Associate Director, KU Center for Telemedicine & Telehealth, University of Kansas Medical Center
Clinical Assistant Professor, Dept. of Psychiatry and Behavioral Sciences, University of Kansas Medical Center
President/CEO, Wright Psychological Services

Amanda Pfannenstiel LCP, LCAC – FY2022 Chair
Clinical Director, Corporate
Saint Francis Ministries
Vision, Mission & brief Subcommittee history

What we know about behavioral health issues and needs in rural & frontier areas

FY2021 Objectives and Progress

FY2022 Goals and Plans
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.

March 24, 2016 Rural/Frontier Charter
Mission

To collaborate through research to statistically understand and promote accessibility and availability of behavioral health services in frontier and rural Kansas counties.
FY2021 Goals and Progress

- Telebehavioral Health Study
- Suicide Prevention
- Service Accessibility
- Data Integration across Subcommittees
Goal 1

Telebehavioral Health Study
Year 1: Consumers/potential consumers of behavioral health and/or substance abuse treatment: survey (electronic) and phone interviews

Year 2: Administrators of Community Mental Health Centers (CMHCs) and Community Health Centers (CHCs): Key informant interviews & follow-up focus groups

Year 2: Behavioral Health Professionals (working in CMHCs, CHCs, addiction clinics, or private practice) Survey, possible follow-up focus groups

Year 2: Primary Care Physicians: and Emergency Department Clinical Staff Survey and key informant interviews

Year 3: Provide educational opportunities to address identified barriers to the effective and ethical use of behavioral and/or substance abuse treatment telehealth in Kansas and increase capacity of healthcare providers to participate in delivery of behavioral health care in Kansas

Year 4: Evaluate changes in behavioral healthcare practices and policies by primary care physicians, emergency department staff, behavioral healthcare providers, substance abuse treatment teams, and administrators of community mental health centers and community health centers. Surveys and interviews

Year 4: Evaluate changes in awareness, attitudes, experiences, and perceived barriers of consumers/potential consumers of behavioral health services related to access to behavioral healthcare in their communities and use of behavioral telehealth options. Surveys and interviews

Year 4: Workgroup charged with developing a report to Governor’s Behavioral Health Services Planning Council with recommendations for policy action
Purpose: Leverage the COVID-induced, high-volume tele-behavioral activity data in Kansas since March 2020 to better understand its effects on behavioral health equity in rural parts of Kansas, including Kansas frontier areas. This work will be the culmination of discussions and planning that have occurred for the last 2 years and will be conducted by telehealth experts at the University of Kansas Medical Center (KUMC).

This study is designed to inform policy makers and behavioral health service organizations about the feasibility of tele-behavioral health services for rural and frontier regions of the state. Findings from the study will be applicable to informing best practice, tele-behavioral health training, and overall quality improvement strategies for meeting the behavioral health care needs of Kansans across the state.
Claims Data
- Source: Kansas Medicaid and Blue Cross/Blue Shield of Kansas
- Description: Cost savings and utilization of services

Organization Data
- Source: Provider and clinic reports
- Description: Treatment trends, telehealth implementation/utilization, workforce productivity, financial impact

Clinical Data
- Source: Partner’s EHRs
- Description: Telebehavioral health utilization, visit type, client/patient volume, cancellations/no-shows

Consumer Feedback
- Source: Organization Surveys
- Description: Best practices, consumer needs/preferences, benefits/barriers of telebehavioral health
There were 719 violent deaths among Kansas residents captured by KSVDRS in 2017. Of these:

- suicides accounted for 73% (n=528) and is the second leading cause of death among age groups 15-24 and 25-44 years old.
- About 78% of suicide deaths were among males, who had 3.6 times the suicide rate of females (32.0 versus 9.0 per 100,000 persons).
- Most suicides (84%) were among non-Hispanic Whites, who had the highest suicide rate (21.5 per 100,000 persons) among all races and ethnicities.
- Young and older adults from 3 age groups (25-34, 35-44, 45-54) had higher suicide rates than the average.
- Among those 18 years and older, for every non-veteran suicide, about 3 veterans died a suicide death.
- Regarding occupations among those 16+ years, males in Farm/Forestry/Fishing had the highest suicide rate, 158.4 per 100,000 persons.
- Females workers in Healthcare Support had twice the suicide rate, 21.0 per 100,000 persons, of the average among female workers.
- About 3 in 10 females (16+yrs) who died by suicide did not have a paid position or were unemployed.
- Frontier counties had higher suicide rate, 27.0 per 100,000 persons, than the KS average.

[https://www.kdheks.gov/idp/KsVDRS.htm](https://www.kdheks.gov/idp/KsVDRS.htm)
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<tr>
<th>KS Leading Causes of Death, 2017</th>
<th>Deaths</th>
<th>Rate***</th>
<th>State Rank*</th>
<th>U.S. Rate**</th>
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<tr>
<td>1. Heart Disease</td>
<td>5,723</td>
<td>157.9</td>
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<td>5,494</td>
<td>157.2</td>
<td>20th</td>
<td>152.5</td>
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<td>3. Chronic Lower Respiratory Disease</td>
<td>1,832</td>
<td>51.7</td>
<td>12th</td>
<td>40.9</td>
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<td>4. Accidents</td>
<td>1,567</td>
<td>49.4</td>
<td>33rd</td>
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<td>5. Stroke</td>
<td>1,355</td>
<td>37.7</td>
<td>23rd</td>
<td>37.6</td>
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<td>6. Alzheimer's disease</td>
<td>894</td>
<td>24.3</td>
<td>39th</td>
<td>31.0</td>
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<tr>
<td>7. Diabetes</td>
<td>674</td>
<td>25.0</td>
<td>8th (tie)</td>
<td>21.5</td>
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<td>8. Suicide</td>
<td>553</td>
<td>19.1</td>
<td>13th (tie)</td>
<td>14.0</td>
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<td>9. Flu/Pneumonia</td>
<td>540</td>
<td>15.0</td>
<td>20th</td>
<td>14.3</td>
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<td>10. Kidney Disease</td>
<td>541</td>
<td>15.0</td>
<td>18th (tie)</td>
<td>13.0</td>
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</table>

https://www.cdc.gov/nchs/pressroom/states/kansas/kansas.htm
Kansas Suicide Trends

Age-adjusted Suicide Mortality Rate per 100,000 population

State: Kansas  Measurement Period: 2017-2019

18.7 deaths/100,000 population

Source: Kansas Department of Health and Environment
Measurement period: 2017-2019
Maintained by: Kansas Department of Health and Environment
Last update: March 2021

Graph Selections
INDICATOR VALUES
- Change over Time
- View by Subgroup
- Race/Ethnicity

Compared to
- US Value (13.8 in 2014-2016)
- Prior Value (18.6)
- Trend
- HP 2020 Target (10.2)
- HP 2030 Target (12.8)

Age-adjusted Suicide Mortality Rate per 100,000 population

https://www.kansanshealthmatters.org/indicators/index/view?indicatorId=1341&localeId=19
R/F Subcommittee efforts

- Included stakeholders/members of the agricultural community
  - Invite Jane Adams to an upcoming meeting for consultation and guidance in this area.
- Reviewed suicide prevention and consumer engagement approaches of community mental health centers and other rural organizations.
  - High Plains Community Mental Health Center’s (HPMHC) *Hope in the Heartland*
  - Four County Mental Health Center’s (FCMHC) radio announcements, which identified and normalized the experience of stress particular to rural communities.
  - Southeast Kansas Mental Health Center (SEKMHC): #StopTheSpike campaign
  - Ford County has invested in Crisis Intervention Teams, and the R/F Subcommittee will consider ways to encourage other rural and frontier communities to adopt this approach.
  - In-coming R/F Subcommittee Chair, Monica Kurz actively shared suicide training opportunities for providers throughout the year for dissemination to rural/frontier partners.
- Active participation in statewide coalitions to represent rural and frontier needs and perspectives related to suicide prevention. Shawna Wright (Chair) and Monica Kurz (Incoming Co-Chair) were members of the Kansas Suicide Prevention Coalition Steering Committee and the Kansas 988 Coalition.
Understanding the Unique Needs of Rural/Frontier Kansas through Maps

Shawna Wright, PhD, LP

Associate Director, KU Center for Telemedicine & Telehealth
Clinical Assistant Professor, Dept. of Psychiatry and Behavioral Sciences, University of Kansas Medical Center
Chair, Rural & Frontier Subcommittee, Kansas Governor’s Behavioral Health Services Planning Council
Kansas Mental Health Professional Shortage Areas 2017

Health Professional Shortage Areas: Mental Health, by County, 2017 - Kansas

• Wrote a letter to the Kansas Behavioral Sciences Regulatory Board in December as the Board considered legislative priorities for the upcoming session. The R/F Subcommittee endorsed the utilization of telesupervision across behavioral health disciplines for professionals requiring supervision for independent licensure.
  - HB 2208, a bill requested by the Board of the BSRB that includes many helpful statutory changes, including expanded authorization of supervision by televideo, changes to required hours, and other significant modifications to requirements for licensees and aspiring licensees.
  - Sponsor an educational learning session on Telesupervision this year at the Association of Community Mental Health Centers of Kansas Annual Conference.
• Supports HB 2209 (Enacting the psychology interjurisdictional compact to provide for interjurisdictional authorization to practice telepsychology and temporary in-person, face-to-face psychology and will continue to advocate for its passage as part of the Subcommittee’s goal to encourage the BSRB to expand reciprocity of behavioral health licenses across state lines.
• Supports all behavioral health disciplines to maintaining COVID-19 waiver changes for reimbursement from federal payors HR945/S286.
• Collaborated with the 2020 Special Committee on Kansas Mental Health Modernization and Reform. Shawna Wright (Chair) worked with the Telehealth workgroup to assist with identifying and organizing State telebehavioral health priorities.
• Supports Stepping UP, a national initiative to reduce the number of people with mental illnesses in jails.
  - Shawna Wright (Chair) was invited to speak on a panel at the postponed 2021 Statewide Behavioral Health Summit. a part of the national initiative from the National Center for State Courts, State Justice Institute, Conference of State Court Administrators, and Conference of Chief Justices on addressing the Court and Community Response to the Issue of Mental Health. Dr. Wright will discuss statewide needs and provide a rural and frontier perspective.
Goal 4

Data Integration across Subcommittees
Actions

- The R/F Subcommittee met with two other subcommittees during the FY2021 year and discussed collaboration and data sharing. The Subcommittee has found through direct meetings and membership liaisons that other subcommittees share similar interests. The R/F Subcommittee will continue to explore opportunities for collaboration and data sharing in the upcoming year with a focus on learning how to leverage the Microsoft Teams platform.

- The R/F Subcommittee has adopted the SMART goals approach to assist with measuring outcomes and directing the Subcommittee efforts.
Noteworthy Efforts FY2020

• Member involvement in local and state initiatives to represent rural and frontier geographies (KSPC, 988 Coalition)
• Hosted a Virtual Legislative Coffee in November 2020
• Partnered with the State Epidemiological Outcome Workgroup
• Cross-collaboration and membership with other subcommittees
• Diversifying membership
FY2022 Goals and Objectives

- Evidence-Based Practices
- Suicide Prevention and Postvention
- Service Accessibility
- Data Integration and Information
FY 2022
Leadership

• **Chair:** Amanda Pfannenstiel
• **Co-Chair:** Monica Kurz
• **Secretary:** Ian Brown
Goal 1

Evidence-Based Practices
Objectives

- Identify topic areas pertinent to Rural/Frontier populations. (Telebehavioral health study, Telebehavioral health supervision training, etc.)
- Locate partners with mutual interests (Evidence-based Practices Subcommittee, etc.)
- Pursue 1-2 research/training opportunities.
Goal 2

Suicide Prevention and Postvention
Objectives

- Provide data and input on rural/frontier populations
- Identify ways to increase awareness of available resources and then engage with those resources
- Collaborate with community partners to address any barriers
Goal 3

Service

Accessibility
Objectives

• Advocate to BSRB on reciprocity of licenses across state lines
• Advocate for all disciplines to maintain waiver changes for reimbursement from federal payors HR945/S.286, using data when possible
• Support workforce opportunities for behavioral health professions
Goal 4

Data Integration and Information
Objectives

- Identify current access/use of platform (Microsoft Teams)
- Identify R/F member to take lead on uploading R/F data to platform.
- Explore opportunities to educate other subcommittee members and members of legislature on rural/frontier needs (R/F Maps PowerPoint, Virtual Coffee, etc.)
The R/F Subcommittee recommends *championing use of telebehavioral health* to address barriers through several mechanisms:

- Include the client/patient home as a recognized originating site (i.e., allow telebehavioral health billing to the home)
  - Include telephone-only telebehavioral health services in all Kansas geographies that have insufficient broadband access.
- Advocacy for all behavioral health disciplines to maintain waiver changes for reimbursement from federal payors HR945/S.286.

The R/F Subcommittee recommends the **inclusion of rural and frontier representatives on all State behavioral health initiatives** (e.g., Mental Health Modernization, 988 Coalition, Mobile Crisis Initiatives, etc.). Behavioral health policy and decision-making expectedly occurs in the State’s urban centers; however, more than 80% of the State is classified as rural or frontier. Rural and frontier representatives are imperative to strategic planning and implementation given their unique experiences, expertise, and familiarity with local behavioral health resources and barriers.

The R/F Subcommittee recommends the **passage of HB 2209 Enacting the psychology interjurisdictional compact to provide for interjurisdictional authorization to practice telepsychology and temporary in-person, face-to-face psychology** as a means of increasing access to qualified behavioral health professionals and specialty behavioral health care in Kansas.

The R/F Subcommittee recommends the **dedication of resources to strengthen the continuum of care in R/F areas by increasing the number of available crisis beds** for the non-insured and/or underinsured to fill the gap in the western half of the state.

The R/F Subcommittee recommends **statewide adoption of KDHE’s Frontier through Urban Continuum definition** via partnerships with GBHSPC and other subcommittees by Executive Order.

The R/F Subcommittee recommends the **adoption of a common software platform (e.g., Microsoft Teams) to assist collaboration and communication with other GBHSPC subcommittees** and data integration across groups. Further, the R/F Subcommittee recommends that all subcommittees be trained on the utilization and features of a shared software platform.
Thank You:

The Rural and Frontier Subcommittee thanks you for your continued support and dedication to the citizens of Kansas.
Questions?

For more information contact:

Amanda Pfannenstiel, Chair
amanda.pfannenstiel@st-francis.org
785-259-2031

Monica Kurz, Co-Chair
monica@ksphq.org
785-841-9900
Governor’s Behavioral Health Services Planning Council

Service Members, Veterans and their Families (SMVF)

Subcommittee Annual Report

FY2020
Introduction

Per the Veterans Data Collection site in year 2020 Kansas population is comprised of 8.1% veterans, 176,444 adults. Out of those veterans between 20.5 and 22.9% have housing issues and 6.7% live in poverty. And there is a total of 1.6 million female veterans in the United States.

For over a decade, researchers have been calling for communities to increase their capacity to support military-connected community members (Bowen, Orthner, Martin and Mancini, 2001). With almost 70% of military families living off-installation, they are increasingly reliant on their local communities for support and resources that meet their needs. 2019 year’s survey findings suggest that more than showing appreciation of service and demonstrating understanding of military life, it’s military family cultural competence – respondents’ perceptions of community awareness, community appreciation, community understanding, community support, and community respect of military-connected families – that is the foundation upon which military families’ sense of belonging to their local civilian community may be based. Military family resilience is, in large part, contingent on an effective, culturally competent support network within the community (Unger, 2019).

National Guard and Reserve families feel local civilian support agencies are not effective in addressing their needs. Many National Guard and Reserve family respondents live more than an hour from a military installation, making local resources important. However, nearly half feel their local civilian support agencies are not effective in addressing their needs. In addition to increasing resources in the community, in open-ended responses, Reserve family respondents also indicate improving Tricare/VA/health care as another way their local civilian communities could best support them. Many local agencies do not have employees that can bill Tricare due to not having a licensure that Tricare supports. Due to this information the SMVF subcommittee has made a strong effort to include representation from the National Guard and Reserves.

Military and veteran family respondents who perceive that civilians in their local communities have greater military family lifestyle competence feel a greater sense of belonging to that community. Forty-seven percent of military family respondents feel their local civilian community has limited military family lifestyle cultural competency (MFLCC). MFLCC includes community awareness, appreciation, understanding, support, and respect of military families and their service. Similarly, 40% of military family respondents do not feel a sense of belonging to their local civilian community.

Suicide is one of the most urgent health problems facing America today, and it is the focus of the DoD Office of the Inspector General’s Top Management Challenges for Fiscal Year (FY) 2020. While the World Health Organization estimates that 2% of individuals in developed countries have had suicidal thoughts or attempts in a 12-month time period, among this year’s military family respondents, 4% of spouses and 6% of service members indicated that they had seriously considered attempting suicide in the past year. Similarly, 4% of those respondents who were spouses of veterans and 9% of veteran respondents reported the same.
Although there is a need for greater MFLCC among individual community members, private and nonprofit organizations that provide programming or resources in the local civilian community can prioritize cultural competence to effectively serve military-connected community members, focusing on MFLCC as a preventative capacity-building effort instead of a response to issues. Organizations, corporations, and philanthropies can begin by understanding the role formal and informal support networks play in the lives of military families. While informal networks are the more common means of support, culturally competent formal networks organized by private or nonprofit programs or resources, schools, religious organizations, and civic groups can set the conditions for these crucial supports to develop. Cultural competence is a well-established cornerstone to effective support; extending this same expectation to military and veteran family experiences sets the conditions for their success and a stronger community overall. Kansas must bill a stronger support system for our SMVF population.

History

The SMVF Subcommittee 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 SMVF issues. The sub-committee has continued to identify resources and address the broader behavioral health care needs of veterans, service members and their families. It has also work toward increased collaboration among providers in the community behavioral health system the VA and other provider networks that focus on veterans, service members and their families. The sub-committee continues to help build a stronger integrated care safety net for our SMVF population.

In January 2020 the subcommittee voted in new Chair, Vice Chair and Secretary. Bylaws were written under the new leadership, small break off groups formed to complete FY2019-20 goals if possible, and new goals developed April 2020. New leadership and members continue to work to recruit members from across the state that have knowledge of the SMVF population, knowledge of resources and willingness to work to create a broader safety net across the state of Kansas and mitigate care gaps. Currently the SMVF subcommittee is comprised of a Chairperson, Vice chairperson, Secretary and 19 members.

In May 2021 Andrea stepped down as liaison to accept another position with the State. The position was filled August 2021. Andrea did an outstanding job as liaison and helped to move goals forward

Laura Brake accepted the position of CIT/Veterans Program Coordinator in August 2021. She has met with the Chair and Co-Chair at this time and shows a willingness to learn and help continue the forward motion of the SMVF state subcommittee.

Mission

To ensure that servicemembers, veterans 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.

Membership

Subcommittee members now represent a variety of individuals, agencies and community partners who work with the SMVF population, active service members, have veteran status, and/or a family member of a service member/veteran. Examples include but are not limited to representation from Community Mental Health Centers, Veterans Services, Child Welfare Agencies, Managed Care Organizations (MCOs), University Partners, Law Enforcement, Veteran Service Organizations both local and State representation, Community College Partners, Air Force, Army, Marines, Navy, female and male veterans, Housing Authority, Data collections, NAMI, National Guard, and Air Guard.

A membership list with area of the state they represent is provided.
# FY20-21 GBHSPC Veterans Subcommittee Membership

**Chair:** Shereen Ellis, Aetna Better Health of Kansas  
**Vice Chair:** Kathy Shepard, Four County Mental Health

## Full Membership

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<thead>
<tr>
<th>NAME</th>
<th>ORGANIZATION</th>
<th>Area of Representation</th>
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<tr>
<td>Andrea Clark</td>
<td>KDADS</td>
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<td>Charles Bartlett</td>
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<td>Kathy Shepard</td>
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<td>Five Counties in South East Kansas</td>
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<td>Janell Stang</td>
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<td>Christopher Bowers</td>
<td>Washburn University &amp; Commander VFW</td>
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<td>Shari LaGrange-Aulich</td>
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<td>Lori Bishop</td>
<td>Executive Director Flint Hills Volunteer Center/RSVP</td>
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<td>Crystal Dalmasso</td>
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<td>Angela Gabel</td>
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<td>Jason Hess</td>
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<td>Wes Cole</td>
<td>GBHSPC</td>
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<td>Senator (Retired)</td>
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<td>Joshua Klamm</td>
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<td>Timothy Marlar</td>
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<td>Tony Nutz</td>
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<td>Lisa Galindo</td>
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<tr>
<td>Mary McBride</td>
<td>National Guard Association of KS</td>
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FY20-21 Goals and progress

- Create a website called, LiveConnectedKS.org/com.net
  - Goal has been met
- Request all schools to ask if the student has a parent or guardian that is currently or has served, establish where the data is being stored and how to access and give information to community partners including but not limited to CMHCs, LHD, and MCOs
  - Subcommittee was able to locate school data from the Education Department
  - Subcommittee identified if CMHCs, LHD or other agencies want the data they can contact the Education Department directly to receive reports from each school that does complete the questionnaire
  - Encouraged Education Department to stress importance of collecting data on SMVF population at enrollment
  - Goal is completed to the best of this subcommittee’s ability
- Have PsycArmor training on KStrain.org, make aware to and all CMHCs, LHD, PD, Sheriff Departments, hospitals, FQHCs, EMS, MCOs, Hotlines and any other later identified organizations that the training is there and free of charge.
  - In order to track trainings consistently, it has been decided to not put trainings on KStrain.org and use the PsycArmor platform only.
  - Letter has been developed and given to KDADS for approval and distribution
    - Letter not needed as the State has purchased a data package to identify who has taken trainings and which Community Mental Health Centers are Certified in Veterans Culturally Competency
  - Identified courses that train providers in military culture and recommended
    - completed
  - SMVF subcommittee request funding of $12,000 to be paid to PsyArmor in order to create a data base that will track who has taken what courses and which agencies have SMVF Cultural Competence status
    - completed
- Identify all upcoming events, summits, conferences, and trainings being offered in 2020 and put on an events calendar.
  - This will be on going and kept on the LiveConnected Website
  - Subcommittee continues to increase the diversity of membership to obtain additional knowledge in all SMVF areas of life.
• Identify Mental Health 1st Aid Trainers and train at least 20% of the VSO, VFW, and Legion members across the state
  o Letter developed and given to KDADS for approval and distribution
    ▪ Put on hold by the State
    ▪ Subcommittee expanded training to QPR as well as MHFA
  o Funding request of $4,500 to cover training cost to train 100 members of a VSO or VFW across Kansas
    ▪ SMVF subcommittee was given a $5000.00 donation. The subcommittee allocated the funds to training VSO’s in two areas of the state. The 1st training will take place September 24th in Erie, KS hosted by Post 102.

• Create a LiveConnected campaign
  o Complete the PSA with Governor Kelly (TBA)
    ▪ On hold due to COVID restrictions

Report completed by
Shereen Ellis, LSCSW
Chair of the SMVF subcommittee
Governor’s
Behavioral Health
Services Planning Council

Service Members, Veterans
and their Families (SMVF)
Subcommittee Annual Report
FY20-21
SMVF Subcommittee Leaders

- Shereen Ellis, Chair
  Aetna Better Health Of Kansas
  Parent to a Kansas Army National Guard Veteran and Legion Commander

- Kathy Shepard, Co Chair
  Four County Mental Health

- Janell Stang, Secretary
  Community Engagement Institute, WSU

- Laura Brake, Liaison
  KDADS
Overview

**Mission:**
To ensure that servicemembers, veterans 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.
FY20 Year in Review

- Live Connect Kansas website was funded and is now live
  - www.Liveconnectedks.org

- Live Connect Facebook page has been created and is live
  https://www.facebook.com/LiveConnectedKS

- New members were recruited to join the SMVF subcommittee that have strong leadership roles in Kansas as well as strong ties to the SMVF population including Air Guard, National Guard, Housing Authority and Community Colleges

- Kansas was Nationally recognized by CVS/Aetna for the work being done to improve veterans' services

- SMVF subcommittee has representation at the Prevention Subcommittee and the Rural and Frontier Subcommittee

- Andrea Clark stepped down as liaison in June 2021

- Laura Brake was hired August 2021 as the new liaison

- SMVF subcommittee has identified and set up the 1st VSO Veterans Suicide Prevention Training
Review FY20 Goals

- Created a website called, LiveConnectedKS.org
- Ensure that all schools are asking at enrollment if the student has a parent or guardian that is currently or has served. Establish where the data will be stored and how to access and disseminate information to community partners including but not limited to CMHCs, LHD, and MCOs
- Place PsychArmor training on KStrain.org, make aware to and advertise to all CMHCs, LHD, PD, Sheriff Departments, hospitals, FQHCs, EMS, MCOs, Hotlines and any other later identified organizations that the training is there and free of charge.
- Identify all upcoming events, summits, conferences and trainings being offered in 2020 and put on an events calendar.
- Identify Mental Health 1st Aid Trainers and train at least 20% of the VSO, VFW and Legion members across the state
Resource Requests for Action

- SMVF subcommittee request funding of $12,000 continue to be paid to PsychArmor in order to fund data base that will track who has taken what courses and which agencies have SMVF Cultural Competence status.

- Funding request of $5,000 to continue training members of a VSO or VFW across Kansas in Mental Health 1st Aid or QPR.
<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura Brake</td>
<td>KDADS</td>
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<tr>
<td>Charles Bartlett</td>
<td>KDADS</td>
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<tr>
<td>Gary Henault</td>
<td>KDADS</td>
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<tr>
<td>Chairperson Shereen Ellis</td>
<td>Aetna Better Health of Kansas</td>
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<td>Co-Chairperson Kathy Shepard</td>
<td>Four County Mental Health</td>
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<td>Secretary Janell Stang</td>
<td>WSU Community Engagement Institute</td>
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<td>Angela Gabel</td>
<td>Kansas Air Guard</td>
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<tr>
<td>Shari LaGrange-Aulich</td>
<td>SAVE Farm &amp; Konza Prairie Community Health Center-BH</td>
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<tr>
<td>Lori Bishop</td>
<td>Executive Director Flint Hills Volunteer Center/RSVP</td>
</tr>
<tr>
<td>Crystal Dalmasso</td>
<td>DCCCA</td>
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<tr>
<td>Aaron Estabrook</td>
<td>Manhattan Housing Authority City Commissioner</td>
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<td>Jason Hess</td>
<td>SACK</td>
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<td>Wes Cole</td>
<td>GBHSPC</td>
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<td>Larry Salmans</td>
<td>Senator (Retired)</td>
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<td>Stephanie Davis</td>
<td>Topeka VA</td>
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<td>NAME</td>
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<tr>
<td>Steve Christenberry</td>
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<td>Angela Gabel</td>
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<td>Timothy Marlar</td>
<td>VSO State Representative</td>
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<td>Christopher Bowers</td>
<td>Washburn University &amp; VFW Commander (Topeka)</td>
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<td>Lisa Chaney</td>
<td>Greenbush</td>
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<td>Tony Nutz</td>
<td>NAMI</td>
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<td>Joshua Klamm</td>
<td>Topeka Police Department</td>
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<td>Lisa Galindo</td>
<td>Kansas National Guard</td>
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<tr>
<td>Mary McBride</td>
<td>National Guard Association of KS</td>
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<tr>
<td>Alan Parsons</td>
<td>Independence Community College Veteran Success Program</td>
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<tr>
<td>Cassandra Hornbaker</td>
<td>Robert J. Dole VA Medical Center</td>
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</tbody>
</table>
Questions ??

A Salute to all our Men and Women in Uniform
Thank You for Your Service!

THANK YOU !!
Honoring our veterans: An interview with Shereen Ellis, Chair Kansas SMVF

- By Babani, Stacy COMMUNICATIONS CONSULTANT

Pictured (l-r) at the Governor’s signing of the Kansas Veterans Suicide Prevention Proclamation: Sergeant Clam, CIT officer, Topeka, KS; Matt McGuire, Veterans and CIT coordinator, KDADS; Christopher Ellis, Commander post 102, Erie, KS; Shereen Ellis, ABHKS Emergency Services System of Care Administrator and current Chair, Kansas SMVF Subcommittee; Major Pitts, US Army

Imagine you’re a veteran, recently returning to rural Kansas from deployment in Afghanistan. You’ve been away from your home for so long that your family, friends and community now seem very foreign to you. You’re struggling to make connections to your old life, while finding purpose and meaning in your new life. You’re not sleeping, and you feel like a stranger in your own home. Who do you reach out to? Where do you go for help?

According to the Kansas Prevention Collaborative, over 220,000 Kansans identify as veterans, with nearly 173,000 of them identifying as having served during wartime. Additionally, since 2005, there has been a statistically significant increasing trend in the rate of suicide of Kansas Veterans ages 18-34.

Despite the staggering statistics, the State of Kansas is working to increase veteran services. This includes improving veteran health care, encouraging cultural competency with community partners, providing greater employment resources, and preventing suicide, as well as addressing other social
determinants of health (SDoH) and quality of living issues through the State’s Governor’s Challenge to Prevent Suicide among Service Members, Veterans, and Their Families (SMVF).

“Communication around mental and behavioral health issues has traditionally been closed off in the veteran population,” said Shereen Ellis, Aetna Better Health of Kansas (ABHKS) Emergency Services System of Care Administrator, and the State’s SMVF’s current Chair. “Plugging veterans into veteran specific and additional community resources allows for connections that they may not have been able to establish with civilians. Additionally, communicating with veterans, to create a culture change around cultural competency, can help identify and support those who are at heightened risk for suicide or SDoH issues.

In honor of Veterans Day, Medicaid Segment Communications (MSC) conducted an interview with Shereen, who spoke about her work with ABHKS and SMVF, and about her late son, Christopher Ellis, a veteran, who sadly passed away in a motorcycle accident this past summer. Christopher spent 5 years in Afghanistan and 11 years in the National Guard. He also was the youngest Legion Commander in Kansas, Post 102 in Erie, KS, and served on both the Governor’s Veterans Suicide Prevention Committee and the SMVF. Below are excerpts from that conversation:

MSC: Tell us about your role with ABHKS?

Shereen: I am on the Systems of Care team. I look at crisis and emergency services, systemically identifying needed resources to help members improve their physical and mental health so that they may live and stay in the least restrictive environment.

MSC: Tell us about the role you play on the SMVF? Are you a veteran?

Shereen: I am not a veteran, but I am the granddaughter, niece, wife and mother of veterans. I was the lead for the Family Readiness Group when my son Christopher was deployed. Due to a lack of services for our veteran’s in Kansas, that population became a focal point in recent years. As a representative of Aetna, I have worked on the Governor’s Veteran’s Suicide Challenge and now the Service Members, Veterans and Families (SMVF) Subcommittee. I am the current Chair and work with the Kansas Department of Aging (KDADS), which oversees behavioral health and managed care organizations. Reduction in veteran suicide is an important matter for current Kansas Governor Laura Kelly. I helped write the bylaws for the SMVF Subcommittee and have guided our current members to think strategically about and be mindful of our veterans as we work towards our goals.

MSC: Tell us why historically there have been so few services for veterans in the State of Kansas, and why the shift to expand those services?

Shereen: When the SMVF Subcommittee originally started there was not much movement to create change or improve services. Traditionally local community partners, such as the Community Mental Health Offices’ (CMHCS), have not wanted to serve the SMVF population due to lack of funding. The expectation was to serve the SMVF population at a local Veterans Administration (VA) facility. However, there are only three main VA facilities in Kansas, with less than a handful of smaller offices scattered across the State, and none in the Western part. These facilities have months of waiting lists for both mental health and primary care services. Some veterans have to drive over six hours to see a provider at a local VA. This was the practice until Governor Kelly came into office and Kansas became part of a Federal pilot program called the Governor’s Veteran’s Suicide Prevention Challenge.
Commissioner Andrew Brown, head of the KDADS Behavioral Health Services (BHS) Commission, reached out to me asking if I knew of any veterans that would like to serve on the committee. I spoke to my son Christopher and his wife, both are veterans. My son joined the committee, and later Commissioner Brown asked me to join due to my vast knowledge of the Kansas Community Mental Health System and connections across the State, including some from my long history working in mental health and new connections that have resulted from my current position with Aetna. Aetna has strong partnerships with the State in several areas, so it was natural for the State to look to Aetna for help solving veterans’ issues.

MSC: What key projects/resources is SMVF working on?

Shereen: Our current projects include:

- LiveConnectedKS
- SAVE Farm
- PsycArmor
- Veteran’s suicide prevention and awareness PSA

LiveConnectedKS

Under the approval and funding of KDADS, the SMVF Subcommittee is working with a State-contracted agency to develop the LiveConnectedKS website as a one-stop resource shop for the SMVF population. In addition to veteran resources, the site will include links to educational workshops, conferences and events. Christopher coined the name LiveConnectedKS.

Through Christopher’s involvement with the State and SMVF Subcommittee, he wrote a Federal Bill to place a suicide prevention peer support officer at VFW and Legion posts throughout Kansas. The Bill is currently moving through the State’s approval process. If it passes, it will move on to the national level. Kansas Governor Kelly is 100% behind this Bill. Due to all of his efforts to help improve services and reduce veteran suicide rates, the State is going to dedicate the LiveConnectedKS site to him, as well as fly the State flag over the capitol in honor of his birthday on November 21.

SAVE Farm

The SMVF Subcommittee recommended that KDADS create a partnership with the non-profit SAVE (ServiceMember Agricultural Vocation Education) Farm program. With State approved funding, SAVE, which teaches veterans how to farm and utilize the best of the land’s ability, will be working to expand its services to over 200 veterans and their families annually.

The SAVE program links veterans with local farmers who do not have future generations to take over the farming business and who do not want to sell to a large corporation. The program pays the farmer to help train the veteran and pays the veteran to learn the ins and outs of farming, including how to manage finance and understand best practices to yield the most profitable crops and herds. For example, about five years ago, SAVE taught a veteran how to start and run a honey farm. Now the veteran is making a substantial profit.

PsycArmor

The SMVF Subcommittee recommended that KDADS partner with the organization PsycArmor to provide important veteran mental health educational services and to be able to collect data on
veteran suicide prevention awareness, etc. PsycArmor is an online platform that provides the SMVF population with the opportunity to complete behavioral health and suicide prevention trainings. The trainings range from simple 15-minutes to longer, in-depth sessions presented by therapists, counselors and doctors. KDADS agreed to fund the data collection portion of the initiative and SMVF Subcommittee is working with PsycArmor on the parameters of the data they are collecting and sharing with the State.

Veteran’s suicide prevention and awareness (PSA)

The SMVF Subcommittee recommended and Governor Kelly has agreed to film a PSA on veterans’ suicide prevention and awareness for broadcast across the State of Kansas. Writing is complete and production will begin once the COVID-19 pandemic subsides.

Want to learn more about the SMVF or getting involved in veteran affairs in your state, email Shereen Ellis.
### 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.
State Medicaid Agency

<table>
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<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
</table>
| Dr. Jane Adams     | Family Members of Individuals in Recovery (to include family members of adults with SMI) |                                                                  | 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 Ave. Topeka KS, 66603  
PH: 785-368-6391  
FX: 785-296-0256                  | charles.bartlett@ks.gov                                      |
| Robbin Cole       | Providers                                                | Pawnee Mental Health Services                                   | 2500 Meade Circle Manhattan KS, 66502          | robbin.cole@pawnee.org        |
| Wes Cole          | Others (Advocates who are not State employees or providers) |                                                                  | 937 Walnut Osawatomie KS, 66064  
PH: 913-755-3655                       | scole@micoks.net                                              |
| Hope Cooper       | State Employees                                          | Kansas Department of Corrections                                  | 714 SW Jackson, Ste. 300 Topeka KS, 66603  
PH: 785-296-4213                       | Hope.Cooper@ks.gov                                           |
| Ric Dalke         | Providers                                                | Iroquois Center for Human Development, Inc.                     | 2505 Lundman Dr Hutchinson KS, 66502          | riccarold27@gmail.com         |
| Daniel Decker     | State Employees                                          | Kansas Rehabilitation Services                                   | 555 S. Kansas Ave. Topeka KS, 66612  
PH: 785-368-7143                       | daniel.decker@ks.gov                                         |
| Al Dorsey         | Others (Advocates who are not State employees or providers) |                                                                  |                                                 | alfonzodorsey67@gmail.com    |
| Kristin Feeback   | Family Members of Individuals in Recovery (to include family members of adults with SMI) |                                                                  | 14031 Birch Street Overland Park KS, 66224  
PH: 620-212-5082                        | kfeeback@comcare1.org                                        |
| Victor Fitz       | Persons in recovery from or providing treatment for or advocating for SUD services |                                                                  | 2547 Aberdeen Lane Salina KS, 67401  
PH: 316-390-3406                       | victor@sackansas.org                                       |
<p>| Ashley Grill      | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health) |                                                                  |                                                 | <a href="mailto:ashleygrill@yahoo.com">ashleygrill@yahoo.com</a>        |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organization/Agency</th>
<th>Address/Contact Details</th>
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</thead>
<tbody>
<tr>
<td>Brenda Groves</td>
<td>Parents of children with SED/SUD</td>
<td></td>
<td><a href="mailto:newhorizonsdementia@gmail.com">newhorizonsdementia@gmail.com</a></td>
</tr>
<tr>
<td>Shane Hudson</td>
<td>Providers</td>
<td>Central Kansas Foundation</td>
<td><a href="mailto:shudson@ckfaddictiontreatment.org">shudson@ckfaddictiontreatment.org</a></td>
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<td>Clara Kientz</td>
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<td></td>
<td><a href="mailto:cvkientz@gmail.com">cvkientz@gmail.com</a></td>
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<td>Christina Mayer</td>
<td>Providers</td>
<td>DCCCA</td>
<td><a href="mailto:cmayer@dcca.org">cmayer@dcca.org</a></td>
</tr>
<tr>
<td>Ericka Nickelson</td>
<td>Parents of children with SED/SUD</td>
<td></td>
<td><a href="mailto:erika.jean.gillespie@gmail.com">erika.jean.gillespie@gmail.com</a></td>
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<tr>
<td>Stephanie Salisbury</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td><a href="mailto:stephaniesalisbury@outlook.com">stephaniesalisbury@outlook.com</a></td>
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<tr>
<td>Fran Seymour-Hunter</td>
<td>State Employees</td>
<td>Kansas Dept of Health and Environment</td>
<td><a href="mailto:Fran.Seymour-Hunter@ks.gov">Fran.Seymour-Hunter@ks.gov</a></td>
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<tr>
<td>Rodney Shepherd</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td></td>
<td><a href="mailto:rodney@cornerhouseinc.org">rodney@cornerhouseinc.org</a></td>
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<tr>
<td>Brenda Soto</td>
<td>State Employees</td>
<td>KS Department for Children and Family Services</td>
<td><a href="mailto:Brenda.Soto@ks.gov">Brenda.Soto@ks.gov</a></td>
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<td>Guy Steier</td>
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<td><a href="mailto:judges@12d.org">judges@12d.org</a></td>
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<tr>
<td>Dr. Mark Thompson</td>
<td>State Employees</td>
<td>KS Department of Education</td>
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<tr>
<td>Dr. Sherrie Vaughn</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>NAMI Kansas</td>
<td><a href="mailto:sbaugh@namikansas.org">sbaugh@namikansas.org</a></td>
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<tr>
<td>Jancinta Warrington</td>
<td>Representatives from Federally Recognized Tribes</td>
<td></td>
<td><a href="mailto:jancinta.warrington@ks.gov">jancinta.warrington@ks.gov</a></td>
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</tbody>
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*Council members should be listed only once by type of membership and Agency/organization represented.*

**Footnotes:**

There have been some delays from the Governor’s office in making appointments to the Council.

State Education Agency - Dr. Mark Thompson  
State Vocational Rehabilitation Agency - Daniel Decker  
State Criminal Justice Agency - Hope Cooper  
State Housing Agency (currently vacant) - Al Dorsey moved to an Ex Officio role  
State Social Services Agency - Brenda Soto (Department for Children and Families)  
State Health (MH) Agency - Charles Bartlett  
State Medicaid Agency - Fran Seymour-Hunter  

Mike Dixon (Ex-Officio Member)
## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2023  
End Year: 2024

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<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
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<td>have received, mental health services)</td>
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<td>adults with SMI)</td>
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<td>Parents of children with SED/SUD*</td>
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<td>Vacancies (Individuals and Family Members)</td>
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<td>Others (Advocates who are not State employees or providers)</td>
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<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td>66.67%</td>
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<td>State Employees</td>
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<td>Providers</td>
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<td>Vacancies</td>
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<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>33.33%</td>
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<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
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* 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:**

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025