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:

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

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 limted 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 (Juszczak, 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.

	U.S. Census 2019 Estimates	Mental Health Estimates*	SUD Estimates**
Kansas Population	2,913,314	144,344	13,201
By Race			
White (non-Hispanic)	75.4%	76.74%	75.65%
African American	6.1%	8.18%	13.33%
American Indian/Alaska Native	1.2%	2.64%	2.77%
Asian	3.2%	.92%	.53%
Native Hawaiian/Other Pacific Islander	.10%	.22%	.43%
Other (other races, two or more races, unknown, etc.)***	3.1%	11.32%	7.29%
Ethnicity			
Hispanic or Latino	12.2%	6.78%	11.89%
By Gender			
Female	50.2%	52.72%	39.02%
Male	49.8%	46.61%	60.98%

* 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.