Governor's Behavioral Health Services Planning Council
Kansas Citizens' Committee on Alcohol and Other Drug Abuse (KCC)
Annual Report, September 2022

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
Dana Schwartz	Prevention
Daniel Warren, Past Chair	Treatment
Jessica Eckels	Treatment
Sara Jackson, Chair	Treatment
DJ Gering	Public Health
Brad Sloan	Citizens
Al Dorsey	Citizens
Kelsey Ellis	Citizens
Jamie Felton	Citizens
Ngoc Vuong	Citizens
Lindsie Ford	Citizens
Victor Fitz	GBHSPC Liaison
Stacy Connor	Higher Education
Shawna Allen	Mental Health
Tina Abney	Child Protective Services
Megan Bradshaw	Juvenile Justice Authority
Todd Hixson	Law Enforcement
Libertee Thompson, recorder	Discretionary
Diana Marsh	KDADS/KCC Support Staff

Executive Summary

2021 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 second 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 2021, 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.

2022 Report Preview

In addition to the unresolved recommendations above, we highlight the top six priority areas that have come to our attention during the 2021-2022 Fiscal Year:

1) Including identified **Sobering Units** to all current and future Crisis Stabilization Centers (p3-6)
2) Helping people who use drugs to experience fewer complications, including overdose, hepatitis C, and HIV, by supporting **Harm Reduction Practices** (p6-7)
3) Requiring all medical and nursing school curriculum include **SUD courses or practical training** (p7-8)
4) Increasing the workforce pipeline while also addressing regulatory barriers to treatment that have arisen due to the **Workforce Crisis** (p8-9)
5) Collecting data and changing committee representation to address **Substance Use Health Disparities and Equity** (p9-11)
6) Addressing Barriers and Strategies for **Rural and Frontier Behavioral Health Care** (11-12)

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 invite a member of the Kansas Department of Agriculture/Office of Primary Care and Rural Health to speak to the KCC to provide more information regarding mental health and substance use in the rural areas. We will also gain information about health disparities in the behavioral health domain, including the homeless, which is essential in identifying and advocating for populations that are poorly served by our current treatment options. We will continue to diversify membership in the subcommittee to ensure that both needs and resources are considered both within and alongside the behavioral health system. In **conclusion,** we appreciate your commitment to Kansas and we hope you find this report useful.

Detailed Report

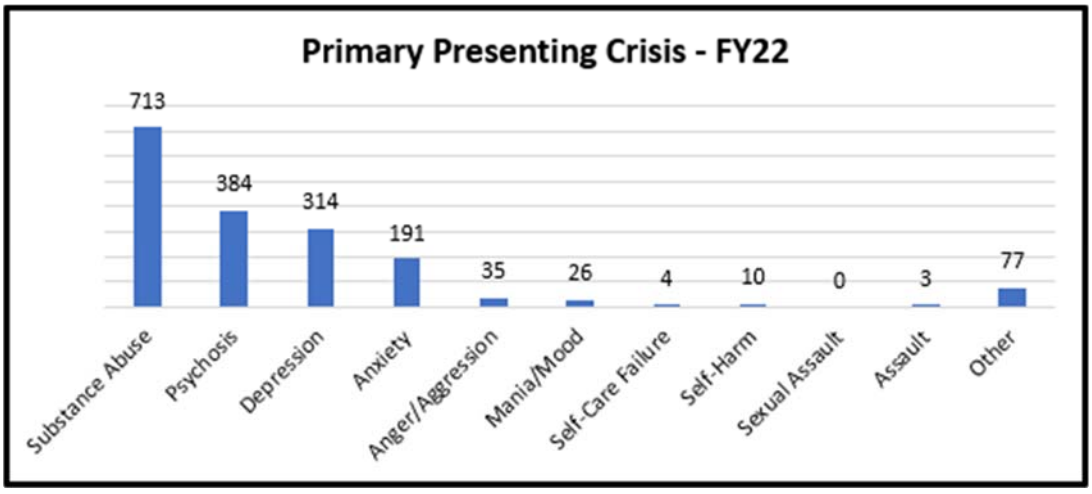
Sobering Units within Crisis Stabilization Centers

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 additional CSCs throughout the State (focusing on those behavioral health deserts) to also include separate sobering units to serve the non-insured and underinsured.

Sobering units focus on relieving the criminal justice system and the emergency medical system by diverting intoxicated adults or those intoxicated on other drugs from jail and emergency departments. A person under the influence can suffer numerous harms, including injury from falls, exposure to the elements or victimization. Typically, the intoxicated person is brought to jail or the ED until they have sobered up sufficiently to no longer be considered a danger to themselves. Sobering Units are not intended to be treatment facilities or rehabilitation for alcohol use disorders, though they are considered one of the ways individuals can be referred to treatment (i.e. detoxification, residential treatment) if desired.

One of the current crisis stabilization centers, RSI, provides a 24-hour assessment and triage for individuals experiencing a mental health crisis through their Crisis observation, Short-term Crisis Stabilization and Sobering Beds. RSI serves as a resource for Wyandotte, Johnson, Douglas, and Leavenworth County residents. The services are offered in partnership with Wyandot Behavioral Health Network, Johnson County Mental Health Center, Heartland Regional Alcohol and Drug Center (RADAC) and Kansas Department of Aging and Disability (KDADS).

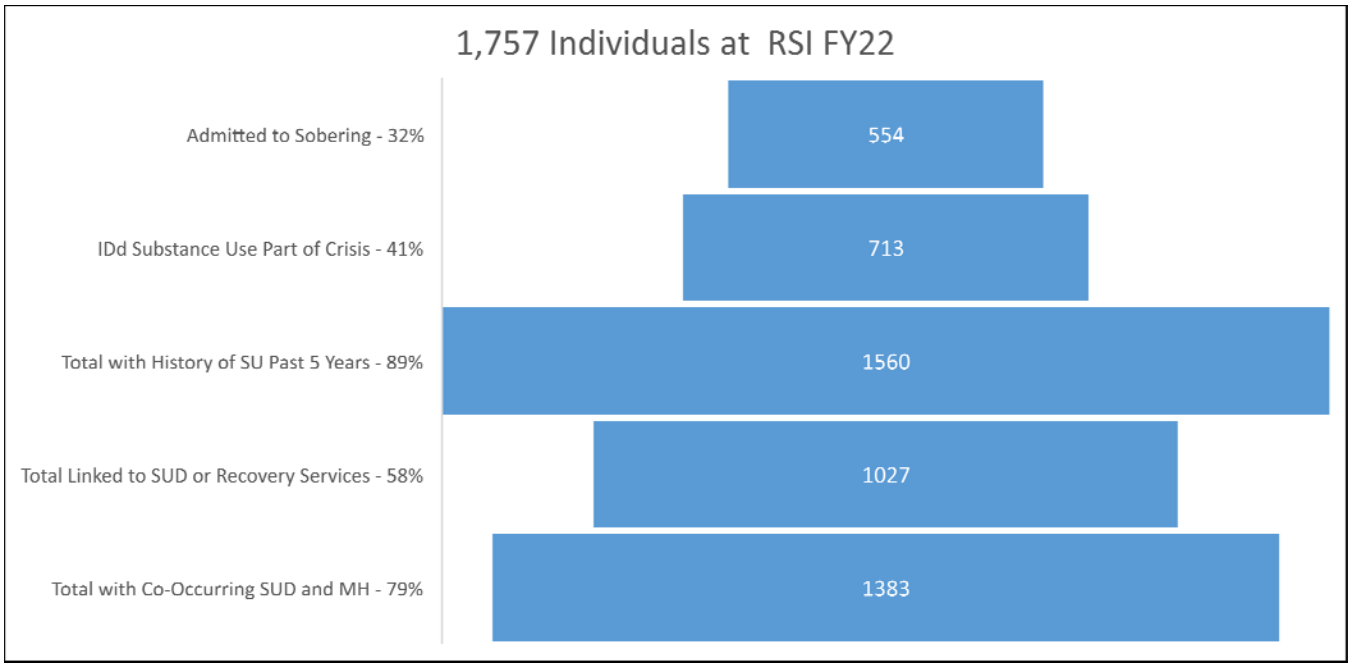
A report from Fiscal Year 2022 shows the following:



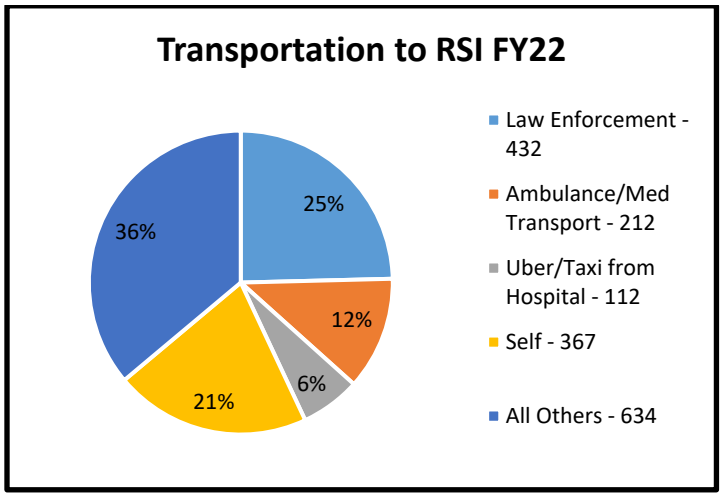
Forty-one percent (713) indicated substance use was their primary presenting crisis to RSI; the highest of all presenting crisis in FY 2022.

Thirty-two percent (554) of the individuals that presented to RSI were specifically admitted to the Sobering Unit. The primary purpose was short term (less than 24 hours) sobering of adults who did not need hospital-based care. The Sobering Unit at RSI offered a safe place for clients to wait for the effects of alcohol or drug intoxication to wane before discharging or transitioning to Observation or Stabilization.

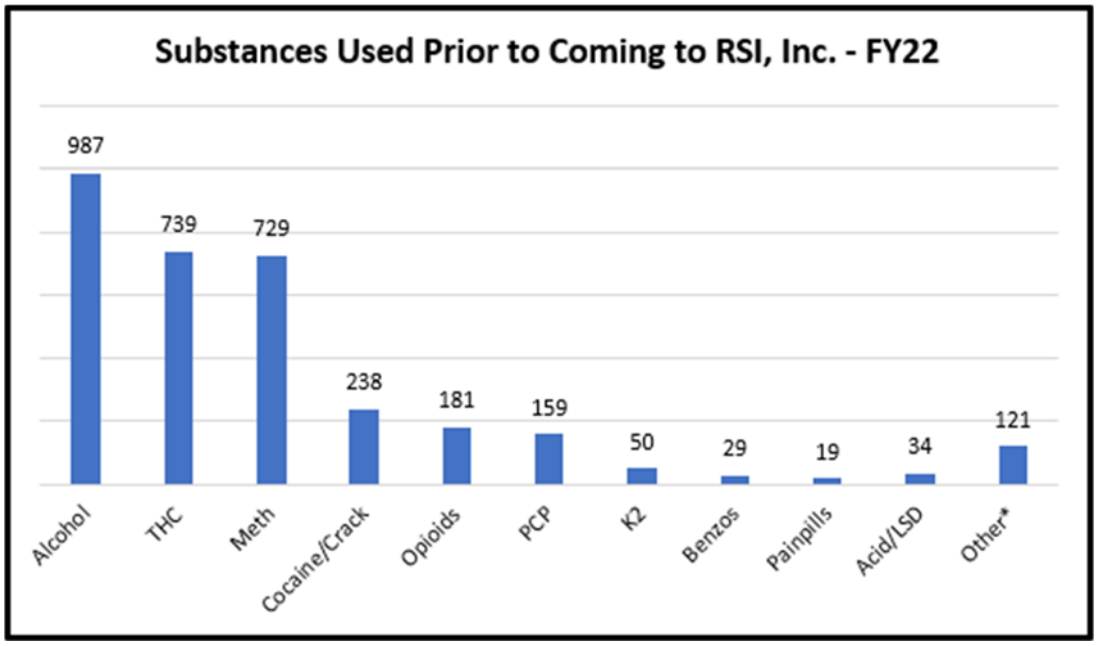
In addition, fifty-eight percent of the individuals that accessed RSI were linked to substance use assessments, direct referrals to detox and/or residential treatment or provided additional recovery services and resources. These numbers illustrate the importance of having a separate unit designated for those individuals presenting with substance use intoxication.



Sobering units can accept individuals referred from ambulances, law enforcement, emergency departments, clinics, other community programs, or via self-referral. The chart below identifies the various methods of transportation to RSI. This is a demonstration of how the criminal justice system and the emergency medical systems in the counties served, were relieved by diverting intoxicated adults from jail and emergency departments.



As drug use trends across Kansas change, it is important for the Sobering Units to incorporate the ability to stabilize adults intoxicated on other drugs as well as alcohol. Substances used prior to coming to RSI include the following:



Sobering Units, as part of CRC's, serve a critical role in individual client engagement and care, identifying the broad needs of a population at risk of alcohol- or drug-related harms and providing advocacy for high-quality and integrated care and services within the system. 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. We also recommend Kansas 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.

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 users to view overdoses in near real time in 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. The ODMAP in Kansas is populated directly from the Kansas Board of EMS. EMS recently began sharing their data with ODMAP, thanks to the efforts of HIDTA and KBI. 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 encourage communities to utilize the data and spread awareness of the benefits from ODMAP.

Training for Medical professionals in Substance Use Disorders (SUD)

SUD Courses or Practical Training for medical professionals: With medical professionals in Kansas encountering patients dealing with opioid and other use disorders, it is critical to ensure they have access to training for substance use disorder (SUD) issues. Currently, only 8% of American medical schools offer a separate, required course on addiction medicine and 36% have an elective course; minimal or no professional education on substance use disorders is available for other health professionals.

Recommendations:

- We propose medical and nursing school curriculum include courses or practical training on SUD's as a requirement. This gap is addressed at the national level by way of HHS/SAMHSA grant funding for universities to train graduate-level students in the medical field on treatment of opioid use disorders, including the prescription of medications for OUDs (HHS Press Office, August, 2022).
- Federal and State policies should require or incentivize medical, nursing, dental, pharmacy and other clinical professional schools to provide mandatory courses to properly equip young healthcare professionals to address substance misuse and related health consequences.
- Similarly, associations of clinical professionals should continue to provide continuing education and training courses for those already in practice.

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:

- **Peer Support Professionals**: We are encouraged by the State supporting the essential role of people with lived experience by expanding training and certification to include more frequent/standard training opportunities for KCPM certification. We also recommend the State would benefit by adding continuing education requirements and re-certification/review for peers in the field, like CEU requirements for licensed staff. We recommend further enhancing support by allowing peer individual and group services to be considered as a primary and reimbursable service across all payors.

- Substance use is an ongoing chronic, relapsing disorder. Peers can fill a gap that often exists with individuals with SUD by focusing on recovery first and by helping to rebuild and redefine the individual's community and life. Peers offer valuable guidance by sharing their own experiences, strength and hope and helping those that suffer from Substance Use Disorders build skills and identify new positive social environments. Currently in the State of Kansas, billable peer services are limited to people in treatment programs and must be provided by the participating treatment program. Our recommendation is to "decouple" these services providing the opportunity to complete peer service work before, during and after the SUD treatment continuum of care. This will give individuals in recovery a supportive non-judgmental relationship that may be lacking in their lives and the opportunity to continue to create strategies towards living fulfilling lives for themselves.

- 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 tele-medicine 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.

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 2021 Estimates	Mental Health Estimates*	SUD Estimates**
Kansas Population	2,934,582	144,344	13,201
By Race			
White (non-Hispanic)	76.74%	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 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. Data should include, not only the existing data that is currently collected for the SABG, but other data that might not be collected through agencies/programs supporting the homeless and the rural communities. This 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 that is reflective of those impacted and those identified in this report. A more diverse membership would allow the KCC to facilitate a better understanding of the effects of racial disparities across Kansas, while we are building capacity around data collection. Having diverse voices from the community and individuals with lived experience will provide insight into barriers that exist to limit access to services.
- Explore the Kansas Department of Agriculture/Office of Primary Care Health Board with the intent of sharing substance use date collected by this agency.
- Commission a committee to review state-wide public health disparities in connection to mental health and substance use disorder services.

Rural and Frontier Behavioral Health Care Barriers

Research has demonstrated the problems of Rural and Frontier Areas of Kansas are unique and distinct from those of more urban parts of Kansas. Rural areas are (areas characterized by low population density, limited economic base, cultural diversity, high level of poverty, limited access to cities) have serious behavioral health problems (alcohol and substance use, depression, and suicide) equal to or greater than urban areas. Equally troubling is the insufficient range of services and volume available to treat behavioral health concerns. Not only do the rural areas have shortages of behavioral health professionals, but the turnover rate for service providers is high and providers that remain often express feelings of isolation from other behavioral health professionals. Other barriers in Rural and Frontier Areas of Kansas include:

Stigma and Cultural Issues: Those that reside in the Rural and Frontier areas often are faced with a social stigma of behavioral health concerns. There may be a mistrust of health professionals in the rural and frontier areas due to a limited number of culturally competent service providers. Also, there is a tendency to focus on addressing treatment of illness versus early intervention and prevention.

Structural and Organizational Issues: Those served in the Rural and Frontier areas often have a lack of public transportation and difficulties and distances accessing care even when transportation is available. The inadequate infrastructure for telehealth connections is also a concern. In addition, there often is a lack of peer support services and consumer led groups.

Access and Workforce: There are excessive wait times available for those served in the Rural and Frontier areas in addition to a lack of trained staff members/providers/clinicians and significant distances to service providers. In addition, there is often a lack of incentives for professionals to work in rural areas.

Recommendations:

- There are rural and frontier models that work and deliver culturally competent care. These programs, no matter where they are located or how they are organized, share a common theme – the need to make better use of limited resources in communities. The bottom line is to identify a way to promote the models that have proven outcomes, can be considered "best practices" and can be replicated across a variety of rural and frontier communities.

- Funding policies need to include in-home, in-school or other non-hospital settings (CRC's). Rural-proven strategies should allow providers to work through a combination of licensed and case-management staff. Recognition of and commitment to rural and frontier is vital to the formation of "rural friendly" policies in Kansas.

- The Rural and Frontier could benefit from the significant expansion and use of telehealth. Technologies continue to make telehealth more affordable and usable. It is a greatly underused resource for behavioral health services in rural and frontier areas.

- Continue to 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 marginalized communities throughout Kansas, including race, ethnicity, sexual orientation, disability and access to housing. This information could assist in targeting program delivery to specific state and local needs and encourage collaborative partnerships.

- Utilize the Kansas Department of Agriculture/Office of Primary Care and Rural Health to capture information regarding mental health and substance use in the rural and frontier areas.