Substance Abuse and Mental Health Services Administration

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# Substance Abuse Prevention and Synar Site Visit Report

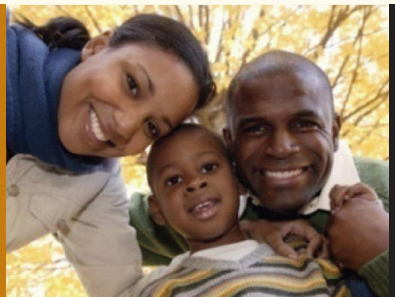
# Kansas

## Federal Fiscal Year 2014

March 19–21, 2014

Strategic Prevention Framework Advancement & Support

Center for Substance Abuse Prevention



DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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# Contents

# Site Visit Summary

The Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321) enacted by Congress in July 1992 authorized the Substance Abuse Prevention and Treatment Block Grant (SABG) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's Center for Substance Abuse Prevention (CSAP) is charged with providing policy and program guidance to help states[1] use and report on the 20-percent primary prevention set-aside of the SABG. CSAP is committed to providing support that can advance Single State Authority (SSA) and state substance abuse prevention systems. Toward this end, CSAP conducts site visits to 1) understand the SSA's progress in developing and sustaining strong, state prevention infrastructure; and 2) identify areas in which the state may need CSAP technical assistance (TA) to develop or enhance its prevention system and Synar program.

This report is a summary of the most recent CSAP site visit for Kansas, which was conducted on March 19–21, 2014. The site visit involved discussions with state participants about the state's capacity for using performance management processes to achieve sustainable improvements in the substance abuse indicators and outcomes measured by SAMHSA's National Outcome Measures (NOMs) as well as other state-specific goals and objectives.

This Site Visit Report contains key findings related to state prevention system strengths, challenges, and "unique and notable practices." The Site Visit Report also contains recommendations intended to help Kansas enhance its ability to implement the five steps of the Strategic Prevention Framework (SPF), or an equivalent planning process, to achieve population-level reductions in the incidence and prevalence of substance abuse and related problems and consequences. These findings and recommendations are discussed throughout the report and summarized in appendix A of this report.

## Background

The Site Visit Report is intended to provide an accurate and objective analysis of the state prevention system and Synar program at the time of the visit; however, the report also may refer to findings from previous site visit reports to document changes and trends in state system development over time. These findings are relevant to issues discussed during CSAP's 2014 SABG site visit and might be addressed through TA from SAMHSA.

The previous CSAP site visit, conducted in 2009, found a number of strengths in the Kansas prevention system, including staff that had a passionate commitment to prevention, the fact that SSA allocates more than the required 20 percent of the SABG for prevention, and a funding mechanism that supported prevention infrastructure with taxes and license fees from substance abuse treatment.

Challenges noted by CSAP team in 2009 included that Kansas had adopted few of the advances that had occurred in the prevention field since the original implementation of its current prevention system 22 years ago. The state reported that it relies on historical processes and funding based on Regional Prevention Centers (RPCs) that were heavily dependent on education, information dissemination, and alternative activities. The site visit team suggested that the state's ability to reduce substance abuse and related problems would benefit from using data-driven priorities and targeted outcomes to direct resources and activities across the lifespan.

The site visit team also recommended that Kansas assess existing resources (human, financial, and other), capacity, and substance abuse across the lifespan, and develop a plan for prevention system development and substance abuse prevention with: 1) targeted goals for priority substance abuse and system issues; 2) targeted objectives for related intervening variables; 3) measurable outcomes; 4) an implementation plan with clearly defined roles, responsibilities, and timelines; 5) an evaluation plan sufficient for monitoring progress toward outcomes and providing information for midcourse adjustments as needed; and 6) a sustainability plan to identify existing and needed state, local, and federal funding sources for achieving desired outcomes into the future.

The 2009 site visit team also recommended that the SSA strengthen local capacity to address cultural competence at all levels of its prevention system, and identify and implement a more formal process for helping coalitions to serve as a state grassroots advocacy network to advance prevention and help achieve desired population-level outcomes.

[1]In this document, the word state refers to the 50 states and the District of Columbia and to the Territories, Pacific jurisdictions, and Native American tribe that receive SABG funds.

# Prevention System Elements

## *Prevention System Organization*

### SSA Prevention System

The Kansas Department for Aging and Disability Services (KDADS) serves as the SSA in Kansas, with responsibilities for preventing and treating alcohol and other drug addiction and administering mental health programs and programs for the elderly and people with physical and developmental disabilities. The Community Services and Programs Commission (CSPC) within KDADS houses Behavioral Health Services (BHS) and three other units. BHS is charged with oversight and administration of the SABG and Community Mental Health Services Block Grant as well as problem gambling and suicide prevention funds. BHS is divided into three units: Programs and Policy, Prevention and Problem Gambling, and Quality Assurance. During the site visit, BHS staff noted that the Prevention and Problem Gambling unit was intentionally created as an independent single unit but works closely with the other two BHS units.

The Director of BHS reports to the Commissioner of CSPC, who reports to the Secretary of KDADS. The Secretary of KDADS reports to the Governor and is one of 11 department secretaries who—with the Commissioner of Juvenile Justice Authority, the Adjutant General of the National Guard, and the Lt. Governor—make up the Kansas State Cabinet.

KDADS, CSPC, and BHS are all relatively new state agencies that resulted from major state reorganizations in 2012 and 2013. At the time of the 2009 CSAP site visit, the SSA was Addiction and Prevention Services within Kansas Behavioral Health and Disability Services (KBHDS), both of which were housed within the Kansas Department of Social and Rehabilitation Services. In 2012, KBHDS was moved to the newly formed KDADS and CSPC, with mental health, addiction, and all prevention services integrated into the newly formed BHS. In October 2013, BHS went through a reorganization to further integrate programs into a continuum of care across addictions and mental health services. This change aligned prevention and substance use disorder services with the problem gambling and suicide prevention programs.

BHS staff noted the agency has embraced this reorganization as an opportunity to strategically integrate problem gambling, suicide prevention, and mental health promotion into the behavioral health prevention infrastructure and leverage resources across multiple systems. As part of the integration, the Governor's Mental Health Planning Council was renamed and restructured as the Governor's Behavioral Health Planning Council (Governor's Planning Council). BHS staff noted that findings from a task force appointed by the Governor to examine behavioral health issues identified a need to focus on prevention and promotion and to improve the state's ability to engage communities in mental health planning.

The Prevention and Problem Gambling Program Manager (Prevention Manager) serves as Kansas' National Prevention Network (NPN) representative. According to state organizational charts (see appendix E), the Prevention Manager reports to the Director of BHS and is the only filled full-time staff position within the division that is designated for substance abuse prevention. (At the time of the site visit there was a vacant problem gambling services position.) The Prevention Manager also serves as the point of contact for Synar, mental health promotion and suicide prevention, and other prevention programs administered by BHS. A CSAP Prevention Fellow assists the Prevention Manager with internal projects and duties as assigned.

The Southeast Kansas Education Service Center/Greenbush funds two consultant positions that are supervised by the Prevention Manager and housed within BHS: a Program Consultant who assists with SABG programming, guidance for the RPCs, and the Synar Program; and a Training and Technical Assistance (T/TA) Consultant. Collectively, the Prevention Manager and consultants provide management and oversight to all aspects of the SABG prevention set-aside and SAMHSA discretionary grants, and partner with other BHS staff to integrate prevention with other behavioral health services.

In addition to the contractual staff, BHS has several additional contracts for statewide services to support prevention. These include a contract with the Southeast Kansas Education Service Center/Greenbush for assessment and data, the University of Kansas Work Group for Community Health and Development (KU Work Group) for evaluation, Wichita State University to develop and support Youth Leadership in Kansas (YLinK) sites, and the Kansas Family Partnership (KFP) for drug awareness and education initiatives, workforce development, and logistical support.

Kansas received a Strategic Prevention Framework State Incentive Grant (SPF-SIG) from SAMHSA in 2006 that expired in 2012, and KDADS was awarded a 3-year Partnership for Success II (PFS) in 2012. BHS administers the PFS to fund evidence-based prevention strategies to prevent underage drinking and binge drinking.

BHS also administers the Kansas Substance Abuse Profile Team (KSAPT), which serves as the state's epidemiological outcomes workgroup (SEOW). The KSAPT/SEOW was

formed in 2006 with a broad membership of state agencies and tasked with conducting an epidemiological study of the consumption patterns and consequences associated with alcohol, tobacco, and other drug (ATOD) use in Kansas. Current KSAPT members include KDADS, the KU Work Group, Southeast Kansas Education Service Center/Greenbush, KFP, and RPC staff. Kansas' 2014 Behavioral Health Assessment and Plan notes that BHS is examining ways to use KSAPT to help the state assess prevention and treatment needs.

The CSAP team noted that KDADS also has strategic relationships with the Kansas Departments of Revenue (KDOR), Health and Environment (KDHE), and Education (KDOE), each of which are key stakeholders in substance abuse prevention efforts. KDOR conducts Synar inspections and some merchant education activities, maintains Kansas' tobacco license list, and documents current Synar inspection protocols and data collection procedures. KDHE partners with KDADS to support the state's youth tobacco access control efforts, serves as the lead agency for the development of a comprehensive state tobacco prevention plan, and provides vital statistic information that is used in the state's epidemiological profile for prevention. KDOE has subgranted funding to KDADS to administer Safe and Supportive Schools (S3) funding to reduce and prevent underage alcohol use, binge drinking, and/or marijuana use by high school youth. BHS prevention staff noted that this grant program, which ends in September 2014, marks the SSA's first such partnership with KDOE.

As of January 1, 2013, all Medicaid-funded services were moved under KanCare, which is administered by KDADS and KDHE. KDADS administers the Medicaid waiver programs for disability services, mental health, and substance abuse, and operates the state hospitals and institutions, while KDHE maintains financial management and contract oversight of the program. The state is in the process of connecting KanCare with the online health insurance exchange required by the Affordable Care Act. It was not yet clear at the time of the site visit how or whether substance abuse prevention services will be included in KanCare.

## SSA Approach to Prevention

BHS has adopted CSAP's definition of prevention: "Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles." The definition in BHS guidance further notes, "The goal of substance abuse prevention is the fostering of a climate in which (a) alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal; (b) prescription and over-the-counter drugs are used only for the purposes for which they were intended; (c) other abusable substances (e.g., aerosols) are used only for their intended purposes; and (d) illegal drugs and tobacco are not used at all."

In accordance with the definition, primary prevention is defined as strategies designed to prevent substance abuse before any signs of a problem appear and to decrease the number of new cases of a disorder or illness.

Both KDADS' and BHS's visions and missions include a focus on healthy communities. According to its website, KDADS' mission envisions communities that empower older adults and persons with disabilities to make choices about their lives, while its mission is to "foster an environment that promotes security, dignity, and independence for all Kansans." BHS's vision focuses on community support for prevention and recovery throughout the lifespan, and its mission is "Partnering to promote prevention, treatment, and recovery to ensure Kansans with behavior health needs live safe, healthy, successful, and self-determined lives in their communities."

### POTENTIAL ENHANCEMENTS

- *BHS is encouraged to finalize and operationalize the draft charter and establish a prevention subcommittee within the Governor's Behavioral Health Planning Council that can facilitate multiagency input and coordination for prevention efforts.*
- *BHS's ability to maximize SABG funds and achieve outcomes could be significantly enhanced by clearer guidance to help subrecipients better understand what constitutes evidence of effectiveness for prevention strategies.*
- *BHS's ability to support community efforts to reduce substance abuse could be enhanced by the development of accessible and interactive venues (e.g., listservs, collaborative internet-based sites, state coalition association) to help coalitions connect, network, peer mentor one another, and coordinate efforts.*

The Kansas Planning Framework serves as a theoretical and operational framework to guide prevention services targeting the healthy development of children and youth. According to a presentation by BHS staff and consultants during the site visit, the framework links prevention research and practical application and is based on the Communities That Care (CTC) model of risk and protective factors and SAMHSA's Strategic Prevention Framework (SPF). BHS prevention staff and consultants noted that Kansas is very invested in the CTC framework. They also noted that while BHS is working also to integrate the SPF into Kansas' current prevention system, there is significantly more work to do to accomplish this at the community level.

BHS defines evidence-based strategies as those interventions that are:

> "…included in a federal list or registry of evidence-based intervention strategies or reported in a peer-reviewed journal to have produced positive results or documented as effective based on all three of the following guidelines: The intervention is based on a solid theory or theoretical perspective that has validated research; and the intervention is supported by a documented body of knowledge — a converging of empirical evidence of effectiveness — generated from similar or related interventions that indicate effectiveness; and the intervention is judged by a consensus of informed experts to be effective based on their combined knowledge of theory and their research and practice experience. 'Informed experts' may include key community leaders and elders or other respected leaders within indigenous cultures."

Although BHS staff noted that inclusion on the National Registry of Evidence-based Programs and Practices (NREPP) alone is not sufficient criteria for documenting evidence of effectiveness, subrecipients present at the site visit did not appear to have a clear understanding of that and cited using listing on NREPP as evidence of effectiveness in and of itself, even though the NREPP website states that it is not appropriate for use in this way since the site includes all reviewed strategies, including those with very low quality of research ratings. BHS's ability to maximize SABG funds and achieve outcomes could be enhanced by clearer guidance to help subrecipients better understand what constitutes evidence of effectiveness for prevention strategies.

## Multiagency/State Prevention System

In 2013, the Governor's Mental Health Services Planning Council was changed by statute to the Governor's Behavioral Health Services Planning Council (Governor's Planning Council) and charged with the following responsibilities:

- Advocate for adults with serious mental illness, children with a severe emotional disturbance, persons affected by substance use disorders (SUDs), and other individuals with mental illness or emotional problems
- Advise and consult with the Secretary of KDADS with respect to the policies governing the management and operation of all state psychiatric hospitals and facilities, community-based mental health services, and substance use disorder treatment and prevention services
- Monitor, review, and evaluate, not less than once a year, the allocation and adequacy of mental health services and substance use disorders within the state, and
- Other planning, reviewing, and evaluating of mental health and substance use disorder services in this state, as may be requested by the Secretary of KDADS or prescribed by law.

As part of its transition, new positions were added to the council. These consist of two substance abuse treatment providers, one prevention professional, one family member of a person experiencing SUD, two persons in long-term recovery from SUD, and one person who serves as a peer mentor for persons experiencing SUD. Other agencies represented on the council include the Juvenile Justice Authority, Rehabilitation Services, KDOE, Commerce and Housing, and Adult Corrections.

The Governor's Planning Council currently has 10 to 11 subcommittees on a variety of subjects (e.g. employment, housing, children's issues, suicide prevention) that work from charters with established goals and objectives. BHS staff noted that because the council does not currently have a prevention subcommittee, BHS has developed a draft charter to establish one that could also serve as an overarching guidance council for prevention. The CSAP site visit team encouraged BHS to finalize the draft charter so that a multiagency venue for prevention leadership, coordination, and input could be operationalized.

The Kansas Citizens Committee on Alcohol and Other Drug Abuse (KCC)—that was originally established by state statute to serve as advisory committee to the Secretary of KDADS on SUDs and prevention—now also

functions as a subcommittee of the Governor's Planning Council, and the chair of KCC serves as a member of the executive council. KCC comprises 24 members appointed by the Secretary of KDADS that include health care providers; representatives from KDHE, KDADS, and KDOR; community coalitions; community colleges; and substance abuse providers. Although KCC's mission includes advocating for financial and human resources to promote availability and accessibility of services for addiction prevention and treatment for all Kansans, its primary focus appears to be substance abuse treatment.

The Division of Alcoholic Beverage Control (ABC), which is located within KDOR, is responsible for enforcing the alcohol laws of Kansas. ABC sets requirements and issues state licenses and permits to sell alcohol. It also inspects licensed premises and enforces restrictions on underage purchasing and drinking of alcohol. The ABC offers training to law enforcement agents in enforcing underage drinking laws, and enables local agencies to request assistance with enforcement through a web-based request system. The ABC also oversees tobacco licensing and taxation compliance.

Kansas' prescription drug monitoring system (PDMS)—Kansas Tracking and Reporting of Controlled Substances System (K-TRACS)—is credited with keeping the rate of drug overdose deaths in Kansas one of the lowest in the nation. PDMSs allow doctors and pharmacists to log on to a secure website to review the prescription histories of patients. PDMSs can also send notices to providers and pharmacists when potential prescription abuse is detected. In Kansas, all licensed pharmacies that fill patient prescriptions are required by law to use K-TRACS, and many hospitals voluntarily use it as well. State law requires daily reporting, unlike many states, which only require weekly updates.

Kansas is one of the few states that shares data across state lines, and the program also plans to connect to LACIE (the Lewis and Clark Information Exchange), one of the two networks that make up Kansas' statewide health information exchange. In October 2013, K-TRACS implemented a software upgrade to make it more effective in detecting persons who were attempting to evade detection by the system and get multiple prescriptions filled beyond the prescribed dosage by using multiple addresses, different birth dates, and different spellings of their name. The upgrade was part of the software pilot program launched in 2013 by the National Association of Boards of Pharmacy. K-TRACS was established using federal grant funding, but the state pharmacy board appears to be prepared to fill the gap as federal funding ends.

The Midwest High Intensity Drug Trafficking Area (HIDTA) includes the following Kansas Counties: Cherokee, Crawford, Johnson, Labette, Leavenworth, Saline, Seward, Barton, Sedgwick, Finney, Shawnee, Miami, Franklin, and Wyandotte. The Midwest HIDTA focuses on stopping drug trafficking by providing operational support to the Kansas Bureau of Investigation, the Topeka Regional Drug Task Force, the Kansas Intelligence and Information Exchange, the Garden City Drug Enforcement Agency (DEA) Task Force, the Southeast Kansas DEA Task Force, the Wichita DEA Task Force, and the Kansas City/Overland Park DEA Task Force in Kansas and northwest Missouri.

The Kansas Association of Addictions Professionals (KAAP) is a statewide trade association. While it appears to be primarily focused on substance abuse treatment, in 2010–2011 KAAP revised its mission statement to include prevention: "Serving members with advocacy and support to achieve excellence in addiction treatment and prevention." KAAP sponsors trainings, conferences, job postings, networking, a website, and advocacy.

There are four federally recognized tribes in Kansas, all of which are located in the northeastern part of the state: the Iowa Tribe of Kansas and Nebraska, the Kickapoo Tribe of Kansas, the Prairie Band Potawatomi Nation, and the Sac and Fox Nation of Missouri in Kansas and Nebraska. The Iowa Tribe of Kansas and Nebraska is located along the Missouri River on an approximately 2,100-acre reservation straddling the borders of northeast Kansas and southeast Nebraska. According to the 2000 U.S. Census, tribal membership was 2,258 people.

The Kickapoo Tribe of Kansas has approximately 150,000 acres of land in Horton, Kansas and operates the Golden Eagle Casino, which is the largest employer in the county. The tribe provides an array of social services, including a youth substance abuse program, a court system with a drug court counselor, and a police commission. The tribe reported a total membership of 1,653 as of December 2006.

The Prairie Band Potawatomi Nation headquarters are in Mayetta, Kansas, near Topeka. The Potawatomi have a gaming commission, and issue wholesale and retail tobacco licenses. The social services department has an alcohol and drug program, and the court system has a wellness court component. Tribal code makes intoxication in a public or private place an offense punishable by a $150 fine. In addition, tribal law makes it unlawful to possess, use, sell, or distribute any alcoholic beverage

near specified tribal grounds. There are nearly 5,000 enrolled members of the Prairie Band Potawatomi Nation.

The Sac and Fox Nation's tribal headquarters are in Hiawatha, Kansas. Tribal laws make it unlawful to be under the influence of intoxicating beverage, drugs, or other controlled substances, to any degree, in a public or private place where one unreasonably disturbs another person. It is also unlawful to buy, sell, serve, give away, consume, furnish, or possess any beverage or product containing alcohol for ingestion by human beings—or to appear or be found in a place where alcoholic beverages are sold and/or consumed—without written authority of the Tribal Legislative Body. Tribal law also prohibits the purchase, possession, or use of any tobacco product if under the age of 18 years; or the sale or provision of a tobacco product for a person under the age of 18. Cigarette vending machines are also prohibited.

The Kansas Native American Affairs Office was opened in the summer 2011, with the primary purpose of serving as the Governor's liaison to ensure that Native American concerns and needs are addressed in state policymaking decisions. The office coordinates intergovernmental communications between tribal governments, the Governor's Office, and other state agencies.

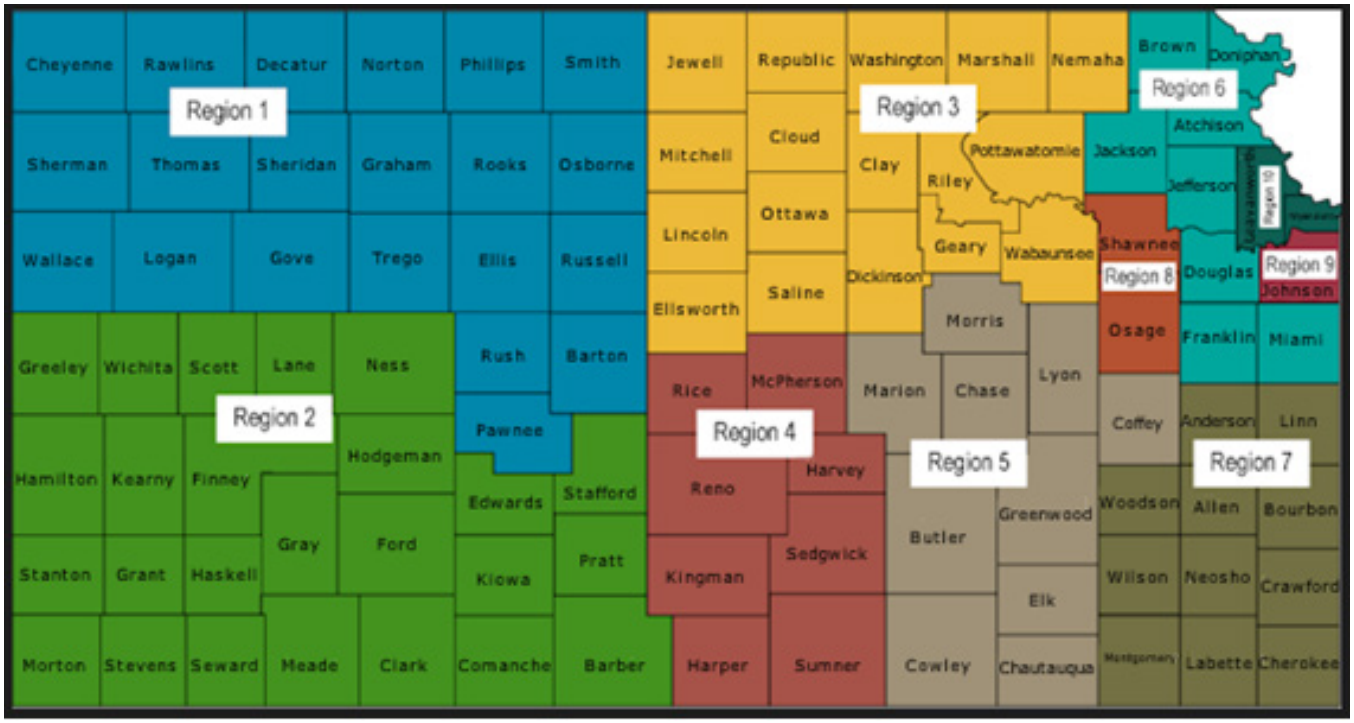
Other statewide racial/ethnic organizations within Kansas include the Coalition of Hispanic Organizations (a collaborative group of Latino organizations in the greater Kansas City metro area in Kansas and Missouri), the Kansas Hispanic and Latino American Affairs Commission, and the Kansas African American Affairs Commission.

## Substate Prevention System

Kansas' substate prevention system has historically consisted of a network of RPCs charged with providing T/TA and some prevention services to all 105 Kansas counties. As illustrated in the map below, there were 10 RPCs at the time of the 2014 site visit. The CSAP team noted that the 22 full-time equivalents (FTEs) in staffing for the 10 RPCs appears to be a very high prevention-staffing ratio per capita as compared to other states.

Kansas' substate infrastructure also includes a number of community coalitions, including 6 PFS grantees, 16 S3 grantees, 14 former SPF-SIG grantees, and 19 to 20 newly identified "Target" communities that have been selected to receive a small amount of funding through a new BHS initiative. One of the PFS grantees is the Prairie Band Potawatomi Tribe, which marks the first time that the Kansas SSA has directly funded a tribal prevention initiative. BHS staff also noted that former SPF-SIG grantees are often asked by BHS to mentor other communities.

Kansas also has two Drug Free Communities (DFC) grantees. The DFC Support Program is a highly competitive federal grant program that provides funding to community-based coalitions working to prevent youth substance use. The CSAP team noted that the number of



Kansas coalitions that have been successful in competing for DFC funding has dropped significantly since 2008, when there were 10 DFC grantees.

The CSAP team also noted that Kansas does not have a formal venue for community coalitions to network, peer mentor each other, and coordinate prevention initiatives—even though they may be working to achieve common outcomes. While KFP maintains a coalition registry and sends out information electronically, there is no interactive listserv or other mechanism to help coalitions communicate directly with each other. Coalition leaders participating in the site visit described efforts to try to connect and collaborate with like-minded coalitions both in and out of the state.

BHS's ability to support community efforts to reduce substance abuse could be enhanced by the development of accessible and interactive venues (e.g., listservs, collaborative internet-based sites, state coalition association) to help coalitions connect, network, peer mentor one another, and coordinate efforts. Toward that end, BHS might benefit from reviewing strategies other states have used to see which, if any, might work well for Kansas.

## *Contextual Conditions and State Substance Abuse Trends*

### Contextual Conditions

**Demographics.** According to the 2010 U.S. Census, Kansas' population of approximately 2,858,118 residents is predominately White (83.8 percent), followed by Black/African American (5.9 percent), two or more races (3.0 percent), Asian (2.4 percent), American Indian and Alaska Native (1.0 percent) , and Native Hawaiian and Other Pacific Islander (0.1 percent). Hispanics and Latinos of any race made up 10.5 percent of the population.

Although U.S. Census data indicate that the median age of Kansas' population is only slightly older than the national average (36.0 years compared to 35.3 years), the proportion of Kansas' population that is over age 60 is growing. The U.S. Census Bureau estimates that nearly 25 percent of Kansas' population will be over age 60 by the year 2030, an increase of 32 percent from 2012.

More than half of Kansas residents live in the northeastern portion of the state, primarily in Kansas City, Overland Park, Lawrence, and Topeka (the state capital). Wichita, which is located in the center of the state, was the most populous city in 2010, with 380,000 residents and a population of more than 600,000 in the greater metropolitan area. Kansas City, which occupies the second largest land area in the state, contains a number of diverse ethnic neighborhoods and is one of the fastest growing metropolitan communities in the country.

**Geography and Substance Abuse Implications.** Although Kansas ranks 15th in size among all states, its population of just 2.9 million residents makes it one of the least densely populated. While the state has 627 incorporated cities, nearly 90 percent of them have fewer than 3,000 people, and many of those have fewer than 1,000 residents. The large geographic size and sparse population density in many parts of the state challenge even coverage of prevention services. For example, some RPCs are tasked with serving many counties.

Kansas has the second largest state highway system in the country after California, with a total of 874 miles that includes two of the busiest Interstate highways in the nation. I-70 is a major east/west route running from Baltimore, Maryland through Kansas and Denver, ending in Utah. I-35 runs from Laredo, Texas on the U.S./Mexican border through Kansas to Minneapolis, ending in Duluth. According to the 2011 National Drug Threat Assessment report from the National Drug Intelligence Center, Kansas City has become an important hub for U.S. drug trafficking because of its location in the middle of the country, and because I-70 and I-35 converge there.

**Economics.** According to 2010 U.S. Census data, Kansas' median household income was slightly lower than the national average ($46,054 compared to $49,276); although the percentage of persons below the poverty level was lower in Kansas (12.6 percent) than the nation as a whole (14.3 percent).

As of February 2014, U.S. Bureau of Labor statistics indicate that Kansas' overall state unemployment rate was 4.9 percent, which was the 13th lowest in the nation. (See appendix G for county-level employment data.) Kansas' economy is heavily influenced by the aerospace industry as several large aircraft corporations have manufacturing facilities in Wichita and Kansas City. Kansas also has eight casinos, five of which are owned and operated by tribes. Revenue from casinos is used to fund the state's problem gambling program.

Kansas ranks 8th in the U.S. in oil and natural gas production and leads all other states in production of wheat although the sale of livestock (especially cattle), provides a larger percentage of annual farm income than the sale of wheat. Overall, manufacturing and service industries are more important to the state's economy than

agriculture, and Kansas has fared better than many states during the economic recession.

In 2012, Kansas Governor Sam Brownback signed HB 2117 into law. This legislation reduces income tax rates, increases the standard deduction, eliminates some income tax credits, and provides tax exemptions for some businesses. The tax reduction is estimated to be around $800 million annually beginning in 2014, totaling $4.5 billion over 6 years. Proponents of the change hope that it will spur economic growth and job creation by small businesses. The tax reductions will also reduce state revenue and will likely have to be paid for either by cutting spending or increasing taxes elsewhere. At the time of the site visit, it was too early to determine how the tax reductions might affect state and local resources for behavioral health services.

**Special Populations.** Kansas is home to three active military bases: McConnell Air Force Base, and Fort Leavenworth and Fort Riley Army posts. Military personnel in Kansas consist of approximately 16,000 active duty military personnel (13,000 Army and 3,000 Air Force), as well as nearly 17,000 Reserve and National Guard troops.

Problems with alcohol and other drug abuse have been well documented among service personnel and are the most prevalent substance-related problems for active and returning service personnel. At greatest risk are formerly deployed personnel with combat exposures, as they are at highest risk for binge drinking and for developing alcohol- and drug-related problems. According to a recent report from the Institutes of Medicine (IOM), increases in drug abuse among veterans are due, in part, to a huge rise in the number of prescriptions for pain-relieving drugs to deal with combat injuries in Iraq and Afghanistan during the past decade.[2] Studies also show that between 36.9 and 50.2 percent of veterans in the Veterans Administration health care system who have served in Iraq and/or Afghanistan have received a mental disorder diagnosis, such as post-traumatic stress disorder or depression.[3]

Kansas is home to 6 state universities, 19 community colleges, and 7 technical colleges/universities, with a combined enrollment of 187,466 in 2011. There are also 28 private universities/schools, several of which are affiliated with churches/theological institutes.

Substance abuse by college students has been a topic of national concern. Data from the national 2011 Core Institute survey, which measures alcohol and other drug (AOD) use among students in institutions of higher education, indicates that 63.4 percent of underage students reported consuming alcohol in the previous 30 days and 44.8 percent of students reported binge drinking[4] in the past 2 weeks. College students also report high rates of consequences because of alcohol and drug use: one-third of students reported some form of public misconduct (e.g., police involvement, fighting, vandalism, and driving under the influence) and 22 percent reported experiencing serious personal problems (e.g., suicidality, injury, sexual assault, AOD dependence).[5] According to data from Kansas' 2012 Treatment Episode Data Set (TEDS) 16 percent of college-aged individuals (18–25 years) met the criteria for alcohol dependence or abuse.

**State Policy Environment.** Kansas' alcohol laws are among the strictest in the nation. The only alcoholic beverage that grocery stores and gas stations may sell is beer with no more than 3.2 percent alcohol by weight ("3.2 beer"). Other liquor sales are allowed solely at state-licensed retail liquor stores, but 3.2 beer must be sold in separate rooms from other alcoholic beverages. Alcohol sales are prohibited on Christmas and Easter. On the days sales are permitted, package sales are prohibited before 9 a.m. and after 11 p.m., and on-premises consumption is prohibited after 2 a.m. and before 9 a.m. Sunday on-premises sales in the state have been permissible only since 2005.

Although the ABC has the power to regulate all alcohol and cereal malt beverages and preempt local laws, cities may vote to exclude package sales and local governing boards may advise on the issuance of licenses in cities and counties. Currently, just 17 counties allow general on-premises alcohol sales; 29 counties do not permit any on-premises sale, although some permit the sale of 3.2 beer; and the remaining 59 counties require a licensed drinking establishment to receive at least 30 percent of its

[2]http://www.iom.edu/Reports/2012/Substance-Use-Disorders-in-the-US-Armed-Forces/Report-Brief.aspx Institute of Medicine of the National Academies Report Brief released 9/17/2012.
[3]Cohen, B. E., Gima, K., Bertenthal, D., Kim, S., Marmar, C. R., & Seal, K. H. (2010). Mental health diagnoses and utilization of VA non-mental health medical services among returning Iraq and Afghanistan veterans. *Journal of General Internal Medicine,* 25 (1), 18–24.
[4]Binge drinking is defined in the survey as consuming five or more drinks in one sitting.
[5]http://core.siu.edu/pdfs/report11.pdf.

revenue from food sales. Not all communities that allow off-premises sales permit sales on Sunday.

As of July 1, 2010, smoking is prohibited in most places of employment and public places, including: restaurants and bars; taxicabs and limousines; and lobbies, hallways, restrooms and other common areas in apartment buildings, multiple-residential facilities, hotels, and motels. This includes the area within 10 feet of any doorway, open window, or air intake where smoking is prohibited. Smoking continues to be permitted in tobacco retail shops, state-licensed gaming and horse track facilities, private recreational clubs, up to 20 percent of hotel/motel sleeping rooms, and designated smoking areas of adult care homes and long-term care facilities. Local communities have the ability to adopt stronger smoke-free laws than the state law.

Two bills to create a medical marijuana program were introduced in the 2013 legislative session, one in the House and one in the Senate, but neither bill emerged from committee.

A summary of additional state laws related to alcohol and other drugs is provided in appendix F.

## State Substance Abuse Trends

Kansas has been experiencing a number of desirable trends with regard to youth substance abuse (from 2003 to 2011, according to the National Survey of Drug Use and Health [NSDUH]). The reported rates of past-30-day use of alcohol, cigarettes, and other tobacco products, and marijuana have all decreased among Kansas youth and are below the 2011 U.S. medians for all. In addition, since 2007, reported age of first use of cigarettes and marijuana among youth has increased and is higher than the 2011 U.S. median for both cigarettes (12.9 percent ) and marijuana (13.9 percent).

Use of other illicit drugs and nonmedical use of prescription psychotherapeutics is an important concern for Kansas youth, however, with NSDUH reported rates of past-30-day use for other illicit drugs increasing from 2.9 percent in 2003 to 5.0 percent in 2011 and NSDUH reported rates of past-30-day use for prescription psychotherapeutics increasing from 2.1 percent in 2003 to 3.7 percent in 2011 to levels that exceed the 2011 U.S. medians (4.4 percent and 3.1 percent respectively). During that same time period, the reported rate of nonmedical use of prescription pain relievers among youth has increased as well, 4.4 percent to 6.0 percent, although the rate is lower than the 2011U.S. median of 6.3 percent.

NSDUH also shows that the reported rate of past-30-day alcohol use by Kansas adults decreased from 58.5 percent in 2009 to 56.2 percent in 2011 and is lower than the 2011 U.S. median (58.3 percent). Also from 2008 to 2011, the reported rates of adult use of illicit drugs other than marijuana and nonmedical use of prescription psychotherapeutics and prescription pain relievers among Kansas adults decreased from 3.6 percent to 2.7 percent and 3.1 percent to 2.3 percent respectively, below the 2011 U.S. medians of 3.2 percent and 2.6 percent, respectively.

While the NSDUH reported rate of adult cigarette use also declined from 27.7 percent in 2003 to 25.7 percent in 2011, the rates remain slightly higher than the 2011 U.S. median of 25.5 percent. The reported rate of adult use of other tobacco products has been increasing (9.6 percent in 2003 to 12.3 percent in 2011) and is several percentage points above the 2011 U.S. median of 8.7 percent. At the same time, the percentage of Kansas adults reporting risk of harm from smoking a pack or more of cigarettes a week has decreased from 94.6 percent in 2003 to 91.8 percent in 2011 and is below the 2011 U.S. median of 93.3 percent. For that same time, the reported rate of past-30-day marijuana use has also increased for adults (4.2 percent to 4.9 percent), although the rate remains below the 2011 U.S. median 6.5 percent.

Alcohol-related traffic fatalities as a percentage of total traffic fatalities and alcohol- and drug-related arrests as a percentage of total arrests have decreased from 38.0 percent in 2003 to 31.9 percent in 2011. Although Kansas has the eighth lowest drug overdose mortality rate in the U.S., with 9.6 per 100,000 people suffering drug overdose fatalities, according to the 2013 Trust For America's Health, *Prescription Drug Abuse: Strategies to Stop the Epidemic* report, this rate has nearly tripled since 1999 when the rate was 3.4 per 100,000.

**Alcohol Trends.** NSDUH data indicate that the percentage of 12- to 20-year olds in Kansas that reported using alcohol in the past 30 days fell from 31.7 percent in 2003 to 25.1 percent in 2011, which was below the U.S. median of 25.5 percent. During that same time, the reported average age of first use of alcohol for youth in Kansas rose from 13.0 years to 13.3 years; however, the percentage of youth that reported perceiving harm from consuming five or more drinks weekly decreased from 74.3 percent in 2003 to 73.0 percent in 2011, which was below the U.S. median, 76.1 percent.

Data from the 2012–2013 Kansas Communities That Care (KCTC) student survey reflect that 24 percent of

students surveyed reported having drunk alcohol in the past 30 days. KCTC data also indicate that reported current alcohol declined in each grade surveyed from 2008–2009 to 2012–2013, with 6th graders showing the largest relative decrease (8.5 percent to 5 percent), and 12th graders showing the smallest decrease (49.5 percent to 42.2 percent). KCTC data also indicate that binge drinking decreased among youth in grades 6–12 from 13.8 percent in 2010 to 10.6 percent in 2013.

Conversely, NSDUH data reflect that the percentage of Kansas adults ages 21 and older that reported having used alcohol in the past 30 days increased from 52.1 percent in 2003 to 56.2 percent in 2011, although this rate was below the U.S. median of 58.3 percent. During that same time, the percentage of adults reporting harm from consuming five or more drinks weekly increased from 78.4 percent to 79.4 percent, which was slightly above the U.S. median of 79.0 percent.

Estimates from the U.S. Centers for Disease Control and Prevention's (CDC's) 2011 Behavioral Risk Factor Surveillance System (BRFSS) indicate that Kansas adults ages 18 and older have a lower prevalence of binge drinking than the rest of the nation (17.0 percent compared to 18.3 percent), as well as a lower prevalence of heavy drinking among adults 18 and older (5.4 percent compared to the national prevalence of 6.6 percent). TEDS data indicate that alcohol dependence with a secondary drug (20.2 percent) and alcohol dependence alone (16.9 percent) were the second and third most common reasons for admissions of Kansans of all ages to state-funded treatment in 2012.

**Tobacco Trends.** Tobacco use among Kansas youth ages 12 to 17 has been declining. According to NSDUH data, the percentage of Kansas youth ages 12 to 17 that reported having smoked cigarettes in the past 30 days dropped from 13.0 percent in 2003 to 9.6 percent in 2011, although this rate was slightly (0.8 percent) above the U.S. median. For this period, youth reported an increase in average age at first use of cigarettes from 12.1 years to 13.4 years, which was higher than the U.S. median of 12.9 years. Although perceived peer disapproval of smoking a pack a day increased during this period from 84.3 percent to 89.1 percent, the percentage of youth that reported perceiving harm from smoking a pack a day decreased (92.4 percent to 92.0 percent). KCTC data reflect that 8 percent of students surveyed reported having smoked in the past 30 days in 2012–2013 (down from 10.8 percent in 2006–2007), and cigarette use has declined noticeably for each grade surveyed from 2008–2009 to 2012–2013.

NSDUH data also reflect a decline in the percentage of youth that reported having used other tobacco products, from 6.5 percent in 2003 to 5.6 percent in 2011. During the same period, the average reported age of first use of other tobacco products rose from 12.9 years to 14.1 years, which was higher than the U.S. median of 13.7 years. The 2011 Kansas Epidemiological Profile notes that more than 1 in 10 middle and high school youth reported using smokeless or spit tobacco in the past 30 days, with males reporting a prevalence six times that of female students.

As with youth, NSDUH data reflect a reduction in the percentage of Kansas adults that reported having smoked cigarettes in the past 30 days (from 27.7 percent in 2003 to 25.7 percent in 2011), which was slightly higher than the U.S. median (25.2 percent). During that same time, the reported average age at first use of cigarettes in Kansas adults rose from 15.3 years to 15.7 years. However, the percentage of adults that reported perceiving harm from smoking a pack a day decreased during this period from 94.6 percent to 91.8 percent, which was lower than the U.S. median of 93.3 percent in 2011.

NSDUH data reflect an increase in the percentage of adults ages 18 or older who reported having used tobacco products other than cigarettes in the past 30 days from 9.6 percent in 2003 to 12.3 percent in 2011, which was higher than the U.S. median of 8.7 percent. During that same period, the reported average age at first use of tobacco products other than cigarettes for Kansas adults rose from 18.1 years to 19.3 years, which is slightly lower than the U.S. median of 19.8 years.

**Marijuana Trends.** NSDUH data reflect that the percentage of Kansas youth ages 12 to 17 that reported having used marijuana in the past 30 days decreased from 7.4 percent in 2003 to 6.6 percent in 2011, which was 13 percent below the 2011 national median of 7.6 percent. During that same period, the average age of first reported use of marijuana for Kansas youth rose from 13.5 years to 14.2 years. However, disapproval and perception of harm associated with marijuana use is decreasing among Kansas youth, which could affect future use. From 2003 to 2011, the percentage of youth that reported disapproval of someone their age trying marijuana decreased from 83.8 percent to 81.3 percent, while the percentage reporting moderate or great risk of harm from smoking marijuana once or twice a week decreased from 86.1 percent to 79.0 percent.

KCTC data reflect that 9 percent of all participating students in the 6th, 8th, 10th, and 12th grades reported having used marijuana in the past 30 days in 2012. Current marijuana use in 6th and 8th grades remained constant from 2008–2009 to 2012–2013, while rates in the 10th and 12th grades reflected slight increases (12.5 percent to 13.3 percent, and 16.7 percent to 17.3 percent, respectively). TEDS data indicate that marijuana was the second most commonly cited primary drug of dependence for youth ages 12 to 17 that were admitted to the state-funded treatment system in 2012, accounting for 36.5 percent of all admissions for marijuana dependence.

Although the percentage of Kansas adults ages 18 or older who reported having used marijuana in the past 30 days increased from 4.2 percent in 2003 to 4.9 percent in 2011, this rate remained slightly below the national median of 6.5 percent in 2011 according to NSDUH data. Although the average reported age at first use of marijuana for Kansas adults increased from 17.9 years in 2003 to 18.2 years in 2011, the percentage reporting moderate or great risk of harm from smoking marijuana once or twice a week decreased from 81.6 percent to 72.0 percent. TEDS data indicate marijuana was the fourth most commonly cited primary drug of dependence among 18- to 20-year olds admitted to state-funded treatment in 2012, accounting for 14.7 percent of all admissions for marijuana. Overall, marijuana dependence was the primary reason for admissions of all persons of all ages to state-funded treatment in 2012 (29.8 percent).

**Other Illicit Drug Trends.** Illicit drug use is a growing concern among Kansas youth. NSDUH data indicate that the percentage of youth that reported having used illicit drugs other than marijuana in the past 30 days increased overall from 2.9 percent in 2003 to 5.0 percent 2011, which was slightly above the U.S. median of 4.3 percent in 2011. However, during that same time, the average reported age at first use of illicit drugs other than marijuana for Kansas youth rose from 12.6 years to 13.4 years. TEDS data indicate that dependence on hallucinogens was the third most commonly cited drug of dependence for youth ages 12 to 17 years that were admitted to state-funded treatment in 2012 (22.7 percent of all admissions for hallucinogens).

NSDUH data also reflect that the percentage of Kansas adults ages 18 or older that reported having used illicit drugs other than marijuana in the past 30 days increased overall from 2.5 percent in 2003 to 2.7 percent in 2011, although this rate remained below the U.S. median of 3.2 percent in 2011. During that same time, the average reported age at first use of illicit drugs other than marijuana for adults ages 18 or older rose from 19.1 years to 21.3 years. TEDS data indicate that hallucinogens were the most commonly reported illicit drug of dependence for Kansans ages 18 to 20 who were admitted to state-funded treatment in 2012 (27.3 percent of all admissions for hallucinogens), while heroin was the most commonly reported illicit drug of dependence for Kansans ages 20 to 25 years (28.6 percent of all admissions for heroin) followed closely by hallucinogens (also 27.3 percent of all admissions).

**Nonmedical Use of Prescription and Over-the-Counter (OTC) Drug Trends.** The percentage of Kansas youth ages 12 to17 who reported nonmedical use of prescription psychotherapeutics in the past 30 days rose from 2.1 percent in 2003 to 3.7 percent in 2011, according to NSDUH data. This rate was 19 percent above the national median of 3.1 percent in 2011. While the percentage of 12- to 17-year olds who reported nonmedical use of prescription pain relievers in the past year also rose (from 4.4 percent to 6.0 percent) in that same time, this rate was below the U.S. median of 6.3 percent in 2011. TEDS 2011 data indicate that dependence on sedatives among youth ages 12 to 17 years accounted for 14.3 percent of all admissions for sedatives, followed by other stimulants at 12.5 percent.

NSDUH data reflect that the percentage of Kansans ages 18 and older who reported nonmedical use of prescription psychotherapeutics in the past 30 days increased very slightly from 2.2 percent to 2.3 percent in 2011, while the percentage that reported nonmedical use of prescription pain relievers in the past year declined slightly from 4.4 percent to 4.2 percent for the same period.

**Other Substance Abuse Trends.** TEDS data suggest disparities in ATOD use by Kansans by race and ethnicity. For example, although Blacks/African Americans make up less than 6 percent of the population of Kansas, they accounted for 15 percent of those admitted to state-funded treatment in 2012 and were significantly overrepresented among all races and ethnicities among those admitted for primary dependence on PCP (73 percent), smoked cocaine (52.6 percent), cocaine—other route (32.2 percent), marijuana (21.8 percent), and alcohol with a secondary drug (13.7 percent). Hispanic/Latinos, who make up 10.5 percent of the state's population, were overrepresented among all races and ethnicities among those admitted for primary dependence

on other/unknown drugs (18.2 percent), inhalants (17.6 percent), cocaine through other routes (16.4 percent), and marijuana (14.7 percent).

BRFSS trend data from 2006 to 2011 show that Kansas males had significantly higher prevalence of binge drinking than females; African Americans had the lowest prevalence of binge drinking; and individuals of college age (18–24) and those with some college education exhibited the highest prevalence of binge drinking.

Nonmedical use of prescription drugs appears to be a major issue among young adults. According to TEDS data, Kansans ages 21 to 25 accounted for 25 percent of all admissions for dependence on stimulants other than amphetamines, 23.5 percent of all admissions for dependence on opiates other than heroin, and 19.8 percent of all admissions for dependence on tranquilizers.

## Substance Abuse Needs Assessment

Substance abuse prevention needs assessment data are primarily collected through the KCTC student survey and archival sources. KSAPT also uses data from a variety of state and national sources to create and update the state's epidemiological profile periodically; the previous epidemiological profile from 2006–2011 was updated in May 2013. In addition to NSDUH and BRFSS, national data sources include SAMHSA's State Epidemiological Data System (SEDS), which provides consequence and consumption indicators based upon nationally available data sources; the Monitoring the Future student survey funded by the National Institute on Drug Abuse; and the Environmental Photographic Interpretation Center's National Clandestine Laboratory Seizure System.

State data sources include the following:

- KDOR databases of all active tobacco and liquor licenses
- Kansas Department of Transportation's Kansas Accident Records System
- KDOE student data
- Kansas Bureau of Investigation offense and arrest reports
- Kansas Sentencing Commission
- KDHE's Bureau of Epidemiology and Public Health Informatics, Office of Health Assessment
- KDHE's Center for Health and Environmental Statistics, Office of Vital Statistics, Birth Certificates and death statistics.

### POTENTIAL ENHANCEMENTS

- *BHS's ability to further target prevention funds by identifying populations most in need of prevention could be enhanced by cross-tabulation and analysis of available data to identify relationships between substance abuse and other characteristics.*
- *BHS's ability to analyze and effectively address the high rates of prescription drug abuse by Kansas youth and adults might benefit from an exploration of how K-TRACS data could be accessed and used at the state and local levels to tailor prevention initiatives and strategically target them to those populations and areas most in need.*

The KCTC survey has been administered annually free of charge throughout the state since 1994. The survey tracks teen use of ATOD and provides a baseline for teen participation in, perception of, and attitudes toward prosocial and antisocial behavior at the peer, school, family, and community levels. Surveys are administered each year to students in 6th, 8th, 10th, or 12th grades between December 1 and January 31. The survey is offered to all districts and participation is voluntary. A parent letter is sent home with students 2 weeks prior to the date of administration, informing them of the study and giving them the option to decline their child's participation if they desire to do so.

The survey is available in two formats. The comprehensive version contains all questions pertaining to the CTC model of risk and protective factors, including sections on demographics and school climate; peer influences; ATOD use; community-based perceptions; and family domain. The alternate version of the survey excludes family domain questions. The survey is available in a paper booklet format, an online format, or a combination of the two. A paper-only version of the survey is available in Spanish.

The survey methodology is a convenience sample and does not take into account sampling procedures. Because the KCTC is a school-based survey, it may exclude youth with severe substance abuse dependence and therefore provide an underestimate of substance abuse consumption. Additionally, the results of the KCTC are not weighted to reflect sample design or nonresponse/participation rates.

BHS staff and contractors reported that in most years the participation rate has been 70 percent or better. More

than 70 percent of eligible Kansas students participated in the survey in 2012, with 103,800 surveys submitted from 248 school districts. The results of the survey are disaggregated to the school building and/or district level, and all but 15 of Kansas' 105 counties have had sufficient participation to get a county-level report. RPCs and community coalitions participating in the site visit noted, however, that it is difficult for many coalitions to get access to school building or district-level data. When they can get access, they frequently cannot make it public.

BHS contracts with Greenbush to use data from the KCTC survey to create statewide "Hot Spot" maps indicating trends and prevalence of youth alcohol, cigarette, and marijuana use by county. The RPCs use the "Hot Spot" maps to identify priority substance abuse problems to address in local communities.

KSAPT created an initial epidemiological profile in 2006, which was updated in SFY 2012–2013 as the *Kansas Substance Abuse Epidemiological Indicators Profile 2006–2011*. The updated profile focuses on consequences and consumption trend data and indicators for ATOD use among youth and adults, as well as overall indicators for substance abuse consequences. Members of KSAPT and BHS prevention staff used prevalence and consumption data in the updated profile to identify past-30-day alcohol and marijuana use among children and youth as the state's two prevention priorities.

While the profile discusses some differences by demographic characteristics, it does not examine or address intervening variables associated with ATOD consumption and consequences. During the site visit, BHS staff noted that the SSA was expanding the epidemiological profile to include more behavioral health indicators.

The profile also notes a number of data gaps relating to community-level aggregation of data in rural areas, participation and response rates, race and ethnicity, tribal information, and information on incarcerated populations. Because of confidentiality protocols, community-level analysis of survey data is not currently possible for small communities. In addition, NSDUH data, which are the state's only source for ATOD data among adults ages 18 and over, are not available at the local level. Some databases in Kansas also are marked by low or uneven participation and response rates. This includes KCTC participation in some communities as well as uneven and inconsistent law enforcement reporting to the Kansas Bureau of Investigation incidence and offence database.

The profile also notes that each database in Kansas records the race and ethnicity of individuals differently. While some data systems combine race and ethnicity, other databases separate them out. Currently most state data systems are designed to report race in three categories only: White, African American, and Other. Kansas also has very limited data on the urban Indian populations in the state and virtually no ATOD information for residents of the four Indian reservations in northeastern Kansas. Finally, the profile noted limited and siloed ATOD information on incarcerated populations.

BHS staff are not using K-TRACS to monitor prescription drug abuse (even though youth prescription drug abuse is increasing in Kansas and is above the national median) and reported being unaware whether they have access to these data. The CSAP team noted that BHS's ability to analyze and effectively address the high rates of prescription drug abuse by Kansas youth and adults might benefit from an exploration of how K-TRACS data could be accessed and used at the state and local levels to tailor prevention initiatives and strategically target them to those populations and areas most in need—including identifying geographic areas in the state where prescription drug abuse is most prevalent.

The CSAP team also noted that BHS staff and subrecipients do not appear to be using all of the data available to them to identify and address behavioral health disparities and issues across the lifespan. Because Kansas' prevalence rates of substance abuse—particularly among youth—are lower than the national median in many areas, efforts to further decrease rates will require identifying those subpopulations at highest risk. Although many of Kansas' survey and archival data sources collect demographic data that can be cross tabulated with substance abuse data (e.g., race/ethnicity, orientation, and age), Kansas reports primarily targeting universal indirect populations with its prevention funds and do not appear to use data to identify priority subpopulations other than youth in general.

In addition, BHS staff and RPCs appear to rely almost exclusively on KCTC data, even though the state has access to other valid state-level data (e.g., KTRACS, BRFSS, NSDUH, college ATOD surveys) that could be used to assess substance abuse issues affecting young adults, adults, and other subpopulations across the lifespan.

BHS's ability to target prevention funds by identifying populations most in need of prevention could be enhanced by cross-tabulation and analysis of available data to identify correlations between substance abuse and demographic characteristics (e.g., age, race/ethnicity, gender, military involvement, among other characteristics of interest).

## *Workforce Development and Capacity Building*

### Workforce Development

BHS has a broad operational framework of the prevention workforce that includes regionally based prevention consultants, coalitions, and prevention providers. This expanded definition allows BHS to increase the reach and depth of its prevention efforts. BHS has also demonstrated a commitment to workforce development by investing funding to support T/TA provision across the state by SSA staff, contractors, and RPCs.

BHS funds KFP to provide coordination and logistical support for prevention specialist trainings and certification, including coordinating and administering annual testing, maintaining an online database of network members currently certified, and providing resources to help prevention providers prepare for the certification exam. KFP provides one 6-hour ethics training per year, alternating between a face-to-face training one year and a web-based training the next year.

The following is a list of prevention workforce development trainings KFP has helped plan coordinate:

- Communicating for Compliance: Tools for Gaining Effective Media Coverage
- Preparing for the Drug Free Years Parenting Training of Trainers
- Los Niños Bien Educados Parenting Training of Trainers
- Effective Black Parenting Training of Trainers
- BASELINE Training of Trainers
- Traumatic Brain Injury Workshops Substance Abuse Prevention Specialist Training (SAPST)
- SAPST Training of Trainers
- Communities That Care Training
- Adolescent Brain Development Workshop
- Kansas Certified Gambling Counselor Training – 2009
- Prevention Ethics Training
- Cultural Competency Trainings
- Strengthening Families Training 2011
- Co-Creating the Future Training
- Collaborative Consulting Workshop
- SPF-SIG Orientation Training Capacity Building, Planning, and Evaluation
- SPF-SIG Implementation and System Development
- AAPS Prevention System Design Learning Events
- Fran Butterfoss Coalition Workshop
- Communities That Care/SPF-SIG Crosswalk Learning Event
- Facilitation 101
- Adaptive Technology and Introduction to Leadership Development.

In addition, KFP develops and distributes an online Red Ribbon Handbook and provides a statewide Red Ribbon Training to educate youth and adults on how they can initiate this campaign in their communities. Kansas Family Partnership has coordinated the Students Against Destructive Decisions Program for Kansas since 2001 and provides trainings, resources, and support to 212 high school and seven middle school chapters each year.

BHS and its consultants and contractors use a variety of methods to deliver T/TA, including traditional instructional methods, web-based conference calls and webcasts, coaching, and peer mentoring. BHS staff noted that training methods also include self-guided and self-paced learning involving self-assessment, practice, and reflection. Although KFP provides a compilation of the results of evaluations from all major trainings, conferences, and learning events that include knowledge gained, attitudes changed, and increase in skill or ability, it was not clear to the site visit team, how KFP shares the evaluation results with the SSA or how the SSA uses the uses the evaluation results.

The 10 RPCs provide TA to communities in utilizing the SPF to engage in effective and efficient assessment, capacity development, planning, implementation, and evaluation processes. RPCs also provide prevention education, training, coaching, and other supports that allow community coalitions to enhance their infrastructure, leadership, mobilization, sector engagement, capacity,

**UNIQUE AND NOTABLE ACCOMPLISHMENTS**

- *BHS is sponsoring a TA initiative that includes a focus on helping former SPF-SIG grantees to sustain their efforts and outcomes.*
- *BHS has developed a Kansas Prevention Network Online Advocacy Toolkit to help local and state substance abuse prevention stakeholders advocate for positive public policies.*

collaboration, and the ability to sustain local prevention efforts over time.

The RPCs also provide training in evidence-based prevention strategies to children/adolescents and their families through two primary processes: initial training through local coalitions and prevention partnerships that support the SPF process, and followup to ensure training of trainers/implementers for high-fidelity delivery of services and programs.

Additionally, BHS provides training on the Online Documentation and Support System (ODSS) as needed to prevention providers and community groups.

However, prevention certification for RPCs, providers, or coalitions is not required. In addition, BHS does not require minimum qualifications or demonstrated competencies for RPCs. At the time of the last site visit, it was noticed that no formal assessment had been conducted to identify core competencies needed by the prevention workforce other than the universal standards required for certification. During the site visit, BHS staff noted that while several RPCs used to maintain staff who were certified prevention specialists, this no longer appears to be a priority as RPC staff did not perceive a benefit to securing and maintaining prevention certification.

BHS also does not have a system in place to ensure that T/TA is implemented at a consistently high level across regions and by all trainers retained by RPCs. This issue is particularly acute given BHS's reliance on the RPCs to address to substance abuse priorities that currently exist within the state's behavioral health prevention workforce as well as emerging issues such as illicit and prescription drug abuse.

During the site visit, BHS staff stated that they plan to redesign the state's prevention system to more effectively incorporate population- and outcomes-based approaches. This transition—along with emerging issues such as illicit drug use and prescription drug abuse—will likely require the acquisition of new core competencies (i.e., specialized knowledge, skills, and abilities) by contractors, prevention staff and community coalitions.

BHS's ability to strategically target workforce development resources and efforts, including T/TA, could benefit from the identification of the core competencies needed at all levels of the Kansas prevention workforce to address the unique conditions of substance abuse priorities in the state. This could support efforts to require minimum qualifications and demonstrated competencies for RPCs staff and trainers.

## POTENTIAL ENHANCEMENTS

- *BHS's ability to strategically target workforce development resources and efforts could benefit from the identification of the core competencies needed at all levels of the Kansas prevention workforce to address the unique conditions of substance abuse priorities in the state.*
- *BHS's ability to strengthen the statewide prevention workforce would likely benefit from a formal assessment of the prevention workforce needs based on identified core competencies.*
- *BHS could further strengthen workforce development efforts by using workforce assessment results to create a strategic workforce development plan that ensures T/TA services are targeting the most pressing workforce needs.*
- *BHS's ability to help communities implement the SPF and sustain outcomes might benefit from more practical, hands-on guidance for conducting assessments and other steps of the SPF.*

The CSAP team also noted that despite its significant investment in workforce development, BHS has not conducted a formal workforce assessment or created a workforce development plan. BHS has created a brief, undated document called *Strategic Recommendations for Comprehensive Workforce Development*. The document states that BHS has conducted a review of the current workforce characteristics, needs, issues, and capacity in order to determine areas of strength in the current prevention workforce, and identify and plan for ways to enhance and strengthen the workforce, while responding to capacity gaps, learning needs, and other priority issues. The document does not cite the data source utilized to conduct the review, but identifies 14 recommendations with associated lead entities and target dates ranging from June 2014 through December 2015.

The recommendations include conducting a workforce assessment, updating prevention competencies for providers and coalitions, aligning T/TA to the new competencies, providing training in cultural competence and sustainability, and establishing an evidence-based practice and policy workgroup. The CSAP team noted that the recommendations consist of process activities, which

are not linked to expected and measurable improvements in prevention workforce performance. In addition, the recommendations do not include the creation of a workforce development plan with targeted goals and objectives and measurable outcomes based on assessment and designed to assist in recruiting, training, and retaining a diverse and highly skilled workforce that is capable of implementing comprehensive prevention approaches.

The CSAP team noted that BHS's ability to strengthen the statewide prevention workforce would likely benefit from a formal assessment of the prevention workforce needs based on identified core competencies. This assessment could inform the scope of T/TA services needed to help funding recipients use the SPF, and select and implement the evidence-based strategies most likely to be effective in addressing substance abuse priorities. As a starting point, BHS might benefit from reviewing workforce assessment tools and plans developed by other states to determine the most relevant components for Kansas.

The team also encouraged BHS to use formal workforce assessment findings—particularly with regard to gaps in identified core competencies, including in the use of effective population-based and environmental approaches—to identify specific goals, objectives, and measurable outcomes for enhanced performance that can be used to guide workforce development efforts and ensure that contractor T/TA services are targeting the most pressing workforce needs.

BHS could further strengthen workforce development efforts by using workforce assessment results to create a strategic workforce development plan that ensures T/TA services are targeting the most pressing workforce needs. Such a plan could include specific and measurable desired workforce outcomes, and associated strategies for all levels of the Kansas prevention workforce for recruitment, T/TA, and retention, as well as strategies for providing and coordinating T/TA that is delivered or sponsored by different agencies and departments.

## Capacity Building

BHS-funded TA is primarily intended to meet specific development needs of communities related to implementation of the SPF. BHS adopted a core team approach to TA as part of the Kansas SPF SIG, and expanded the approach statewide in 2012. All RPC staff and contractors serve as members of one of five core teams organized around the SPF (i.e., assessment, capacity, planning, implementation, and evaluation), while KSAPT/SEOW comprises a sixth core team. The core teams are responsible for helping to develop and deliver T/TA in their subject area across the state. The teams have three primary responsibilities:

- Developing and enhancing of guidance documents, training materials, tools, and other resources associated with each SPF step
- Providing peer review, feedback, and recommendations for SPF deliverables developed and submitted by the 19 target communities receiving SABG funding for local strategic plans
- Providing ongoing training and learning opportunities within and across the core teams and the prevention infrastructure to allow for continuing education and knowledge development.

In 2013, BHS launched an intensive TA effort called the Kansas Strategic Prevention Framework (KSPF). The primary purpose of the initiative is to select, engage, and support "Target" communities in using the first three steps of the SPF to develop long-term, comprehensive prevention plans. Criteria for "Target" communities include sufficient readiness, capacity, and need to implement the first three steps of the SPF.

A secondary focus of the KSPF is to provide support to identified "Developmental/Sustainment" communities that need further coaching and consultation in the areas of mobilization, readiness, capacity development, or coalition infrastructure development. "Developmental/Sustainment" communities include all former Kansas SPF-SIG grantees, which the CSAP team noted as a unique and notable practice given the success of these former grantees in reducing underage drinking.

BHS staff, consultants, and contractors have developed several resources to support the KSPF initiative, including the following:

- KSPF Assessment Guidance Document
- KSPF Milestones, Deliverables, and Work Products Checklist
- Face-to-Face Core Team Training focusing on each step of the KSPF.

Although the TA products focus on the steps of the SPF, some of them tend to be theoretical rather than data driven in terms of helping communities apply the SPF to address substance abuse priorities, and it was not clear to the CSAP team how communities are intended to operationalize some of these materials. For example, although the Assessment Guidance Document appeared to be intended as an introductory guide on community assessment, it included somewhat sophisticated discus-

sions of statistical analysis but did not include practical guidance on how to strategically analyze data to identify priority ATOD problems and consequences, and then drill down selectively to identify priority ATOD behaviors and associated intervening variables as an integral component of the assessment process. The CSAP team also noted that while KSPF TA appears to focus on implementation of each of the five steps, it does not appear to include a focus on helping communities to use the five steps to create and implement the SPF logic model—which focuses on mapping relationships between problems and consequences, ATOD use and abuse, and intervening variables.

BHS staff, consultants, and contractors have also developed a Sustainment training; a Collaboration and Capacity Summary and Workplan, which consists of a survey and analysis of coalition strengths, needs, and followup actions; a Community Readiness Enhancement Workplan to facilitate discussions to strategize an action plan; and a readiness and feasibility rating tool. BHS also uses the Tri-Ethnic Center Community Readiness Handbook to assess and increase community readiness for change.

However, the Sustainment training largely consists of tips and strategies for leveraging partnerships and financing. The sustainability plan template that accompanies it consists of a table with three columns for communities to record strategies and action steps, responsibilities, and target completion dates for the following four categories of activities: coalition infrastructure; prevention processes; engagement, collaboration, relationships and outreach; and in-kind and monetary resource development. It was not clear to the CSAP team how communities would be able to use this process to conduct a comprehensive financing planning process that could be used to secure resources needed to achieve and sustain desired outcomes into the future.

BHS has also developed a Kansas Prevention Network Online Advocacy Toolkit to help local and state substance abuse prevention stakeholders advocate for positive public policies. The Toolkit distinguishes between advocacy and lobbying; provides guidance on each step of the advocacy process, including mobilization and how to create an advocacy plan; discusses best practice "dos and don'ts" and steps for talking to a legislator; as well as practical information on the legislative process in Kansas. The CSAP team noted that this is a unique and notable document that could be very useful to other states interested in building grassroots capacity for prevention advocacy.

BHS's ability to help communities implement the SPF and sustain outcomes might benefit from more practical, hands-on guidance, including more structured and detailed instructions for sustainability planning that begins with a results-oriented approach and includes strategic analysis of strategies to be used as well as administrative burdens associated with potential funding sources. Toward that end, BHS might review effective TA products developed by or for other states to determine whether components of any of them might be helpful to Kansas' substance abuse prevention efforts.

## State Strategic Plan

BHS has been engaged in multiple grant focused planning efforts involving the SABG, the PFS, and the S3 initiative. The state also completed a draft of The Kansas Plan to Reduce Suicide in 2006, and BHS staff reported they would be revising it in upcoming months. Kansas does not currently have a comprehensive, integrated plan for behavioral health prevention and promotion, and BHS staff noted that they would like future planning to be inclusive of all behavioral health prevention and promotion initiatives, including mental health promotion, suicide prevention, and problem gambling in order to maximize resources and outcomes.

### POTENTIAL ENHANCEMENTS

- *BHS's ability to maximize resources and reduce problems associated with all aspects of behavioral health prevention and promotion could be enhanced by using existing planning efforts as the foundation for the development of a unified strategic plan that is based on data-driven logic models that map out the relationships and linkages between problems and consequences, undesirable/risky behaviors, and key intervening variables.*
- *BHS would likely benefit from an effort to map out the relationships and linkages between problems and consequences associated with current prevention system infrastructure and development, current undesirable prevention system "behaviors," and key intervening variables associated with system problems, consequences and undesirable behaviors.*

The SSA's primary and most current plan for prevention appears to be the 2012 *Kansas Strategic Prevention Framework Strategic Plan and Logic Model*. The plan is organized according to the SPF steps and notes that its purpose is to increase the use of evidence-based prevention strategies by providing TA and other resources to communities, to maximize the number and effectiveness of funded coalitions to achieve population-level change.

The plan references the updated May 2013 epidemiological profile and cites the following current intermediate and long-term prevention prevalence outcomes for Kansas students in grades 6, 8, 10, and 12:

- Decrease past-30-day alcohol use from a baseline of 25.63 percent in 2010 to 20 percent in 2014 and 19.5 percent in 2015
- Decrease binge drinking from a baseline of 13.77 percent in 2010 to 11.1 percent in 2014 and 9.5 percent in 2015
- Decrease past-30-day marijuana use from a baseline of 8.29 percent in 2013 to 8.0 percent in 2015.

The plan also identifies intermediate and long-term prevalence outcomes for cigarette and smokeless tobacco use, but at the same time specifies that although these are no longer considered statewide priorities, they were still included in the plan because some funded communities continue to work on them.

The plan includes a logic model that cites four factors as medium-term ATOD outcomes: favorable attitudes toward problem behavior, early initiation of the problem behavior, friends who engage in ATOD use, and underage drinking "influencing factors." The logic model does not define "influencing factors," nor does it identify access to alcohol as a focus for intervention. Short-term outcomes cited in the logic model are generally identified as mobilization; saturation; fidelity; system changes; and changes in knowledge, skills, and abilities. The logic model also includes general information on problem gambling and suicide prevention outcomes.

Short-term outcomes identified in the plan consist of a mix of process measures (e.g., increased number of evidence-based strategies and policies and practices implemented at the community level, number of youth participating in the Youth Summit), system changes (e.g., decrease regional RPC infrastructure development and increase funding to communities), and the maintenance or expansion of current activities (e.g., T/TA provider network, school participation in KCTC).

With the exception of new funding for communities related to the PFS, S3, and KSPF initiatives, many of the state and substate activities identified in the implementation section of the plan appear to be existing activities conducted by longstanding contractors, as opposed to up-to-date, data-driven supported activities to align with the specific systems changes and desired outcomes:

- Administer, aggregate, analyze, and disseminate KCTC student survey data
- Integrate behavioral health data, enhance state epidemiological profile, and increase dissemination and use of SEOW resources
- Maintain and enhance the ODSS for monitoring, tracking, and community-level evaluation
- Collect, review, analyze, and report participant, strategy, and outcomes-level evaluation data at state and community level
- Provide T/TA, coordination, and oversight for the SPF-PFS II, KSPF, and S3 initiatives
- Provide online and material Regional Alcohol and Drug Awareness Resource (RADAR) dissemination and support for statewide campaigns and initiatives
- Implement evidence-based strategies and environmental approaches specified in community-level strategic plans by community coalitions/organizations.

The plan does not identify what changes (and degree of change) are desired with regard to knowledge, skills, and abilities or establish baselines and desired targets for short- and medium/intermediate-outcomes. The plan also does not describe how current efforts or changes in process measures and system development results are directly linked to—and sufficient for achieving—the state's priority prevention outcomes related to alcohol and marijuana use. For example, although BHS staff, contractors, and coalition members participating in the site visit perceived the difficulty of identifying evidence-based approaches for preventing marijuana use as a challenge, this concern was not addressed or discussed in the section of the plan that deals with assessment of gaps in prevention system needs.

In addition, the CSAP team noted that some of the items listed as short-term outcomes—such as significantly decreasing RPC infrastructure and funding, and the shifting of that funding to support community initiatives—may be more commonly classified in the prevention field as long-term prevention system development outcomes. It

is recommended that these kinds of outcomes entail their own analysis of needed changes in intervening variables and existing knowledge, skills, and abilities.

The plan includes general implementation information with regard to timelines and responsibilities for processes, services, and deliverables. In terms of evaluation, it notes that outcome evaluation efforts will primarily use KCTC data, while process evaluation will use ODSS data, aggregated community evaluation reports, and BHS monitoring data.

BHS's ability to maximize resources and reduce problems associated with all aspects of behavioral health prevention and promotion could be enhanced by using existing planning efforts as the foundation for the development of a unified strategic plan that is based on data-driven logic models that map out the correlations and linkages between problems and consequences, undesirable/ risky behaviors, and key intervening variables. These logic models could then be used to inform the development of a state strategic plan for prevention that includes measurable and realistic outcomes and effective strategies.

BHS's ability to achieve its desired changes in prevention system development and functioning would likely also benefit from a similar effort to map out the correlations and linkages between problems and consequences associated with current prevention system infrastructure and development. This would include current undesirable prevention system "behaviors," and key intervening variables associated with system problems, consequences, and the noted problem behaviors.

Key components of a comprehensive plan would include:

- Clear goals related to priority problems and consequences and related behaviors with regard to ATOD use, mental health, problem gambling, suicide prevention, and prevention system development and functioning
- Specific objectives related to key intervening variables and causal conditions that are logically linked to priority problems and consequences and related behaviors
- Targeted outcomes that represent quantifiable progress over time in achieving desired goals and objectives
- State-level strategies and activities that are culturally relevant and logically linked to desired goals, objectives, and outcomes
- An implementation plan with clearly defined roles, responsibilities, and time lines
- An evaluation plan sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed
- A strategic financing component that analyzes all existing resources and infrastructure, and aligns resources to support desired outcomes into the future.

## *Primary Prevention Set-Aside*

At the time of the 2014 CSAP site visit, Kansas' FFY 2014 SABG application was not approved; accordingly, the compliance year used for the 2014 site visit was FFY 2010.

The SSA was found to be in compliance with all requirements of the SABG.

### POTENTIAL ENHANCEMENTS

- *BHS is encouraged to revise ODSS to differentiate reporting on the CSAP six strategies to more accurately identify, collect, and report RPC activities.*
- *BHS's ability to reduce reporting errors in its SABG application might benefit from the implementation of a QA process to review all data and information prior to submission in federal and other reports.*

### Primary Prevention Set-Aside

Kansas meets the 20-percent prevention set-aside requirement of the SABG. In FFY 2010, the SSA reported primary prevention expenditures of $2,672,834 out of a total SABG allocation of $12,333,978, or 21.7 percent.

### Six CSAP Prevention Strategies

According to the FFY 2013 SABG Report (Forms 8ab and 6b), Kansas reported expenditures by the six strategies and the IOM categories using a compliance year of FFY 2010. BHS staff noted, however, that RPCs do not appear to be reporting level of effort spent on CSAP's six strategies consistently or according to established definitions, which skews representation of the work that is being done. For example, while many of the RPCs' assigned tasks are administrative in nature, BHS noted that they frequently report their tasks as community-based strategies.

BHS is encouraged to revise ODSS to differentiate reporting on the CSAP six strategies to more accurately record RPC activities. BHS might further strengthen RPC reporting by updating the ODSS manual to reflect these changes, as well as training RPCs and other subrecipients on how to report their activities.

### Public Review and Comment on SABG Application

Kansas' 2012–2013 Behavioral Health Assessment and Plan notes that the SSA provides ongoing updates on the SABG application process to providers and other stakeholders throughout the year via its website, quarterly meetings with providers and the State Quality Committee, and KCC and KAAP meetings. The BHS website notes that it also held two facilitated discussion sessions with BHS stakeholders during the development of the FFY 2014 SABG application.

### National Outcome Measures

BHS uses ODSS to collect and report NOMs data. Kansas was able to report all required NOMs for compliance year FFY 2010, although the totals for numbers of persons served by individual strategies differed by demographic category, which may indicate issues with how providers are collecting and reporting data. Kansas did report expenditures for evidence-based practices and strategies in Table 37 of the SABG Behavioral Health Report.

In addition, Kansas' FFY 2013 SABG application contains numerous discrepancies between data submitted in tables 33–37 as compared with the information supplied in the narrative. Figures provided in Table 6a and Table 6b appear to be inconsistent with information reported in Table 35, Table 36, and Table 37. Information in these tables about program planning and implementation is expected to relate to across tables.

The state used the period October 1, 2011–September 30, 2012, to report the data in Tables 33–37, and reported using the expenditure period July 1, 2011–June 30, 2012, for fiscal reporting. However, the state used the period of July 1, 2008–June 30, 2010, to report information in Tables 4b, 6a, and 6b in Kansas' 2013 Behavioral Health Report. This period begins before the start date of—and ends before the authorized final date for—expenditures from the FFY 2010 award, which is the required compliance year of these tables.

BHS's ability to reduce reporting errors in its SABG application might benefit from the implementation of a quality assurance process to review all data and information prior to submission in federal and other reports.

## *Implementation*

### Prevention Budget and Funding

Kansas has a relatively robust budget for prevention given its low population density. According to documents provided by BHS, Kansas' planned substance abuse prevention budget for FFY 2014 is $4,720,706, which consists of $2,770,897 from SABG funds, $884,028 in PFS funds, $250,000 in S3 funds from KDOE, and $815,781 in state general funds. BHS also receives 2 percent of the revenue from state-owned casinos to support problem gambling and other addictions prevention and treatment.

KDHE was awarded a 5-year Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Initiative grant from SAMHSA in September 2009, to foster the healthy physical, emotional, social, cognitive, and behavioral development of all children from birth through age 8 through enhanced coordination of state and local services. The FFY 2014 award amount is $850,000. BHS staff noted that Kansas also has a Garrett Lee Smith grant from SAMHSA for suicide prevention, which was awarded to a community-based group, and that KDADS is now coordinating on the grant with the grantee. Kansas State University and Donnelly College in Kansas also have campus-based Garret Lee Smith Suicide Prevention Grants.

Proceeds from an 8-percent state liquor enforcement tax on the retail sales price of liquor sold for off-premise consumption are used to support the ABC. Community funding for alcohol prevention and treatment is supplemented by funding from a 10-percent "drink tax." One-fourth of receipts from the tax are allocated to the State General Fund with remaining revenue credited to the Local Alcoholic Liquor Fund. Allocations are made to cities and counties based on the amount collected from clubs located in that jurisdiction. A city or county receiving an allocation must apply one-third of the funding received on each of the following areas: its general fund, a parks and recreation fund, and an alcohol programs fund.

Kansas' state prevention budget is also supplemented by federal funding that is provided directly to communities.

**UNIQUE AND NOTABLE ACCOMPLISHMENTS**

- *BHS was able to significantly reduce underage drinking and underage binge drinking by providing SPF-SIG funds directly to communities to implement local substance abuse plans.*

In FFY 2014, Kansas has one Sober Truth on Preventing Underage Drinking Act Grant (STOP) for $27,133 and a state/Tribal Suicide Prevention grant ($480,000) in addition to grants already noted. Kansas' two DFC grantees bring an additional $250,000 per year in prevention funding into the state.

## Funding Allocation Processes

BHS allocates the majority of its funding through competitive Requests for Proposals (RFPs) with opportunities for annual renewal based on application and satisfactory performance. Although awards are generally intended to be for 1 year with the option for three 1-year renewals, BHS staff noted that historically the SSA has issued few RFPs for recipients of SABG prevention funds and instead has used multiple amendments to extend funding periods. The last RFP for RPCs was issued in 2011, with the exception of Region 2, which went out for RFP in 2013, because the fiscal agent declined to continue the grant award. SAMHSA discretionary grant funds (e.g., SPF SIG, PFS) are also awarded by competitive RFP process, with these funds going directly to community-based applicants.

Even though funding is allocated competitively, Kansas' pool of prevention subrecipients and contractors has remained largely unchanged since the inception of the system in 1989. BHS staff noted that, with relatively few exceptions, the majority of agencies holding contracts with BHS date back to the inception of the system in 1989. Given BHS's interest in enhancing its ability to achieve sustainable and measurable outcomes, BHS may want to consider adopting a different funding allocation protocol to minimize constraints on the competitive nature due to a static base of subrecipients and contractors. This will also strengthen opportunities for innovation and new approaches to capacity development and problem solving.

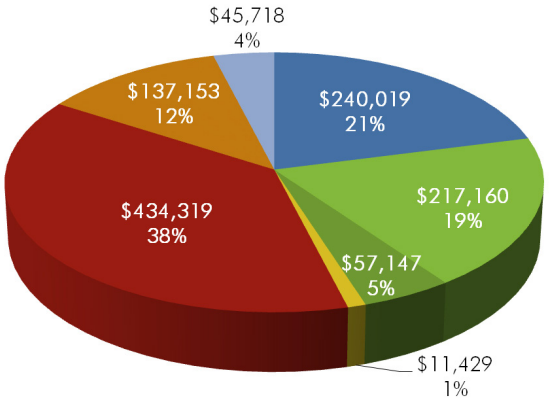
BHS staff noted that funding amounts for RPCs are determined using a formula based on three factors: population, need as determined by a hybrid ranking of targeted substances, and the number of square miles in the region. In 2012, as part of the KSPF initiative, BHS began requiring RPCs to subgrant at least $20,000 in SABG prevention funding each to communities in their region, which marked the first time SABG funding has been used to support community-level prevention funding.

Budget documents supplied by BHS indicate that pending RPC subgrant amounts for community-led prevention range from the minimum $20,000 per region to $61,479, for a total of $337,990, which accounts for approximately 12 percent of all SABG funds. This small amount spread over 10 to 30 communities is not likely to be sufficient to fund the type of comprehensive approaches needed to significantly reduce substance abuse-related problems and consequences. BHS staff expressed a desire to reverse current funding allocations in

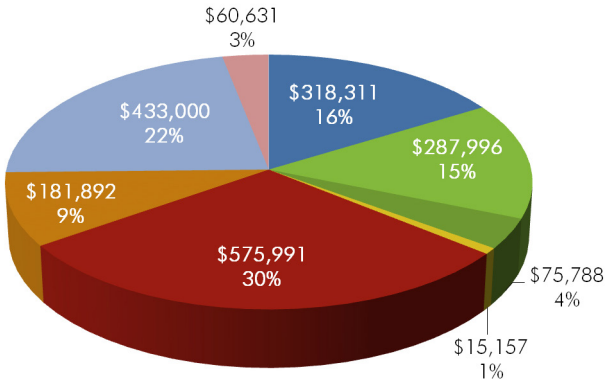
### POTENTIAL ENHANCEMENTS

- *BHS could benefit from using the lessons learned from Kansas' SPF-SIG initiative and investing significantly more funding into the implementation of data-driven and community-led prevention initiatives that use strategies with a high level of documentation of effectiveness.*
- *BHS's ability to achieve documentable outcomes in reduced substance abuse might be enhanced by the use of data to target funding allocations to populations and subpopulations demonstrating the highest documented needs across the lifespan.*
- *BHS's ability to enhance desired prevention outcomes might benefit from a review of prevention expenditures to ensure that funds are invested in those strategies with the highest evidence of effectiveness.*
- *BHS staff, providers, and RPCs noted a need for evidence-based prevention strategies to address marijuana use.*
- *BHS might improve the penetration and impact of its media messages by using data and public health approaches more strategically to determine the subpopulations that most need to be reached, and crafting and deploying media messages accordingly.*
- *BHS's ability to reduce substance abuse-related health disparities across the state might be strengthened by consistently addressing ethnic, linguistic, and cultural issues in each component of the SPF.*
- *BHS's ability to ensure that all funded prevention efforts are targeted and able to achieve desired outcomes would benefit from increased guidance and requirements that all subrecipient grantees and contractors use the SPF to guide their work.*

### FFY 2010 Kansas SABG Reported Expenditures by CSAP Strategies




### FFY 2010 Kansas SABG Total Prevention Funds Reported Expenditures by CSAP Strategies





the future to more closely mirror the allocation processes used in its successful SPF-SIG initiative, wherein just 15 percent was allocated to state and regional infrastructure and 85 percent of funds supported implementation of community prevention plans.

RPCs and KFP are funded through grants, while Southeast Kansas Education Service Center/Greenbush and the KU Work Group are funded through contracts. BHS does not use outcome-based contracting in that the deliverables and performance indicators identified in its prevention grants and contracts focus on completion of processes and activities only. For example, although the grant award documents for KFP and the RPCs indicate that the funding is intended to help build capacity to achieve the state's priority prevention outcomes, funding award documents do not specify capacity outcomes and neither KFP nor the RPCs are required to document outcomes related to measurable changes in capacity that in turn could be expected to lead to improvements in substance abuse-related problems and consequences.

## Prevention Expenditures and Allocations

**Prevention Expenditures for FFY 2010.** As reported in their FFY 2013 SABG Application, Kansas reported the largest allocations of SABG funds in FFY 2010 (see pie chart above left) were for community-based process (38 percent), followed by information dissemination (21 percent), education (19 percent), environmental strategies (12 percent), alternative activities (5 percent), "other" prevention strategies (4 percent), and problem identification and referral (1 percent).

The allocation pattern for BHS's total prevention funds for FFY 2010 differed somewhat from that for SABG funds (see pie chart above right). Although community-based strategies still represented the largest area of expenditure (30 percent), funding for Section 1926-Tobacco accounted for the second largest funding category (22 percent), followed by information dissemination (16 percent), education (15 percent), environmental strategies (9 percent), alternative activities (4 percent), "Other" prevention strategies (3 percent), and problem identification and referral (1 percent).

BHS staff and contractors noted, however, that RPCs do not uniformly report their efforts on CSAP's six strategies, which skew representation of the work being provided. For example, RPCs tend to report work done on behalf of coalitions as community-based process, while staff noted that much of RPC work involves information dissemination. The site visit team recommended that BHS may benefit by improving their current ODSS data reporting system and instruction manuals to include a drop-down menu, which clearly differentiates the six CSAP strategies and provides examples for the various reporters

The percentage of funding allocated to evidence-based strategies in 2010 is difficult to discern, as there appear to be inaccuracies in reported expenditures in Kansas' FFY 2013 SABG Behavioral Health Report. Specifically, although the application states that 100 percent of funded

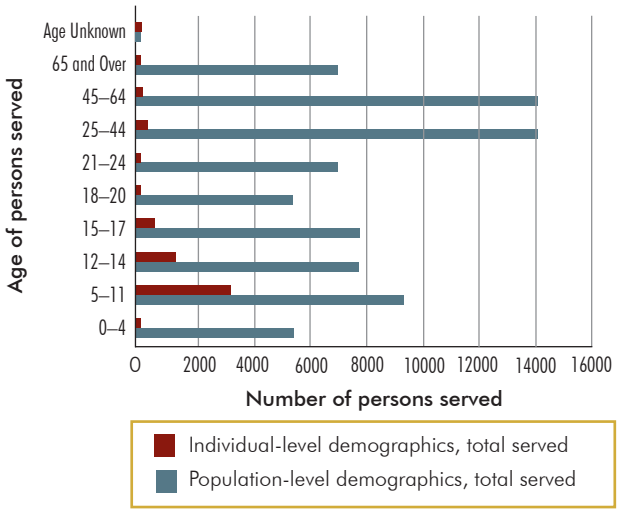
prevention programs were evidence-based strategies designed for universal populations, Table 37 lists expenditures of only $131,299 for evidence-based programs while Table 6b cites expenditures of $1,142,946 in SABG funds for strategies for universal populations.

The CSAP team did note, however, that the SSA's ability to allocate SPF-SIG funding directly to communities during this time period resulted in unique and notable reductions in underage drinking among grantees. From 2007 to 2012, communities receiving SPF-SIG funds reduced reported rates of past-30-day alcohol use from 33.2 percent to 23.6 percent, while reported rates of youth binge drinking declined from 18.3 percent to 12.6 percent.

BHS's ability to significantly prevent and reduce substance abuse problems could benefit from using the lessons learned from Kansas' SPF-SIG initiative and investing significantly more funding into the implementation of data-driven and community-led prevention initiatives that use strategies with a high level of documentation of effectiveness.

**Persons Served in FFY 2010.** As reported in the SABG FFY 2013, BHS reported serving between 5,911 and 5,987 persons through individual-based strategies and 78,797 through population-based strategies in FFY 2010. These figures represent only 0.2 and 2 percent respectively of the state's population of 2.8 million residents. Given the much larger prevalence of reported substance abuse in the state, it could be difficult for BHS to achieve significant outcomes in reduced substance abuse problems and consequences if it does not increase the reach of its prevention initiatives.

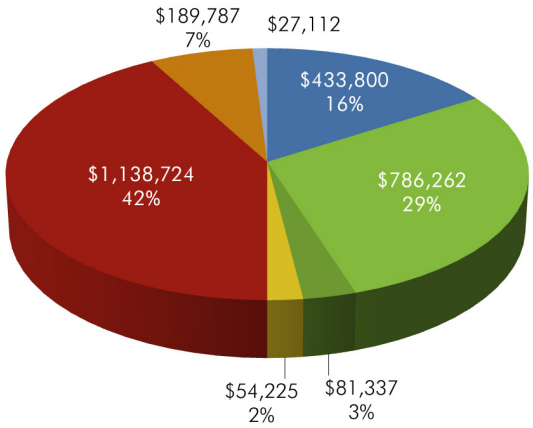
## FFY 2010 Kansas Persons Served by Age Population- and Individual-based Programs and Strategies



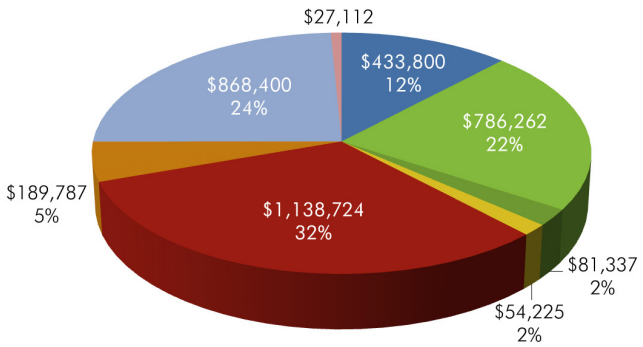

In addition, the fact that BHS reported serving the exact same number of persons through universal indirect strategies as it did for population-based strategies in SABG 2010 suggests that RPCs and prevention providers may be considering the two types of strategies to be synonymous, as opposed to using a broader, public heath conceptual framework in which population-based approaches would also target groups and subpopulations that share higher than average risk (e.g., selective populations).

As reported in the SABG FFY 2013 (and depicted in the bar chart above), the majority of persons reported

## FFY 2013 Kansas SABG Intended Expenditures by CSAP Strategies




## FFY 2013 Kansas Total Funds Intended Expenditures by CSAP Strategies




served by individual-based strategies (76 percent) were 5–11 years of age, followed by teens ages 12 to 14. The majority of persons served by population-based strategies (36 percent) were reported to be 25 to 64 years of age, followed by those 5 to 14 years of age (22 percent). BHS staff noted that population-based strategies tend to be targeted at the parents and family members of children and youth in support of youth prevention efforts.

In general, as described in the Kansas Planning Framework, prevention funding in Kansas historically has been directed to efforts targeting children and youth. The CSAP team noted, however, that many indicators of ATOD use by Kansas adults are showing worsening trends, including increases in the percentage of adults that report current use of alcohol, marijuana, other illicit drugs, and tobacco products other than cigarettes. In addition, the prevalence of smoking and other tobacco use by Kansas adults exceeds the national median, while perception of harm is decreasing and is below the national median. BHS's ability to achieve documentable outcomes in reduced substance abuse might be enhanced by targeting funding allocations to populations and subpopulations demonstrating the highest documented needs across the lifespan.

**Prevention Allocations for FFY 2013.** For FFY 2013, BHS reported that SABG planned allocations for primary prevention will increase to $2,818,980, which reflects 23.1 percent of all SABG funds. These projected expenditures do not include the use of SABG funds for Section 1926-Tobacco efforts.

As was the case in 2010, Kansas' 2013 SABG application reported intent to spend a large portion of SABG and total prevention funding on community-based strategies in 2013 (see pie charts above). As noted previously, however, this category appears to be used by RPCs to report activities that may or may not fit CSAP's definition of a community-based strategy.

Planned expenditures for Section 1926-Tobacco constituted the second highest category of funding when all funding sources were considered, due to Kansas' significant invest of state funds specifically targeting youth retail access to tobacco.

In a change over 2010, BHS reported intending to reduce spending on environmental strategies by nearly half while increasing spending on education and information dissemination. BHS also reported intent to move from expending all prevention funding on strategies targeting universal populations to strategies that also target selective and indicated populations.

BHS appears to place an emphasis on the use of media, mostly planned and implemented as a stand-alone strategy. For example, BHS required SPF-SIG grantees to expend a (20 percent) percentage of all funds on media campaigns and S3 grantees were required to pick one of the following four approaches, all of which involve media: a media campaign only, a media campaign plus an educational strategy, a media campaign plus an environmental strategy, or a media campaign with an educational and environmental strategy.

Prevention research indicates, however, that education, information dissemination, and awareness strategies such as media campaigns are much less effective on their own than when used as to support more comprehensive approaches, particularly those involving an environmental and policy component. BHS's ability to enhance desired prevention outcomes might benefit from a review of prevention expenditures to ensure that funds are invested in those strategies with the highest evidence of effectiveness. In addition, BHS might improve the penetration and impact of its media messages by using data to determine the subpopulations that most need to be reached and crafting and deploying media messages accordingly. BHS staff and subrecipients also noted a need to identify evidence-based prevention strategies to address marijuana use.

BHS allocates nearly 80 percent of SABG prevention funding to support the 10 RPCs. The rest of SABG funds are used to support contracts with Southeast Kansas Education Service Center/Greenbush, KFP, and the KU Work Group. BHS also allocates PFS funds to support six community-level grantees and administers S3 funding on behalf of KDOE to support prevention programming in 16 school districts.

As noted previously, the RPCs provide T/TA as well as some direct prevention services. At the time of the site visit, the RPCs were in the process of selecting and subgranting funding to communities in each RPC catchment area as part of the KSPF initiative. Nineteen communities had been selected at the time of the site visit, with one more to be selected.

The contract with the Southeast Kansas Education Service Center/Greenbush supports collection and reporting of NOMs data; logistical, administrative, and data management support for the KCTC student survey;

support to KSAPT/SEOW; and prevention consultants placed in BHS's office. In addition to the workforce development efforts previously discussed, BHS also funds KFP to provide coordination and logistical support for KCC and prevention event; provide resources to support one-time events such as Family Day, Red Ribbon Week, and the Kansas Youth Leadership Summit; develop an annual advocacy agenda; coordinate statewide substance abuse media campaigns and activities; and maintain a clearinghouse of substance abuse prevention materials for prevention providers and the public. The contract with the KU Work Group maintains ODSS that is used to collect information on the activities and accomplishments of contractors and grantees.

BHS uses state funds to support contracts with KDOR for Synar and tobacco retailer compliance; with KFP for problem gambling prevention efforts, recovery-oriented systems of care work, and administration of KCC; and with Southeast Kansas Education Service Center/ Greenbush for problem gambling prevention. BHS also contracts with Wichita State University to administer the YLinK Program. YLinK supports community youth leadership sites for youth ages 12 to18 with a serious emotional disturbance and provides an array of other services aimed at improving family and peer relationships, fostering community engagement, and supporting training for employment and/or vocational education and self-advocacy skills.

BHS and some RPCs have adapted prevention messages and outreach to be culturally relevant to Hispanic/Latino residents. The KCTC survey is available in Spanish, and BHS staff and providers participating in the site visit described efforts to translate materials and media messages into Spanish. These efforts appear to be most concentrated in Finney County in the southwest portion of the state, where nearly one-half of the population is comprised of Hispanic/Latinos.

Although the population of northeastern Kansas is becomingly increasingly diverse—and Kansas data indicate significant disparities in drug use by race, ethnicity, and other demographics—efforts to develop culturally specific prevention strategies or offer prevention services and materials in languages other than English in that area of the state appear to be limited. The CSAP team noted that BHS's ability to reduce substance abuse-related health disparities across the state might be strengthened by consistently addressing ethnic, linguistic, and cultural issues in each component of the SPF.

## Funding Requirements

BHS has different requirements for different grants and contracts, depending on their scope of work. As noted previously, the deliverables for RPCs involve supporting the KSPF initiative by providing T/TA, guidance, coaching, and feedback to "Target" and "Development/Sustainment" communities, as well as funding to the former. As part of that effort, RPCs are also required to submit separate workplans for each "Target" and "Development/Sustainment" community and to provide all documents and work products related to services provided to these groups. BHS staff noted that RPCs, however, are not required to use data to develop their workplans as their work focuses on T/TA and not direct service.

Other deliverables required of RPCs consist of the following:

- Partner with communities across the region to increase or maintain 80 percent participation in the KCTC survey
- Participate on at least one core team as subject matter experts
- Attend all Learning Events, virtual learning sessions, team meetings associated with the core team to which they are assigned, and provide TA within their area of specialization to "Target" communities both inside and outside of their regions
- Provide position descriptions, level of effort, and contact information for key staff
- Use ODSS to report prevention services provided and community changes associated with RPC work and help KSPF communities to also use the ODSS to report services and changes
- Complete monthly progress and fiscal reports and provide fiscal documentation quarterly
- Participate in virtual, bimonthly coaching sessions with assigned BHS staff.

The CSAP team noted that although BHS's contracts with RPCs state that the SPF should inform their workplans, there are few formal requirements that they do so. For example, although BHS strongly encourages RPCs to base their work on assessment data, there are no contractual requirements that they do so. In addition, RPCs are not required to conduct formal assessments of substance abuse or T/TA needs, or use such assessment data to develop T/TA workplans or strategic plans to identify the most appropriate prevention strategies and approaches for their regions.

Similarly, although RPCs were asked to identify "Target" communities based on need, prevalence, readiness, capacity, and coalition infrastructure, according to BHS staff, RPCs had significant autonomy in deciding which communities to fund. For example, while BHS supplied "Hot Spot" maps indicating counties with the highest rates of youth prevalence of alcohol, marijuana, and tobacco use, RPCs had no contractual requirements to use those data or other specific criteria to select communities for funding. RPCs are also not required to evaluate the outcomes of their efforts in terms of increases in community capacity, which in turn lead to reductions in substance abuse consumption and consequences.

While the KFP grant references state outcomes and priority risk factors, all deliverables are also related to the completion of processes and activities, as with the RPC grants. The specific deliverables required for this grant, other than those previously outlined for workforce development, are as follows:

- Create and support a web-based registry of Kansas coalitions
- Establish and manage a mini-grant process for local level prevention funding
- Provide administrative and logistical coordination for trainings, meetings, and other events
- Coordinate statewide initiatives that increase awareness of or involvement in substance abuse prevention efforts
- Support SSA prevention efforts through technology (e.g., web-based conferencing platform; monitor website traffic; electronically posting prevention news and announcements)
- Coordinate and maintain the RADAR Network Distribution Center and related websites and Advisory Group, and disseminate information on topics including problem gambling, healthy marriage and healthy fatherhood
- Maintain and update the It's Everybody's Business website, update and distribute materials to support Synar compliance, and coordinate with KDOR on resources needed to support Synar compliance
- Participate in quarterly feedback sessions with the SSA
- Submit monthly quarterly and annual reports as required for NOMs, program data, and financial reporting.

The grant does call for KFP to use existing maps and data indicating high-prevalence counties for alcohol and tobacco use to define and describe target areas for outreach and marketing of services and supplies. The grant also requires KFP to conduct an online survey and virtual focus group to determine needs for RADAR materials, and review prevention materials to identify and address needs or gaps in terms of the availability of culturally specific materials.

During the site visit, BHS staff noted that Kansas has historically invested very few ATOD prevention funds into the implementation of evidence-based strategies, and identified this as a "critical gap." Even though BHS invests the bulk of its total prevention funds in RPCs and KFP, the 2012 KSPF Plan notes that they and other funded statewide programs are not required to implement evidence-based strategies. The CSAP team noted that many of the activities performed by RPCs and KFP (e.g., attending coalition meetings, providing presentations, education, information dissemination, Red Ribbon week activities) have not been determined to be evidence-based on their own, and are not being conducted as a core component of an overarching strategy that has been documented to be evidence-based.

Funded community-level programs, however, are expected to implement evidence-based strategies. BHS staff and consultants noted that community strategic plans are reviewed and approved by the Core Teams and either the Project Team or the BHS Prevention Team at the state level. The plan states that criteria for approval include the following factors:

- Quality of community assessment
- Conceptual fit and alignment of proposed strategies with targeted outcomes and risk and protective factors
- Strength of evidence that strategies meet the CSAP definition for evidence-based strategies
- Ratio of individual versus environmental approaches with an emphasis on sustainable policy and practice change
- Level of saturation, intensity, and duration sufficient to achieve short, intermediate, and long-term outcomes.

Given BHS's significant investment in the RPCs and KFP, its ability to ensure that all funded prevention efforts are targeted and able to achieve desired outcomes would benefit from increased guidance and requirements that all subrecipients and contractors use the SPF to guide their work. This would include developing comprehensive and targeted workplans that are based on valid and locally representative data that accurately identify priority problems and consequences, and desired changes in

organizational capacity and/or substance abuse behaviors and associated intervening variables. The CSAP team also recommends that BHS require all subrecipients and contractors to implement strategies that are supported by data and can meet a set minimum standard for documentation of effectiveness of their work.

## Evaluation

BHS monitors grantees and contractors for fiscal compliance and performance on a monthly basis, and grantees participate in virtual coaching sessions with BHS prevention staff on a bimonthly basis, or more frequently as needed or identified in corrective action plans.

BHS uses ODSS to collect and report program data and monitor subrecipients, who are required to track process data and report progress toward completion of specified activities on a monthly basis. ODSS has the capacity to sort data for a variety of reports and graphs, which is intended to assist in evaluating the progress of subrecipients and community coalitions in completing activities. The KU Workgroup and BHS staff review all ODSS entries each month for reliability and progress.

The primary performance measure for RPCs is documentation that their grantees complete SPF steps one through three (i.e., assessment, capacity building and planning) with 100 percent fidelity. Fidelity of implementation is measured by the timely submission of work products and deliverables for each targeted community. Work products and deliverables consist of a series of tasks, worksheets, templates, and other documentation that have been developed for each of the three steps. Performance measurement does not appear to include the level of quality with which each task is completed, but only that it be completed.

RPCs are not required to collect and report outcome data, or develop and implement evaluation plans. Their work is also not evaluated by BHS or the communities they serve in terms of the degree to which funded RPC strategies and activities increased community capacity sufficiently to have an actual impact in reducing substance abuse-related problems and consequences or ATOD use.

KFP's performance measures mirror and quantify its deliverables (e.g., register a minimum of 40 coalitions on a web-based registry during the first year, distribute a minimum of 23,350 RADAR materials quarterly, increase the number of unique website users by 10 percent each year). KFP is also required to conduct annual customer satisfaction surveys with those accessing KFP's RADAR and administrative/logistical services. The performance measures for the surveys are response rates of at least 50 percent, with at least 85 percent of respondents reporting satisfaction with the services and materials they received. KFP is not required to evaluate the degree to which RADAR materials and services increase the knowledge, skills, or abilities of those accessing them.

### POTENTIAL ENHANCEMENTS

- *BHS's ability to measure the effectiveness of its significant investment in the RPCs and other statewide subrecipients would be greatly enhanced by expanding requirements that they evaluate their funded strategies and activities.*
- *BHS's ability to document the value and outcomes of its subrecients could be enhanced by the development of a statewide evaluation system that is capable of monitoring intermediate and long-term outcomes, as well as the degree to which those subrecipients appear to be achieving their desired impact in support of state and local priorities and target populations.*

BHS does not have a statewide evaluation system that can monitor and document the outcomes of its portfolio of funded preventive initiatives and contracts. ODSS tracks process outcomes only and cannot monitor intermediate or long-term subrecipient outcomes and tie those outcomes back to funded prevention strategies. The absence of this evaluation infrastructure limits BHS's ability to identify and implement midcourse adjustments in implementation processes and redirect or reallocate funds as needed to achieve desired outcomes.

BHS's ability to measure the effectiveness of its significant investment in the RPCs and other statewide subrecipients would be greatly enhanced by expanding requirements that they evaluate the degree to which their funded strategies and activities result in increases in capacity that can be linked to reductions in substance abuse-related problems and consequences.

In addition, BHS's ability to document the value and outcomes of its portfolio of funded preventive initiatives and contracts could be significantly enhanced by the development of a statewide evaluation system that is capable of monitoring intermediate and long-term outcomes for all contracts and grants, as well as the degree to which those initiatives and strategies appear to be achieving their desired impact in support of state and local priorities and target populations.

## Summary and Technical Assistance Themes

Since the last CSAP site visit in 2009, Kansas has undergone a significant state reorganization that has resulted in the integration of formerly separate programs into a continuum of care across substance abuse and mental health services. This change also aligned prevention, problem gambling, and suicide prevention programs.

BHS appears to have embraced the reorganization as an opportunity to leverage resources across multiple areas and funding sources. BHS's redesign of its integrated approach to prevention, however, remained in an early stage of development at the time of the 2014 site visit, with most of the state's prevention funding still invested in the historical RPC system and statewide contracts, and very few funds available to support community-led prevention efforts.

The stakes are high in Kansas. Use of illicit drugs other than marijuana and nonmedical use of prescription psychotherapeutics are a significant concern for Kansas youth, with reported rates of past-30-day use for both increasing from 2003 to 2011 to levels that exceed the U.S. median. The reported rate of nonmedical use of prescription pain relievers among youth has increased as well. The reported rate of adult cigarette use in Kansas also remains higher than the U.S. median, and the reported rate of adult use of other tobacco products has been increasing and is several percentage points above the U.S. median. The reported rate of past-30-day marijuana use has also increased for Kansas adults.

These problems are taxing Kansas' publicly funded treatment system and exacting a toll on its budget and the lives of its citizens. Reducing them will require a results-oriented response that can accurately identify the characteristics of the subpopulations that are most at risk for substance abuse—as well as the key intervening variables putting them at risk—and strategically target prevention funding and initiatives accordingly.

Many of the recommendations included in this report for enhancing Kansas' ability to significantly prevent substance abuse rely on access to valid and representative assessment data for planning and evaluation. Although BHS has access to a variety of data, gaps in local data on key populations—including adults and groups deemed to be at higher risk for substance abuse—challenge local prevention planning efforts. Where data exist that are representative and valid, greater analysis of the relationships between demographic characteristics and problem behaviors could help BHS and communities to identify the populations most in need of prevention services and target funding and craft efforts accordingly. The state's ability to develop a comprehensive strategic plan for substance abuse—and support communities in similar efforts at the local level—also hinges on having valid and representative data across the lifespan.

BHS has engaged in strategic planning processes to address substance abuse prevention and mental health promotion that have identified targeted outcomes for reductions in youth alcohol and marijuana use. Its current prevention plan does not, however, address how substance abuse outcomes are to be achieved or identify intervening variables, immediate and intermediate outcomes, or courses of action to be undertaken to achieve these outcomes. The plan also does not directly link planned system improvements to desired substance abuse outcomes.

In order to provide a blueprint for the future, BHS is encouraged to use existing planning efforts as the foundation for the development of a comprehensive, data-driven, state strategic plan for substance abuse and problem gambling prevention, mental health promotion, and prevention system development. Key components of a comprehensive plan would include:

- Clear goals related to priority behaviors and related problems and consequences, as well as infrastructure development
- Specific objectives related to key intervening variables and causal conditions that are logically linked to priority behaviors and related problems and consequences
- Targeted outcomes that represent quantifiable progress over time in achieving desired goals and objectives
- State-level strategies and activities that are culturally relevant and logically linked to desired goals, objectives, and outcomes
- An implementation plan with clearly defined roles, responsibilities, and time lines
- An evaluation plan sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed
- A strategic financing component that analyzes all existing resources and infrastructure, and aligns resources to support desired outcomes.

Other recommendations identified by the CSAP site visit team to help BHS lead the effort to reduce behavioral health problems in Kansas include:

- Increased requirements for documentation of outcomes and the use of the SPF and evidence-based strategies by all grantees and contractors
- Increased funding for community-led prevention initiatives.
- Increased use of environmental strategies
- Development of a subrecipient and state-level evaluation system that can monitor all prevention investments and document all grantee and contractor outcomes.

A full summary of all site visit findings and recommendations is provided in appendix A of this report.

# Synar Program Development, Organization, Compliance, and Support

## *Synar Program Development and Organization*

KDADS has primary oversight of the Synar requirements in Kansas. KDADS has a formal agreement with KDOR to implement Synar programming including conducting Synar inspections, enforcement, planning, and implementing support strategies such as merchant education). In order to implement these tasks, KDOR created the Cigarette and Tobacco Enforcement (CATE) group. KDOR contracts with Greenbush to draw the Synar sample; develop the Synar survey methodology; collect, analyze and report the Synar survey results; maintain a Synar compliance database; and develop and implement the coverage study.

The Kansas Department of Health and Environment (KDHE) is the primary agency responsible for general tobacco control programing in the state. KDADS, as the lead Synar agency, and KDHE have an informal partnership working collaboratively through the Synar Advisory Group, which was established in June 2005.

The Kansas Synar Advisory Council (SAC) includes membership from KDADS, KDHE, KDOR, the Attorney General's Office, and the Convenience Store Association of Kansas. The group meets twice a year in order to coordinate resources and update key stakeholders on progress. However, it appears that this group is not engaged in a data-driven planning process that would inform future plans for Synar programming.

Other Kansas partners that contribute to the state Synar efforts include the Tobacco Free Kansas Coalition which distributes Synar resource materials and messaging to promote retailer compliance with youth tobacco access laws and the Kansas Family Partnership which develops Synar merchant education materials, including a video for merchants and their staff.

### POTENTIAL ENHANCEMENTS

- *KDADS would benefit from the continued support of a strong SAC to ensure that a collaborative data-driven strategic approach is taken into consideration for the planning, implementation, and monitoring of the Synar program.*

## *Description of Trends in the Kansas Retailer Violation Rate and Other Tobacco Outcomes*

Since the implementation of the Synar amendment in FFY 1997, Kansas has reported a substantial decrease of the state's retailer violation rate (RVR) from 63.0 percent in FFY 1997 to 8.5 percent in FFY 2014. During this period, a mostly continued downward trend was observed until FFY 2005 when Kansas reported a RVR of 38.0 percent, which represented an increase of approximately 16 percentage points as compared to the RVR for the previous year. Kansas was found to be out of compliance in FFY 2005 and selected the alternative penalty option, committing additional state funds for $2,227,097 for Synar compliance activities. The lowest RVR (3.1 percent) was observed in FFY 2013. With an RVR of 8.5 percent, Kansas is in compliance with Synar regulatory requirements for FFY 2014.

Kansas is reporting positive youth and adult tobacco use trends. However, youth perceived risk is trending in a negative direction. According to NSDUH, the percentage of 12- to 17-year-olds in Kansas that report using cigarettes in the last 30 days decreased between FFY 2002–2003 (13.0 percent) and FFY 2010–2011 (9.6 percent). The percentage of youth using tobacco products other than cigarettes decreased between FFY 2002–2003 (6.5 percent) and FFY 2010–2011 (5.6 percent). The percentage of youth who perceived moderate or great risk of harm from smoking one or more packs of cigarettes decreased between FFY 2002–2003 (94.6 percent) and FFY 2010–2011 (92.0 percent).

**Retailer Violation Rates for Federal Fiscal Years 1997–2014 (in percent)**

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target | — | 50 | 38 | 30 | 27 | 25 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |
| Reported | 63.0 | 47.0 | 35.0 | 29.3 | 22.7 | 21.1 | 20.6 | 22.1 | 38 | 19.2 | 19.9 | 12.9 | 15.6 | 8.3 | 7.8 | 7.6 | 3.1 | 8.5 |

### POTENTIAL ENHANCEMENTS

- *Once KDADS and their partners on the SAC review their data to identify contributors to the increase in the RVR, they may consider reviewing current strategies and their costs to identify strategies for positively affecting noncompliance rates.*

## *Summary of Synar Program Compliance*

**Youth Access Law.** The Kansas Department of Taxation is statutorily responsible for enforcing the state's youth tobacco access law, which prohibits the sale or distribution of tobacco products to persons under the age of 18. State law also describes penalties to youth who purchase tobacco products. Additionally, the law provides immunity to youth inspectors if they are with a law enforcement officer.

The youth tobacco access law includes graduated fines for sales clerks and/or storeowners who are in violation. Violations are assessed as a class B misdemeanor and penalties begin at $250 for a first offense, moving to $500 for a second offense in a 3-month period, $750 for a third offense in a 3-month period and up to a $1,000 fine considering the severity of the offense. According to the state youth tobacco access law, penalties may be assessed to both the clerk and the retailer. The state does not allow the use of an affirmative defense.

According to state law, in addition to or in lieu of any other penalty provided, upon a finding that a licensee has violated any provision of the youth tobacco access law, including selling, giving, or furnishing tobacco products to minors, the state may assess a civil fine not exceeding $1,000 for each violation against the license holder.

**Enforcement.** Enforcement is always combined with the Synar survey. Inspections are conducted by KDOR's CATE team, which makes a minimum of one controlled buy and one educational visit to each licensee. In FFY 2013, KDOR/CATE conducted 2,032 inspections including the Synar inspections. While the Annual Synar Report (ASR) indicates that Kansas conducts enforcement at both the state and local level, the KDOR/CATE team only spoke to state-level enforcement efforts.

As reported in the FFY 2014 ASR, Kansas issued a total of 280 citations for violations of youth tobacco access laws in FFY 2013: 140 citations were issued to store owners and 140 to salesclerks. From the total of citations issued to owners, 140 resulted in fines; however, no licenses were reported as suspended or revoked. The state does not currently collect data to determine the number of citations issued to clerks that resulted in fines.

**Random, Unannounced Inspections and Valid Probability Sample.** The list frame is based on the Division of Taxation/KDOR tobacco retailer license list. This agency is also responsible for the maintenance of this list, which included 2,652 outlets in FFY 2013. Licenses to sell cigarettes in the State of Kansas are valid for a maximum of 2 years. All licenses expire on December 31 in odd years and must be renewed by January 1 in even years, regardless of issue date.

KDOR contracts with Greenbush to draw the Synar sample. Kansas uses a stratified simple random sample as the sample design with the optimum allocation based on the cost of conducting inspections in different strata. Kansas has 105 counties that for purposes of Synar sampling are divided into four strata based on natural population breakpoints from the 6- to 17-year-old population of the U.S. Census data to accurately reflect the current demographics in the state. Stratum 1 represents the two most populated counties in the state. The six counties in stratum 2 are considered "quasi-urban." Stratum 3 has 28 counties considered to be "medium-sized rural" and the majority of counties reside in stratum 4, "sparse rural" areas.

### POTENTIAL ENHANCEMENTS

- *The state may benefit from collaboration with local enforcement agencies to coordinate youth tobacco access enforcement efforts.*

### POTENTIAL ENHANCEMENTS

- *KDADS may consider the development and implementation of a standardized youth training protocol. This would ensure that inspections are conducted consistently.*
- *KDADS may benefit from the development and application of a data cleaning process to ensure that the information on the completed Synar inspection forms is accurately entered and exported into the database used for determining the RVR.*

Vending machines are included in the Synar survey. The sampling design as described onsite is consistent with the description that is provided in appendix B of the Annual Synar Report.

Kansas conducted a coverage study in calendar year 2012 using a stratified multistage cluster sample. Four areas were stratified in accordance with the Synar sampling process. In the most rural stratum, areas were defined as counties. In the remaining stratum, areas were defined as ZIP Codes, clusters of ZIP Codes, or segments of ZIP Codes. Because of the study, 161 outlets were located. Of those outlets, 159 were matched to the sampling frame, resulting in a coverage rate of 98.8 percent. The state is planning to conduct their next coverage study in calendar year 2017.

Synar inspections are conducted from June to September. Per its contract with KDOR, Greenbush selects the sample for Synar inspections using the described sampling methodology, and generates a list of outlets, which is distributed by KDOR to their CATE adult inspectors according to their designated work regions.

KDOR/CATE agents use the same consummated-buy protocol for the Synar survey and the additional year-round enforcement checks. The inspection team consists of one KDOR/CATE enforcement agent and one underage cooperating individual (UCI). Youth are recruited from various sources, such as local substance abuse coalitions, health departments, schools, and home-schooled youth. The youth are contacted by KDOR and a meeting is scheduled with their parents to explain the process, expectations, and safeguards for the minors. If the youth are still interested, a background check is conducted to ensure that the youth does not have a criminal record. Community members are interviewed to ensure the youth are of good character. If inspectors are satisfied with the screening, the youth are hired. Youth must be between 16 and 17.5 years of age. All adults working with minors are KDOR-commissioned inspectors. If the youth is hired, a KDOR agent provides verbal training on the inspection protocol and safety issues. In addition, a new UCI may shadow an experienced UCI on one or more inspections. At present, there is no standardized protocol.

Each UCI is photographed the day of an inspection and must carry identification. UCIs are instructed to answer all questions honestly, except if asked about working with law enforcement. It is up to the agent whether he or she observes the UCI's attempt to purchase tobacco from inside or outside the establishment. After the purchase attempt is conducted, the UCI returns to the vehicle and the agent completes the inspection form. If the UCI was successful in purchasing tobacco, the UCI adds more detailed information concerning the purchase process to the inspection form. Immediately after the inspection, the agent contacts the retail store manager on duty that day to inform him or her that a sale was made and cites the salesclerk. An administrative citation against the licensee is sent within a 30-day period. The inspection protocol as described on site is consistent with the description provided in Appendix C of the Annual Synar Report.

Local KDOR/CATE staff enters the data from the inspection forms by hand into a central database within 24 hours of receipt by each adult inspector and original forms are faxed to the central KDOR/CATE office. The database is uploaded nightly to the KDOR Controlled Buy server. The server can be accessed by KDOR and KDADS for "real-time" reporting and analysis. Once the inspection data are collected, Greenbush is responsible for the data management, analyses, and reporting into the Synar Survey Estimation System (SSES).

Members of the system review team pulled a random sample (10 percent) of the completed inspection sheets and reviewed them for completeness and accuracy as compared with the SSES raw data submitted in FFY 2014 Annual Synar Report. The result of this review found that 12 out of the 13 sampled paper inspection forms accurately matched with the information provided in SSES. It appears that one inspection form was misclassified as a completed buy into SSES while it was reported as ineligible in the original paper form. Also in the same inspection form, discrepancies were observed in the youth ID number reported. However, in this specific case, the age and gender of the youth were not affected.

Members of the system review team observed five Synar inspections conducted by KDOR/CATE. No sales were made during these inspections. All five observed inspections followed the approved protocol.

**Retailer Violation Rate.** In FFY 2014, Kansas reported a retailer violation rate of 8.5 percent with a standard error of 3.5 percent. While Kansas's RVR was well below the target RVR, the reported standard error did not meet SAMHSA's precision requirement. The precision requirement was not met because the actual weighted violation rate of 8.5 percent was higher than the assumed RVR of 3.1 percent that was used to calculate the sample sizes. A corrective action plan was submitted and approved to ensure future compliance with the precision requirement.

**Reporting.** The ASR was completed and submitted on time on December 23, 2013, and was made available for public comment before submission to SAMHSA, as required, through the KDADS website and also distributed for review by the Kansas Synar Advisory Council.

## State Synar Program Support

**Synar Budget and Funding.** Kansas planned to invest a total of $433,100 state funds in the Synar program for FFY 2014. This includes $13,100 for Synar inspections and $400,000 to KDOR/CATE for additional enforcement and merchant education visits. In addition, $20,000 of these state funds is earmarked for Greenbush to develop the sample design and data analysis to determine the RVR.

In its FFY 2014 SABG plan, Kansas reported not utilizing SABG funds under section 1926 expenditures for FFY 2011.

**Strategic Planning.** Kansas has a comprehensive state strategic plan for tobacco control, the Kansas Tobacco Use and Prevention and Cessation Strategic Plan (2011–2015). KDHE, KDOR, and KDADS are all listed as active partners on the report, as are other state and local health agencies and tobacco prevention advocacy groups. The low RVR is noted as a key tobacco control accomplishment in the plan, and reducing the RVR to 5 percent is a major outcome of the plan. However, due to turnover and staff reorganization, the plan is not actively used by the KDADS staff. KDADS indicated that they are interested in renewing the strategic planning process and developing a data driven strategic plan in the future.

**Policy Development and Education.** The Kansas Tobacco Use and Prevention Cessation Strategic Plan includes several tobacco prevention policy initiatives including goals to promote, implement, and strengthen indoor clean air laws for Kansas and support the adoption of stronger local ordinances; investigate and disseminate best practices related to reducing secondhand smoke exposure in a variety of settings; and to increase tobacco excise taxes to further reduce tobacco consumption and provide additional funding for tobacco prevention and cessation. Many tobacco prevention stakeholders were active partners in developing these priorities and one of the next steps is that the plan will be used to guide legislative decisions.

**State Youth Tobacco Access Support Strategies.** From October 1, 2012, to September 30, 2013, the KDOR/CATE Team completed 2,494 retailer education/inspection visits with tobacco retailers. KDOR/CATE agents provide merchant education in at least one of their annual visits to every licensed outlet. Moreover, retail owners can request KDOR agents and/or RPC staff to provide merchant education to their employees. Educational visits consist of performing an inspection, including checking for the posting of the state-issued license, and verifying that the required signage is posted. Also during the visit, inspectors conduct a random check of cigarette packages for the state's tax stamp; confirm that the brands sold are listed on the Kansas Attorney General's directories of approved brands permitted to be sold in the state; ask the retail dealer if they retain 3 years of invoices on the premises; and address any questions that retail staff may have about the inspection process.

CATE inspectors discuss the techniques to verify age when a Kansas driver's license is presented. Sample driver's licenses are shown and discussed with available staff, noting the slogan, "vertical and green, not 18," as an age verification identifier of the Kansas driver's license.

Brochures displaying the driver's license format for minors under age 18 (vertical with a green bar), persons between 18 and 21 (vertical with a red bar), and individuals over 21 (horizontal with no bar) go out with every outlet license. They serve as reminders to merchants that they do not need to calculate age to determine if a youth

### POTENTIAL ENHANCEMENTS

- *KDADS may benefit from a Synar-specific strategic plan to ensure that the state is able to use a targeted, comprehensive data-driven approach while planning for additional enforcement and merchant education efforts.*
- *The state may benefit from using the strategic planning process to engage key stakeholders and educate policymakers on the importance of youth tobacco access.*
- *The state may benefit from assessing the various languages spoken in the merchant community and providing merchant education materials in those languages to ensure that youth tobacco access messages are accessible to all merchants across the state.*
- *KDADS may benefit from exploring opportunities to collaborate with state and local youth tobacco prevention coalitions to expand the reach of youth tobacco access messaging across the state.*

is old enough to purchase tobacco—they only need to look at the color of the bar. For a new licensee, the CATE inspector conducts an educational visit. If the licensee is a retail dealer who received a prior educational visit, the CATE inspector conducts an enforcement inspection. The difference is that on the initial education visit licensees may be given a written warning for any violations found, whereas at the actual inspection, licensees may be issued a written citation for the violations. The inspector will have an employee or manager, if available, sign the checklist and leave a business card for the licensee to call for further retailer training or questions they may have later. Inspectors also note that the CATE Team will be periodically performing inspections to curb sales of tobacco to minors by sending an underage youth into the establishment to attempt to purchase cigarettes.

Additionally, the Kansas Family Partnership has developed a merchant education website, "It's Everyone's Business" that is accessible to merchants and community members year round. The website provides merchants with information about the youth tobacco access law and provides information for community members and coalitions that are interested in educating retailers about the importance of youth tobacco access laws.

# Appendix A

## Site Visit Recommendations

### *Kansas Substance Abuse Prevention and Synar Site Visit Analysis*

### March 19–21, 2014

## Prevention System Organization

### *SSA Prevention System*

### Strengths

**The KDADS/BHS has developed collegial and collaborative relationships with other state agencies that are key stakeholders of substance abuse prevention efforts.**

KDADS has strategic relationships with the Kansas Departments of Revenue (KDOR), Health and Environment (KDHE), and Education (KDOE), each of which are key stakeholders in substance abuse prevention efforts. KDOR conducts Synar inspections and some merchant education activities, maintains Kansas' tobacco license list, and documents current Synar inspection protocols and data collection procedures. KDHE partners with KDADS to support the state's youth tobacco access control efforts and provide vital statistic information for the state's epidemiological profile for prevention. KDOE has subgranted funding to KDADS to administer Safe and Supportive Schools (S3) funding to reduce and prevent underage alcohol use, binge drinking, and/or marijuana use by high school youth.

**BHS staff noted that the agency has embraced behavioral health integration as a strategic opportunity.**

In October 2013, BHS went through a reorganization to further integrate programs into a continuum of care across addictions and mental health services. This change aligned prevention and substance use disorder services with the problem gambling and suicide prevention programs. BHS staff noted the agency has embraced this reorganization as an opportunity to strategically integrate problem gambling, suicide prevention, and mental health promotion into the behavioral health prevention infrastructure and leverage resources across multiple systems.

### *SSA Approach to Prevention*

### Strengths

**BHS's vision and mission includes a focus on healthy communities.**

BHS's vision focuses on community support for prevention and recovery throughout the lifespan, and its mission is "Partnering to promote prevention, treatment, and recovery to ensure Kansans with behavior health needs live safe, healthy, successful, and self-determined lives in their communities."

**BHS is working also to integrate the SPF into Kansas' current prevention system.**

The Kansas Planning Framework, which serves as a theoretical and operational framework to guide prevention services targeting the healthy development of children and youth, incorporates the use of SAMHSA's SPF.

### Challenges

**BHS subrecipients do not appear to have a clear understanding of what constitutes sufficient evidence of effectiveness for prevention strategies.**

Although BHS has adopted SAMHSA's criteria for evidence-based strategies and also reviews research on evidence of effectiveness for prevention strategies, subgrantees appear to consider listing on the National Registry of Effective Programs and Practices (NREPP) as evidence of effectiveness in and of itself, even though the NREPP website states that it is not appropriate for use in this way since the site includes all reviewed strategies, including those with very low quality of research.

### *Multiagency/State Prevention System*

### Strengths

**BHS is working to establish an overarching, multiagency advisory council for prevention.**

As part of the integration, the Governor's Mental Health Planning Council was renamed and restructured as the Governor's Behavioral Health Planning Council (Governor's Planning Council). The Governor's Planning Council currently has 10 to 11 subcommittees on a variety of subjects that work from charters with established goals and objectives. BHS staff noted that because the council does not currently have a prevention subcommittee, BHS has developed a draft charter to establish one that could also serve as an overarching guidance council for prevention.

**Kansas' prescription drug monitoring system (PDMS)—Kansas Tracking and Reporting of Controlled Substances System (K-TRACS)—is credited with keeping the rate of drug overdose deaths in Kansas one of the lowest in the nation.**

PDMSs allow doctors and pharmacists to log on to a secure website to review the prescription histories of patients. PDMSs can also send notices to providers and pharmacists when potential prescription abuse is detected. In Kansas, all licensed pharmacies that fill patient prescriptions are required by law to use K-TRACS, and many hospitals voluntarily use it as well. State law requires daily reporting, unlike many states, which only require weekly updates. Kansas is one of the few states that shares data across state lines, and the program also plans to connect to LACIE (the Lewis and Clark Information Exchange), one of the two networks that comprise Kansas' statewide health information exchange.

## Challenges

**Kansas does not currently have an advisory group to guide the direction of the SABG prevention set-aside requirements.**

The CSAP team noted that KDADS does not currently have an advisory group to set a clear course of action to reduce use of alcohol, tobacco, and other drugs (ATOD) and achieve other desired behavioral health outcomes and address SABG prevention set-aside requirements.

### *Substate Prevention System*

## Strengths

**BHS's substate infrastructure includes the Prairie Band Pottawattamie Tribe, which is the first time the SSA has funded a tribe.**

The Prairie Band of Potawatomie tribe is one of six grantees receiving PFS funding administered by BHS. This is the first time the state has funded a tribal substance abuse prevention initiative.

**Kansas has two Drug Free Communities (DFC) grantees that supplement substate prevention infrastructure.**

SAMHSA's DFC Support Program is a highly competitive federal grant program that provides funding to community-based coalitions working to prevent youth substance use. The state's two DFC grantees bring an additional $250,000 in federal funding into Kansas for substance abuse prevention.

## Challenges

**The number of DFC grantees in Kansas has declined significantly since 2008.**

The CSAP team noted that the number of Kansas coalitions that have been successful in competing for DFC funding has dropped significantly since 2008—when there were 10 DFC grantees—despite the SSA's history of spending the majority of prevention funding on T/TA to build community capacity for prevention.

**Kansas does not have a formal venue for community coalitions to network, peer mentor each other, and coordinate prevention initiatives.**

While KFP maintains a coalition registry and sends out information electronically, there is no interactive listserv or other mechanism to help coalitions communicate directly with each other. Coalition leaders participating in the site visit described efforts to try to connect and collaborate with like-minded coalitions both in and out of the state.

| Potential Enhancements for Prevention System Organization | |
|---|---|
| 1 | **Advisory council for prevention**<br>BHS is encouraged to finalize and operationalize the draft charter and establish a prevention subcommittee within the Governor's Behavioral Health Planning Council that can facilitate multiagency input and coordination for prevention efforts. |
| 2 | **Criteria for evidence-based prevention**<br>BHS's ability to maximize SABG funds and achieve outcomes could be significantly enhanced by clearer guidance to help subrecipients better understand what constitutes evidence of effectiveness for prevention strategies. |
| 3 | **Coalition collaboration**<br>BHS's ability to support community efforts to reduce substance abuse could be enhanced by the development of accessible and interactive venues (e.g., listservs, collaborative internet-based sites, state coalition association) to help coalitions connect, network, peer mentor one another, and coordinate efforts. Toward that end, BHS might benefit from reviewing strategies other states have used to see which, if any, might work well for Kansas. |

## Key Contextual Conditions and State Substance Abuse Trends

*State Substance Abuse Trends*

### Strengths

**Kansas' alcohol laws are among the strictest in the nation.**

The only alcoholic beverage that grocery stores and gas stations may sell is beer with no more than 3.2 percent alcohol by weight ("3.2 beer"). Other liquor sales are allowed solely at state-licensed retail liquor stores, but 3.2 beer must be sold in separate rooms from other alcoholic beverages. Alcohol sales are prohibited on Christmas and Easter. On the days sales are permitted, package sales are prohibited before 9 a.m. and after 11 p.m., and on-premises consumption is prohibited after 2 a.m. and before 9 a.m. Sunday on-premises sales in the state have been permissible only since 2005.

**Kansas has passed comprehensive clean indoor air legislation.**

As of July 1, 2010, smoking is prohibited in most places of employment and public places, including: restaurants and bars; taxicabs and limousines; and lobbies, hallways, restrooms and other common areas in apartment buildings, multiple-residential facilities, hotels, and motels. This includes the area within 10 feet of any doorway, open window, or air intake where smoking is prohibited.

**Kansas is experiencing a number of desirable trends with regard to youth and adult substance abuse.**

Data from the National Survey on Drug Use and Health (NSDUH) indicate that reported rates of past-30-day use of alcohol, cigarettes and other tobacco products, and marijuana have all decreased among Kansas youth and are below U.S. medians. In addition, age of first use of cigarettes and marijuana among youth has increased and is higher than the U.S. median. Current use of alcohol and cigarettes by Kansas adults is decreasing, and the reported rates of adult use of alcohol, illicit drugs other than marijuana, and nonmedical use of prescription psychotherapeutics and prescription pain relievers remains below the U.S. median.

### Challenges

**Kansas' large geographic size and sparse population density in many parts of the state challenge even coverage of prevention services.**

Although Kansas ranks 15th in size among all states, its population of just 2.9 million residents makes it one of the least densely populated. While the state has 627 incorporated cities, nearly 90 percent of them have fewer than 3,000 people, and many of those have fewer than 1,000 residents. For example, some RPCs are tasked with serving many counties.

**Kansas' geographic position and Interstate highway system are conducive to drug trafficking.**

Kansas has the second largest state highway system in the country after California, with a total of 874 miles that includes two of the busiest Interstate highways in the nation. I-70 is a major east/west route running from Baltimore, Maryland through Kansas and Denver, ending in Utah. I-35 runs from Laredo, Texas on the U.S./Mexican border through Kansas to Minneapolis, ending in Duluth. According to the 2011 National Drug Threat Assessment report from the National Drug Intelligence Center, Kansas City has become an important hub for U.S. drug trafficking because of its location in the middle of the country, and because I-70 and I-35 converge there.

**Use of other illicit drugs and nonmedical use of prescription psychotherapeutics are a significant concern for Kansas youth.**

Reported rates of other illicit drugs and nonmedical use of prescription psychotherapeutics increased from 2003 to 2011 to levels that exceed the U.S. median. The reported rate of nonmedical use of prescription pain relievers among youth increased as well, although the rate is lower than the U.S. median.

**Several substance abuse indicators for Kansas adults are also moving in undesirable directions.**

While the reported rate of adult cigarette use also declined from 2003 to 2011, the rate remains higher than the U.S. median. The reported rate of adult use of other tobacco products has been increasing and is several percentage points above the U.S. median. At the same time, the percentage of Kansas adults reporting risk of harm from smoking a pack or more of cigarettes a week has decreased and is below the U.S. median. The reported rate of past-30-day marijuana use has also increased for adults, although the rate remains below the U.S. median.

**The rate of drug overdose deaths in Kansas has nearly tripled since 1999.**

Although Kansas has the eighth lowest drug overdose mortality rate in the U.S., with 9.6 per 100,000 people suffering drug overdose fatalities, this rate has nearly tripled since 1999 when the rate was 3.4 per 100,000.

**TEDS and BRFSS data indicate disparities in ATOD use by Kansans by race, ethnicity, age, and gender.**

For example, although Blacks/African Americans make up less than 6 percent of the population of Kansas, they accounted for 15 percent of those admitted to state-funded treatment in 2012 and were significantly overrepresented among all races and

ethnicities among those admitted for primary dependence on illicit drugs and alcohol with a secondary drug. Hispanic/Latinos, who represent 10.5 percent of the state's population, were overrepresented among all races and ethnicities among those admitted for primary dependence on other/unknown drugs, inhalants, cocaine, and marijuana. TEDS data also indicate that young adults were overrepresented for nonmedical use of prescription drugs.

### Potential Enhancements for Contextual Conditions and Substance Trends

None noted.

## Substance Abuse Needs Assessment

### Unique And Notable Accomplishments

**The Kansas Communities That Care (KCTC) Survey has provided important and reliable data on youth substance abuse since 1994.**

The KCTC survey has been conducted since 1995 on an annual basis with students in grades 6, 8, 10 and 12. The survey is currently available online or in paper format and in English and Spanish. The results of the survey are disaggregated to the school building and/or district level, and all but 15 of Kansas' 105 counties have sufficient participation to get a county-level report. BHS staff and contractors reported that most years the participation rate has been 70 percent or better.

### Strengths

**BHS is using KCTC data to create "Hot Spot" maps indicating trends and prevalence of youth alcohol, cigarette, and marijuana use by county.**

BHS contracts with Greenbush to use data from the KCTC survey to create statewide "Hot Spot" maps indicating trends and prevalence of youth alcohol, cigarette, and marijuana use by county. The RPCs use the "Hot Spot" maps to identify priority substance abuse problems to address in local communities.

### Challenges

**Community access to KCTC data at the school level tends to be limited.**

RPCs and community coalitions participating in the site visit noted that it is difficult for many coalitions to get access to school building or district-level data. When they can get access, they frequently cannot make it public.

**BHS staff is not using K-TRACS to monitor prescription drug abuse, even though youth prescription drug abuse is increasing in Kansas and is above the national median.**

BHS staff reported being unaware whether they have access to this data.

**Kansas appears to have several data gaps at the state and local levels.**

The *Kansas Substance Abuse Epidemiological Indicators Profile 2006–2011* notes a number of data gaps relating to community-level aggregation of data in rural areas, participation and response rates, race and ethnicity, tribal information, and information on incarcerated populations.

**Although data by race/ethnicity are available, BHS and the RPCs do not appear to be using these data to identify health disparities and target prevention funds.**

Because Kansas' prevalence rates of substance abuse—particularly among youth—are lower than the national median in many areas, efforts to further decrease rates will require identifying those subpopulations at highest risk. Although many of Kansas' survey and archival data sources collect demographic data that can be cross tabulated with substance abuse data (e.g., race/ethnicity, orientation, and age), Kansas reports primarily targeting universal indirect populations with its prevention funds and does not appear to use data to identify priority subpopulations other than youth in general.

**BHS staff and subrecipients do not appear to be using the data available to them to assess ATOD issues across the lifespan.**

BHS staff and RPCs appear to rely almost exclusively on KCTC data, even though the state has access to other valid state-level data (e.g., KTRACS, BRFSS, NSDUH, college ATOD surveys) that could be used to assess issues impacting young adults, adults, and other subpopulations across the lifespan.

| Potential Enhancements for Substance Abuse Needs Assessment | |
|---|---|
| 4 | **Use of data to identify populations most in need of prevention services**<br>BHS's ability to further target prevention funds by identifying populations most in need of prevention could be enhanced by cross-tabulation and analysis of available data to identify relationships between substance abuse and other characteristics (e.g., age, race/ethnicity, gender, military involvement, other characteristics). |
| 5 | **Use of K-TRACS or other data to monitor prescription drug abuse**<br>BHS's ability to analyze and effectively address the high rates of prescription drug abuse by Kansas youth and adults might benefit from an exploration of how K-TRACS data could be accessed and used at the state and local levels to tailor prevention initiatives and strategically target them to those populations and areas most in need, including identifying geographic areas in the state where prescription drug abuse is most prevalent. |

## Workforce Development and Capacity Building

### Unique And Notable Accomplishments

**BHS is sponsoring a TA initiative that includes a focus on helping former SPF-SIG grantees to sustain their efforts and outcomes.**

In 2013, BHS launched an intensive T/TA effort called the Kansas Strategic Prevention Framework (KSPF). The primary purpose of the initiative is to select, engage, and support "Target" communities in using the first three steps of the SPF to develop long-term, comprehensive prevention plans. Criteria for "Target" communities include sufficient readiness, capacity, and need to implement the first three steps of the SPF. A secondary focus of the KSP is to provide support to identified "Developmental/Sustainment" communities that need further coaching and consultation in the areas of mobilization, readiness, capacity development, or coalition infrastructure development. "Developmental/Sustainment" communities include all former Kansas SPF-SIG grantees.

**BHS has developed a Kansas Prevention Network Online Advocacy Toolkit to help local and state substance abuse prevention stakeholders advocate for positive public policies.**

The Toolkit distinguishes between advocacy and lobbying; provides guidance on each step of the advocacy process, including mobilization and how to create an advocacy plan; discusses best practice "dos" and "don'ts" and steps for talking to a legislator; as well as practical information on the legislative process in Kansas. The CSAP team noted that this is a unique and notable document that could be very useful to other states interested in building grassroots capacity for prevention advocacy.

### Strengths

**BHS has a broad operational framework of the prevention workforce.**

BHS's definition includes regionally based prevention consultants, coalitions, and prevention providers, which allows it to increase the reach and depth of its prevention efforts.

**BHS has demonstrated a commitment to workforce development by investing funding to support T/TA provision across the state.**

BHS funds KFP to provide coordination and logistical support for prevention specialist trainings and certification, including coordinating and administering annual testing, maintaining an online database of network members currently certified, and providing resources to help prevention providers prepare for the certification exam.

**BHS has engaged in a preliminary analysis of workforce development needs.**

BHS's Strategic Recommendations for Comprehensive Workforce Development identifies 14 recommendations with associated lead entities and target dates ranging from June 2014 to December 2015.

**BHS is using a variety of methods to provide T/TA.**

BHS and its consultants and contractors use a variety of methods to deliver T/TA, including traditional instructional methods, web-based conference calls and webcasts, coaching, and peer mentoring.

### Challenges

**BHS does not require minimum qualifications or demonstrated competencies for RPCs.**

BHS does not require prevention certification for RPCs, providers, or coalitions, and has not identified core competencies needed by the prevention workforce other than the universal standards required for certification. During the site visit, BHS staff noted that while several RPCs used to maintain staff who were certified prevention specialists, this no longer appears to be a priority as RPC staff did not perceive a benefit to securing and maintaining prevention certification. BHS also does not require

minimum qualifications or demonstrated competencies for RPCs and does not have a system in place to ensure that T/TA is implemented at a consistently high level across regions and by all trainers retained by RPCs. This issue is particularly acute given BHS's reliance on the RPCs to address to substance abuse priorities that currently exist within the state's behavioral health prevention workforce as well as emerging issues such as illicit and prescription drug abuse.

**BHS has not identified the core competencies that will be needed by the prevention workforce to successfully address priority substance abuse issues across the lifespan.**

During the site visit, BHS staff stated that they plan to redesign the state's prevention system to more effectively incorporate population- and outcomes-based approaches. This transition—along with emerging issues such as illicit drug use and prescription drug abuse—will likely require the acquisition of new core competencies (i.e., specialized knowledge, skills, and abilities) by contractors, prevention staff, and community coalitions.

**BHS has not conducted a formal assessment of prevention workforce needs to identify T/TA needs.**

BHS does not have a formal assessment of the degree to which the core competencies (i.e., specialized knowledge, skills and abilities) needed to address the state's substance abuse priorities currently exist within the state's behavioral health prevention workforce.

**BHS does not have a workforce development plan that is based on assessment data that can be used to address recruitment and retention and target workforce development efforts.**

BHS's *Strategic Recommendations for Comprehensive Workforce Development* does not appear to be based on a workforce assessment, and recommendations consist of process activities which are not linked to expected and measurable improvements in prevention workforce performance. In addition, the recommendations do not include the creation of a workforce development plan with targeted goals and objectives and measurable outcomes based on assessment and designed to assist in recruiting, training, and retaining a diverse and highly skilled workforce that is capable of implementing comprehensive prevention approaches.

### *Capacity Building*

### Strengths

**BHS has demonstrated a commitment to capacity building by investing funding to support TA to communities.**

BHS-funded TA is primarily intended to meet specific development needs of communities related to implementation of the SPF.

**BHS has launched an intensive, statewide TA effort to build community capacity to implement the SPF and sustain coalition efforts.**

The primary purpose of the Kansas Strategic Prevention Framework (KSPF) initiative is to select, engage, and support "Target" communities in using the first three steps of the SPF to develop long-term, comprehensive prevention plans. A secondary focus of the KSPF is to provide support to identified "Developmental/Sustainment" communities that need further coaching and consultation in the areas of mobilization, readiness, capacity development, or coalition infrastructure development.

**BHS staff, consultants, and contractors have developed and adopted several resources to support the KSPF initiative.**

BHS staff, consultants, and contractors have developed an Assessment Guidance Document; a KSPF Milestones, Deliverables and Work Products Checklist; Face-to-Face Core Team Training focusing on each step of the KSPF; a Collaboration and Capacity Summary and Workplan which consist of a survey and analysis of coalition strengths, needs, and followup actions; a Community Readiness Enhancement Workplan to facilitate discussions to strategize an action plan; and a readiness and feasibility rating tool. BHS also uses the Tri-Ethnic Center Community Readiness Handbook to assess and increase community readiness for change.

### Challenges

**Although the KSPF TA products focus on the steps of the SPF, it was not clear to the CSAP team how communities are expected to operationalize these materials.**

Several of these resource documents appear to be theoretical rather than data driven in terms of helping communities apply the SPF to address substance abuse priorities. For example, although the Assessment Guidance Document appeared to be intended as an introductory guide on community assessment, it included somewhat sophisticated discussions of statistical analysis but did not include practical guidance on how to strategically analyze data to identify priority ATOD problems and consequences and then drill down selectively to identify priority ATOD behaviors and associated intervening variables as an integral component of strategic prevention planning. In addition, the Sustainment training largely consists of tips and strategies for partnerships and fundraising, and it was not clear how communities would be able to use this process to conduct a comprehensive, results-oriented strategic financing planning process adequate for selectively identifying and securing resources needed to achieve and sustain desired outcomes into the future.

| Potential Enhancements for Workforce Development and Capacity Building | |
|---|---|
| 6 | **Core competencies needed to address all key ATOD issues**<br>BHS's ability to strategically target workforce development resources and efforts, including T/TA, could benefit from the identification of the core competencies needed at all levels of the Kansas prevention workforce to address the unique conditions of substance abuse priorities in the state. This could support efforts to require minimum qualifications and demonstrated competencies for RPCs. |
| 7 | **Formal workforce assessment based on identified core competencies**<br>BHS's ability to strengthen the statewide prevention workforce would likely benefit from a formal assessment of the prevention workforce needs based on identified core competencies. This assessment could inform the scope of T/TA services needed to help funding recipients use the SPF, and select and implement the evidence-based strategies most likely to be effective in addressing substance abuse priorities. As a starting point, BHS might benefit from reviewing workforce assessment tools and plans developed by other states to determine the most relevant components for Kansas. |
| 8 | **Workforce development planning**<br>BHS could further strengthen workforce development efforts by using workforce assessment results to create a strategic workforce development plan that ensures T/TA services are targeting the most pressing workforce needs. Such a plan could include specific and measurable desired workforce outcomes and associated strategies for all levels of the Kansas prevention workforce for recruitment, T/TA, and retention, as well as strategies for providing and coordinating T/TA that is delivered or sponsored by different agencies and departments. |
| 9 | **TA supportive materials**<br>BHS's ability to help communities implement the SPF and sustain outcomes might benefit from more practical, hands-on guidance for conducting assessments and other steps of the SPF. This could include more structured and detailed instructions for sustainability planning that begins with a results-oriented approach and includes strategic analysis of strategies to be used as well as resources needed, and administrative burdens associated with potential funding sources. Toward that end, BHS might review effective TA products developed by or for other states to determine whether components of any might be helpful to Kansas' efforts. |

## State Strategic Plan

### Strengths

**BHS has developed a prevention plan that identifies measurable outcomes for underage drinking and marijuana use.**

The *2012 Kansas Strategic Prevention Framework Strategic Plan and Logic Model* (SPF Plan) uses data to establish the following current intermediate and long-term prevention prevalence outcomes for Kansas students in grades 6, 8, 10, and 12:

- Decrease past-30-day alcohol use from a baseline of 25.63 percent in 2010 to 20 percent in 2014 and 19.5 percent in 2015.
- Decrease binge drinking from a baseline of 13.77 percent in 2010 to 11.1 percent in 2014 and 9.5 percent in 2015.
- Decrease past-30-day marijuana use from a baseline of 8.29 percent in 2013 to 8.0 percent in 2015.

### Challenges

**Kansas does not have a comprehensive, integrated plan for behavioral health prevention and promotion.**

Although BHS has multiple plans, they are not integrated and do not provide a comprehensive approach to address behavior health and promotion in Kansas.

**BHS's SPF Plan does not provide a clear path for how desired outcomes are to be achieved.**

The SPF Plan does not: identify what changes (and degree of change) are desired with regard to changes in knowledge, skills and abilities; establish baselines and desired targets for short- and medium-/intermediate-outcomes; or describe how the changes in process measures and system development and the maintenance of current efforts are directly linked to—and sufficient for achieving—the state's priority prevention outcomes related to alcohol and marijuana use.

| Potential Enhancements for State Strategic Plan | |
|---|---|
| 10 | **Comprehensive strategic plan for substance abuse prevention**<br>BHS's ability to maximize resources and reduce problems associated with all aspects of behavioral health prevention and promotion could be enhanced by using existing planning efforts as the foundation for the development of a unified strategic plan that is based on data-driven logic models that map out the relationships and linkages between problems and consequences, undesirable/ risky behaviors, and key intervening variables. These logic models could then be used to inform the development of a state strategic plan for prevention that includes measurable and realistic outcomes and effective strategies. Key components of a comprehensive plan would include:<br>■ Clear goals related to priority behaviors and related problems and consequences, as well as infrastructure development<br>■ Specific objectives related to key intervening variables and causal conditions that are logically linked to priority behaviors and related problems and consequences<br>■ Targeted outcomes that represent quantifiable progress over time in achieving desired goals and objectives<br>■ State-level strategies and activities that are culturally relevant and logically linked to desired goals, objectives, and outcomes<br>■ An implementation plan with clearly defined roles, responsibilities, and time lines<br>■ An evaluation plan sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed<br>■ A strategic financing component that analyzes all existing resources and infrastructure, and aligns resources to support desired outcomes. |
| 11 | **Comprehensive strategic plan for prevention system development**<br>BHS's ability to achieve its desired changes in prevention system development and functioning would likely also benefit from an effort to map out the relationships and linkages between problems and consequences associated with current prevention system infrastructure and development, current undesirable prevention system "behaviors," and key intervening variables associated with system problems, consequences, and undesirable behaviors. Key components of a comprehensive plan would mirror those element listed above. |

## Primary Prevention Set-Aside

### Challenges

**RPCs do not appear to be reporting level of effort spent on CSAP's six strategies consistently or according to established definitions.**

For example, while many of the RPCs' assigned tasks are administrative in nature, BHS noted that they frequently report their tasks as community-based strategies. Although ODSS uses a "drop-down" menu for reporting prevention activities, it appears that RPCs are not consistently reporting their activities.

**Kansas' FFY 2013 SABG application contains numerous discrepancies between data submitted in Tables 33–37 and supplied in narrative.**

Figures provided in Table 6a and Table 6b appear to be inconsistent with information reported in Table 35, Table 36, and Table 37. These tables are expected to relate to each other.

**Kansas appears to have used a reporting period different than the required standard reporting period for some information supplied in its FFY 2013 SABG application.**

The state used the period of July 1, 2008–June 30, 2010, to report information in Tables 4b, 6a, and 6b in Kansas' 2013 Behavioral Health Report. This period begins before the start date of—and ends before the authorized final date for—expenditures from the FFY 2010 award, which is the required compliance year for these tables.

| Required Followup Action |
|---|
| None noted. |

| Potential Enhancements for Primary Prevention Set-Aside | |
|---|---|
| 12 | **Strengthen reporting on CSAP's six strategies**<br>BHS is encouraged to revise ODSS to differentiate reporting on the CSAP six strategies to more accurately identify, collect, and report RPC activities. BHS might further strengthen RPC reporting by updating the ODSS manual to reflect these changes as well as a training for RPC on how to report their activities. |
| 13 | **Quality assurance (QA) process for review of federal reports**<br>BHS's ability to reduce reporting errors in its SABG application might benefit from the implementation of a QA process to review all data and information prior to submission in federal and other reports. |

## Implementation

### Unique And Notable Accomplishments

**BHS was able to significantly reduce underage drinking and underage binge drinking by providing SPF-SIG funds directly to communities to implement local substance abuse plans.**

BHS used SPF-SIG funds to directly support implementation of community-led prevention plans targeting underage drinking and underage binge drinking in communities with high prevalence of both issues. From 2007 to 2012, SPF-SIG communities in Kansas reduced underage drinking from 33.2 percent to 23.6 percent, while communities without SPF-SIG funding reduced rates at a much lower rate (29.1 percent to 23.7 percent). Similar results were seen for underage binge drinking, with SPF SIG-funded communities lowering rates much more significantly (from 18.3 percent to 12.6 percent) than communities without SPF-SIG funding (15.6 percent to 12.4 percent).

### *Prevention Budget and Funding*

### Strengths

**Kansas has a robust overall budget for prevention given its low population density.**

Unlike many states, which rely just on SABG funding for prevention the State of Kansas also allocates state general funding of more than $800,000 per year for prevention. In addition, Kansas has been successful in acquiring federal discretionary grant funds of more than $1.1 million per year to supplement prevention efforts. According to budget documents supplied by BHS, these funding sources combined with SABG primary prevention funds amounted to $4,720,706 for a population of 2.9 million people.

### *Funding Allocation Processes*

### Strengths

**BHS allocates funds through competitive requests for proposals (RFPs).**

BHS allocates the bulk of its funding for community and family-based services and contracts for RPCs and statewide contractual services through competitive RFPs. RFPs are issued every year, with opportunities for annual renewal based on application and satisfactory performance.

**RPCs are subgranting some SABG funding to support community-led prevention.**

In 2012, as part of the KSPF initiative, BHS began requiring RPCs to subgrant at least $20,000 in SABG prevention funding each to communities in their region, which marked the first time SABG funding was used to support community-level prevention funding.

**BHS expressed interest in investing significantly more prevention funding into community-led prevention efforts.**

BHS staff expressed a desire to realign current funding allocations in the future to more closely mirror the allocation processes used in its successful SPF-SIG initiative, wherein just 15 percent of funding was allocated to state and regional infrastructure and 85 percent was used to support the implementation of community prevention plans.

### Challenges

**Even though funding is allocated competitively, the pool of subrecipients and contractors has remained relatively unchanged since the inception of the system in 1989.**

BHS staff noted that, with relatively few exceptions, the majority of agencies holding contracts with BHS date back to the inception of the system in 1989. Given BHS's interest in enhancing its ability to achieve sustainable and measurable outcomes, the static base of subrecipients and contractors not only constrains the competitive nature of the funding process, but also can limit innovation and new approaches to capacity development and problem solving.

**BHS allocates a relatively small portion of SABG funding to support community-led prevention initiatives.**

Budget documents supplied by BHS indicate that pending RPCs subgrant amounts for community-led prevention range from the minimum $20,000 per region to $61,479, for a total of $337,990, which accounts for only approximately 12 percent of all SABG funds. This small amount spread over 10 to 30 communities is not likely to be sufficient to fund the comprehensive approaches needed to significantly reduce substance abuse-related problems and consequences.

**BHS does not use outcome-based contracting.**

Deliverables and performance indicators identified in its prevention grants and contracts focus on completion of processes and administrative activities only. For example, although the grant award documents for KFP and the RPCs indicate that the funding is intended to help build capacity to achieve the state's priority prevention outcomes, funding award documents do not specify capacity outcomes, and neither KFP nor the RPCs are required to document outcomes related to measurable changes in capacity that in turn could be expected to lead to improvements in substance abuse-related problems and consequences.

### *Prevention Expenditures and Allocations*

### Strengths

**BHS and some RPCs have adapted prevention messages and outreach to be culturally relevant to Hispanic/Latino residents.**

The KCTC survey is available in Spanish and BHS staff and providers participating in the site visit described efforts that had been made to reach out to and adapt prevention approaches to be culturally relevant and appropriate to the state's Hispanic/Latino population, including translating materials and media messages into Spanish. These efforts appear to be most concentrated in Finney County in the southwest portion of the state, in which nearly one-half of the population is made up of Hispanic/Latinos.

### Challenges

**SABG prevention funds in Kansas currently have very small reach and scope.**

BHS reported serving between 5,911 and 5,987 persons through individual-based strategies and 78,797 through population-based strategies in FFY 2010. These figures represent only 0.2 and 2 percent respectively of the state's population of 2.8 million residents. Given the much larger prevalence of reported substance abuse in the state, it could be difficult for BHS to achieve significant outcomes in reduced substance abuse problems and consequences if it does not increase the reach of its prevention initiatives.

**Prevention funding in Kansas is focused on youth, even though adults demonstrate elevated rates of ATOD use and abuse.**

BHS staff noted that prevention funding in Kansas has historically been directed to efforts targeting youth. The CSAP team noted that many indicators of ATOD use by Kansas adults are showing worsening trends, however, including increases in the percentage of adults that report current use of alcohol, marijuana, other illicit drugs, and tobacco products other than cigarettes. In addition, the prevalence of smoking and other tobacco use by Kansas adults exceeds the national median, while perception of harm is decreasing and is below the national median.

**BHS reported reducing support of environmental prevention by nearly half in FFY 2013 compared to FFY 2010.**

In 2013, BHS reported intending to reduce spending on environmental strategies while increasing spending on education and information dissemination. In 2010, BHS reported allocating 12 percent of all SABG funds to environmental prevention, but only 7 percent in 2013. Environmental strategies accounted for an even smaller percentage of BHS's total prevention budget for 2013 (5 percent), compared to 2010 (9 percent).

**BHS relies on media on its own as a primary prevention strategy.**

BHS appears to invest a considerable amount of funding in media and communications approaches, including allowing the subrecipients to choose media as a stand-alone prevention strategy. Prevention research indicates, however, that media is most effective when used as a supportive strategy for environmental and other comprehensive approaches.

**Efforts to develop culturally specific prevention strategies and offer prevention services and materials in languages other than English appear to be limited in some parts of the state.**

For example, although the population of northeastern Kansas is becomingly increasingly diverse—and Kansas data indicate significant disparities in drug use by race, ethnicity, and other demographics—efforts to develop culturally specific prevention strategies or offer prevention services and materials in languages other than English appear to be limited.

### *Funding Requirements*

### Challenges

**There are no clear or consistent requirements for how RPCs should subgrant funds to communities or select communities for funding.**

Although RPCs were requested to identify "Target" communities based on need, prevalence, readiness, capacity, and coalition infrastructure, according to BHS staff, RPCs have had significant autonomy in deciding which communities to fund.

For example, while BHS supplied "Hot Spot" maps indicating counties with the highest rates of youth prevalence of alcohol, marijuana, and tobacco use, RPCs had no contractual requirements to use that data or other specific criteria to select communities for funding.

**While BHS's contracts with RPCs note that the SPF is to be used inform their workplans, there are no formal requirements for them to do so.**

For example, although BHS strongly encourages RPCs to base their work on assessment data, there are no formal requirements that RPCs do so. In addition, RPCs are not required to conduct formal assessments of substance abuse or T/TA needs or use such assessment data to develop T/TA workplans or strategic plans to identify the most appropriate prevention strategies. RPCs are also not required to evaluate the outcomes of their efforts in terms of increases in community capacity, which can lead to reductions in substance abuse consumption and consequences.

**RPCs and KFP, subrecipients funded by BHS, are not required to use evidence-based prevention strategies or approaches, even though they receive the majority of all prevention funding.**

During the site visit, BHS staff noted that Kansas has historically invested very few ATOD prevention funds into the implementation of evidence-based strategies, and identified this as a "critical gap." Even though BHS invests the bulk of its prevention funds in RPCs and KFP, the 2012 KSPF Plan notes that they and other funded statewide programs are not required to implement evidence-based strategies. The CSAP team noted that many of the activities performed by RPCs and KFP (e.g., attending coalition meetings, providing presentations, education, information dissemination, Red Ribbon week activities) have not been determined to be evidence-based on their own and are not being conducted as a core component of an overarching strategy that has been documented to be evidence-based.

| Potential Enhancements for Implementation | |
|---|---|
| 14 | **Community funding**<br>BHS's ability to significantly prevent and reduce substance abuse problems could benefit from using the lessons learned from Kansas' SPF-SIG initiative and investing significantly more funding into the implementation of data-driven and community-led prevention initiatives that use strategies with a high level of documentation of effectiveness. |
| 15 | **Needs-based funding across the lifespan**<br>BHS's ability to achieve documentable outcomes in reduced substance abuse might be enhanced by the use of data to target funding allocations to populations and subpopulations demonstrating the highest documented needs across the lifespan. |
| 16 | **Use of evidence-based strategies**<br>BHS's ability to enhance desired prevention outcomes might benefit from a review of prevention expenditures to ensure that funds are invested in those strategies with the highest evidence of effectiveness. The CSAP team also recommends that BHS require all subrecipients and contractors to implement strategies that are supported by data and documented to be effective. |
| 17 | **Evidence-based strategies for marijuana**<br>BHS staff, providers, and RPCs noted a need for evidence-based prevention strategies to address marijuana use. |
| 18 | **Media campaigns**<br>BHS might improve the penetration and impact of its media messages by using data and public health approaches more strategically to determine the subpopulations that most need to be reached, and crafting and deploying media messages accordingly. |
| 19 | **Use of culturally and linguistically relevant approaches**<br>BHS's ability to reduce substance abuse-related health disparities across the state might be strengthened by consistently addressing ethnic, linguistic, and cultural issues in each component of the SPF. |
| 20 | **Use of SPF to inform workplans**<br>BHS's ability to ensure that all funded prevention efforts are targeted and able to achieve desired outcomes would benefit from increased guidance and requirements that all subrecipient grantees and contractors use the SPF to guide their work. This would include developing comprehensive and targeted workplans that are based on valid and locally representative assessment data that accurately identify priority problems and consequences, and desired changes in organizational capacity and/or substance abuse behaviors and associated intervening variables. |

## Evaluation

### Strengths

**BHS has a solid protocol for monitoring process data, and uses corrective action plans when applicable.**

BHS monitors grantees and contractors for fiscal compliance and performance on a monthly basis, and grantees participate in virtual coaching sessions with BHS prevention staff on a bimonthly basis, or more frequently as needed or identified in corrective action plans.

**ODSS is able to collect, report, and facilitate the development of prevention program data.**

BHS uses ODSS to collect and report program data and monitor subrecipients, who are required to track process data and report progress toward completion of specified activities on a monthly basis. ODSS has the capacity to sort data for a variety of reports and graphs, which is intended to assist in evaluating the progress of subrecipients and community coalitions in completing activities. The KU Workgroup and BHS staff review all ODSS entries each month for reliability and progress.

**BHS requires RPCs and other subrecipients to track process data and monitor progress toward completion of activities.**

BHS requires RPCs and their subrecipients to report services provided and community changes associated with their work in both target and non-target communities throughout their regions on the ODSS on a monthly basis.

### Challenges

**BHS does not require RPCs or other statewide subrecipients to collect and report outcome data or develop evaluation plans.**

RPCs are not required to collect and report outcome data, or develop and implement evaluation plans. Their work is also not evaluated by BHS or the communities they serve in terms of the degree to which funded RPC strategies and activities increased community capacity sufficiently to have an actual impact in reducing substance abuse related problems and consequences or ATOD use. In addition, KFP is not required to evaluate the degree to which RADAR materials and services increase the knowledge, skills, or abilities of those accessing them.

**Although KDADS performs statewide evaluation of all CSAP-funded prevention initiatives, including evaluation at the community level, these efforts do not include non-CSAP-funded prevention activities.**

Because evaluation efforts are limited to each CSAP-funded program, BHS's efforts to monitor, document, and assess Kansas' progress toward prevention strategic plan outcomes are not comprehensive. Further, evaluation is conducted only at the individual program level; however, BHS does not integrate these efforts into a consolidated evaluation plan at the statewide prevention system level, including CSAP-funded and non-CSAP-funded prevention activities. ODSS tracks process outcomes only and cannot monitor intermediate or long-term subrecipient outcomes and tie those outcomes back to funded prevention strategies. The absence of this evaluation infrastructure limits BHS's ability to identify and implement midcourse corrections in implementation processes and redirect or reallocate funds as needed to achieve desired outcomes.

| Potential Enhancements for Evaluation | |
|---|---|
| 21 | **Outcome evaluation**<br>BHS's ability to measure the effectiveness of its significant investment in the RPCs and other statewide subrecipients would be greatly enhanced by expanding requirements that they evaluate the degree to which their funded strategies and activities result in increases in capacity that can be linked to reductions in substance abuse-related problems and consequences. |
| 22 | **Statewide evaluation system**<br>BHS's ability to document the value and outcomes of its subrecients (RPCs and KFP) could be significantly enhanced by the development of a statewide evaluation system that is capable of monitoring intermediate and long-term outcomes, as well as the degree to which those subrecipients appear to be achieving their desired impact in support of state and local priorities and target populations. |

# Synar Recommendations

## Synar Program Development and Organization

### State Synar Program Organization

#### Strengths

**Kansas has an interagency partnership between KDADS, KDOR, and KDHE, including other partnerships such as Tobacco Free Kansas Coalition and the Kansas Family Partnership.**

Through these formal agreements, partner agencies maintain collaborative working relationships around the Synar program and tobacco prevention.

**Kansas has an active Synar Advisory Group.**

Kansas's SAC meets twice a year to provide updates to partner agencies. All of the key partners are represented on the SAC. This provides a formal venue for partners to come together and plan for Synar implementation.

#### Challenges

**It appears that the SAC is underutilized.**

The SAC meets on a biannual basis to provide updates to key partners. However, it does not appear that the group is using RVR data by region to target merchant education and enforcement efforts. KDADS staff identified SAC as an important component of the Kansas Synar program, as it is intended to serve as a vehicle for ongoing monitoring of the progress of the state's efforts to lower the RVR.

#### Potential Enhancements

| | |
|---|---|
| 1 | **KDADS indicated that they planned to meet with the SAC to determine the group's future direction.**<br>KDADS would benefit from the continued support of a strong SAC to ensure that a collaborative data-driven strategic approach is taken into consideration for the planning, implementation, and monitoring of the Synar program. |

### NOMs and RVR Trends

#### Strengths

**Kansas has sustained RVR below 10 percent since FFY 2010.**

Kansas has consistently reported an RVR lower than 10 percent for the last 4 years.

#### Challenges

**For FFY 2014, the RVR has risen 5 percentage points.**

The RVR for FFY 2014 was 8.1 percent, a substantial increase as compared to the RVR for previous years. The state has identified that they will examine their data in order to identify factors that contributed to this increase.

#### Potential Enhancements

| | |
|---|---|
| 2 | **Kansas has identified that they will examine their Synar data to identify factors that contributed to the increase in their RVR.**<br>Once KDADS and their partners on the SAC review their data to identify contributors to the increase in the RVR, they may consider reviewing current strategies and their costs to identify strategies for positively affecting noncompliance rates. |

## State Synar Program Compliance

### State Law

#### Required Followup Action

None noted.

### Strengths

**The Kansas youth tobacco access law is comprehensive and provides a foundation for the Synar program.**

The Kansas law prohibits selling tobacco to youth under the age of 18, as well as youth possession and consumption of tobacco products. It includes graduated fines for store employees and retail owners who sell to youth and provisions to revoke tobacco retailer licenses for multiple youth tobacco access violations.

### Challenges

None noted.

| Potential Enhancements |
|---|
| None noted. |

## Enforcement

| Required Followup Action |
|---|
| None noted. |

### Strengths

**Kansas has year round enforcement in every outlet in the state.**

Kansas performs a minimum of two visits per year to each tobacco outlet in the state for compliance inspections and merchant education purposes in addition to the Synar inspections. This ensures that there is a significant enforcement presence across the state and provides incentives for retailers and clerks to be vigilant about youth tobacco access. Additionally, because Kansas conducts multiple enforcement visits in each outlet, the state is able to take advantage of the graduated penalties described in the state youth access law.

### Challenges

**No coordination among local and state agencies regarding the state's activities to enforce youth access to tobacco laws.**

Although in the 2014 ASR, Kansas reported that enforcement of youth tobacco access laws occurred at both the state and local level, there is no information or data available on the type of local enforcement activities that are being conducted or the number of counties that are doing local enforcement.

| Potential Enhancements | |
|---|---|
| 3 | **Coordinate with local enforcement agencies around youth tobacco access enforcement efforts.**<br>The state may benefit from collaboration with local enforcement agencies to coordinate youth tobacco access enforcement efforts. This will allow the state to maximize its already substantial enforcement effort and collect local level data for planning. |

## Random, Unannounced Inspections and Valid Probability Sample

| Required Followup Action |
|---|
| None noted. |

### Strengths

**KDOR's real-time updated tobacco inspections database.**

While tobacco retailer licenses are updated every 2 years, KDOR/CATE agents update the list in real time to reflect any changes they identify in the field. Because of this, KDADS is able to easily access a current, accurate license list when the pull the Synar sample.

### Challenges

**No standardized training is available for youth inspectors.**

Although KDOR agents go through an annual training and receive a written inspection protocol, neither the training nor the inspection protocol is available to the youth inspectors. Currently, youth inspector training is limited to agent discussion and shadowing other youth inspectors.

**Review of KDOR's Synar inspection data showed one error.**

During the assessment of Kansas' FFY 2014 SSES data submission, the system review team examined a random sample (10 percent) of the completed inspection sheets and reviewed them for completeness and accuracy as compared with the SSES raw data submitted in FFY 2014 Annual Synar Report. The result of this review found that one inspection form was misclassified as a completed buy into the SSES system, while it was reported as ineligible in the original paper form.

| Potential Enhancements | |
|---|---|
| 4 | **Develop a standardized process to train youth inspectors.**<br>KDADS may consider the development and implementation of a standardized youth training protocol. This would ensure that inspections are conducted consistently. |
| 5 | **Develop a data cleaning process.**<br>KDADS may benefit from the development and application of a data cleaning process to ensure that the information on the completed Synar inspection forms is accurately entered and exported into the database used for determining the RVR. |

## Retailer Violation Rate

### Required Followup Action

None noted.

### Strengths

The state reported an RVR of 8.5 percent in FFY 2014, which is below SAMHSA's RVR target rate.

### Challenges

**Kansas' reported standard error for FFY 2014 is above the maximum standard error required to meet the SAMHSA precision requirement.**

In FFY 2014, Kansas reported an RVR of 8.5 percent with a standard error of 3.5 percent, which is below SAMHSA's RVR target rate. While Kansas' RVR was well below the target RVR, the reported standard error did not meet SAMHSA's precision requirement. The precision requirement was not met because the actual weighted violation rate of 8.5 percent was higher than the assumed RVR of 3.1 percent that was used to calculate the sample sizes. However, a corrective action plan was submitted and approved to ensure future compliance with the precision standard error.

### Potential Enhancements

None noted.

## Annual Synar Report

### Required Followup Action

None noted.

### Strengths

None noted.

### Challenges

None noted.

### Potential Enhancements

None noted.

# Synar Program Support

## State Synar Program Budget and Funding

### Strengths

**The state has leveraged state funds for Synar enforcement and merchant education.**

The Synar program is supported by more than $433,100 in state funds, which are used to implement additional enforcement and education visits in each outlet. This represents a significant investment in youth tobacco access prevention by the state.

### Challenges

None noted.

| Potential Enhancements |
|---|
| None noted. |

## State/SSA Strategic Plan for Youth Tobacco Access Prevention

*State/SSA Strategic Plan for Youth Tobacco Access Prevention*

### Strengths

**Kansas has a comprehensive state strategic plan for tobacco prevention and cessation.**

KDHE, KDOR, and KDADS are all listed as active partners on the Kansas Tobacco Use and Prevention and Cessation Strategic Plan, as are other state and local health agencies and tobacco prevention advocacy groups. The low RVR is noted as a key tobacco control accomplishment in the plan, and reducing the RVR to 5 percent is a major outcome of the plan.

### Challenges

**KDADS currently does not actively use the current strategic plan for tobacco prevention and cessation.**

KDOR CATE maintains real-time data available for tobacco inspections at state and local levels; however, these data do not appear to be considered in planning, implementation, and monitoring of the prevention strategies for the Synar program.

| Potential Enhancements | |
|---|---|
| 6 | **KDADS has identified that they would benefit from revitalizing the strategic planning process.**<br>While the current strategic plan includes Synar goals and objectives, KDADS may benefit from a Synar-specific strategic plan to ensure that the state is able to use a targeted, comprehensive data-driven approach while planning for additional enforcement and merchant education efforts. |

## State Synar Program Policy Development and Education

### Strengths

**The current Kansas Strategic Plan for Tobacco Prevention and Cessation lays out tobacco prevention policies.**

The current state strategic plan includes statements that the purpose of the plan is to inform policymakers about tobacco prevention and cessation. The plan also lays out several policy priorities including strengthening indoor clean air laws, reducing secondhand smoke exposure in a variety of settings; increasing tobacco excise taxes to further reduce tobacco consumption; and providing additional funding for tobacco prevention and cessation.

### Challenges

**Community's low perception of tobacco prevention as a priority to address.**

KDADS staff reported that youth tobacco access prevention at the state and community levels may not be perceived as a priority when compared with high consumption and consequences data for other substances. This makes it difficult to compete for limited funds.

| Potential Enhancements | |
|---|---|
| 7 | **Engage stakeholders in promoting the importance of youth tobacco access efforts.**<br>The state may benefit from using the strategic planning process to engage key stakeholders and educate policymakers on the importance of youth tobacco access. This could elevate the visibility of youth tobacco access across the state. |

## State Youth Tobacco Access Support Strategies

### Strengths

**Kansas has partnered with the Department of Motor Vehicles to create easy-to-recognize underage identification cards.**

Kansas has a driver's license that allows for easy age identification, where the license is horizontal for everyone 21 and older, vertical with a green bar for those who are 17 and under, and vertical with a red bar for those who are 18 to 20 years of age. This makes it easier for merchants to identify youth using identification that indicates they are under age.

**KDADS has developed a merchant education website to provide easy access to Synar merchant education materials.**

The Kansas Family Partnership has developed a merchant education website that is accessible to merchants and community members year-round. The website provides merchants with information about the youth tobacco access law, and also provides information for community members and coalitions who are interested in educating retailers about the importance of youth tobacco access laws. Anyone can order materials for free and support youth tobacco access efforts locally.

### Challenges

**Merchant education and media campaign materials are only provided in English.**

Currently, merchant education materials, including videos, are available in English only, although based on the state's demographics there may be a need to have them available in other languages. This would ensure that the youth access messages the state is investing in are accessible to the diverse merchant community across the state.

**KDADS does not coordinate youth tobacco access messaging with state and local coalitions.**

Kansas has a network of state and local tobacco coalitions. While these coalitions have access to merchant education materials, the SSA does not actively coordinate with these coalitions or leverage their support to educate communities about the importance of youth tobacco access. This severely limits the reach of KDADS's youth tobacco access messaging.

### Potential Enhancements

| | |
|---|---|
| 8 | **Assess language needs of the merchant community for education materials.**<br>The state may benefit from assessing the various languages spoken in the merchant community and providing merchant education materials in those languages to ensure that youth tobacco access messages are accessible to all merchants across the state. |
| 9 | **Engage tobacco prevention coalitions in coordinated youth access efforts.**<br>KDADS may benefit from exploring opportunities to collaborate with state and local youth tobacco prevention coalitions to expand the reach of youth tobacco access messaging across the state. |

# Appendix B

## Participant List From the Site Visit

| Name | Title | Organization |
|---|---|---|
| **State Participants** | | |
| Marcia Bartelson | Project Director | Sumner County Drug Action Team, Inc. |
| Sondra Borth | Executive Director | Reno County Communities That Care |
| Angie Brown | Program Consultant | BHS, Community Services and Programs Commission/Kansas Department for Aging and Disability Services |
| Lisa Chaney | Director of Research and Evaluation | Southeast Kansas Education Service Center, Greenbush |
| Carol Cramer | Program Manager | Tobacco Use Prevention Program, KDHE |
| Jessica Davis | Tobacco Program Manager | ABC, CATE Team, Kansas Department of Revenue |
| Sarah Fischer | Prevention and Problem Gambling Program Manager | BHS, Community Services and Programs Commission/Kansas Department for Aging and Disability Services |
| Angela Hagen | Director of BHS | BHS, Community Services and Programs Commission/Kansas Department for Aging and Disability Services |
| Marci Rosencutter | Tobacco Enforcement Inspector Senior | ABC, CATE Team, KDOR |
| Brenda Salvati | Prevention Services Program Director | Regional Prevention Centers at Preferred Family Healthcare |
| Melanie Snider | Community Services and Program Projects and Grants Coordinator | Financial and Information Services Commission Kansas Department for Aging and Disability Services |
| Hope Sullivan-McMickle | Training and Technical Assistance Consultant | BHS, Community Services and Programs Commission/Kansas Department for Aging and Disability Services |
| Jason Verbeckmoes | Director | Prevention and Wellness Services Mirror, Inc. |
| Peter Vopata | Prevention Fellow | BHS, Community Services and Programs Commission/Kansas Department for Aging and Disability Services |
| Michelle Voth | Executive Director | Kansas Family Partnership |
| Jomella Watson-Thompson | Associate Director | Community Paticipation and Research, KU Work Group |
| **CSAP Team** | | |
| Sandra Adrovet | State Project Officer | State Project Officer, Division of State Programs, CSAP |
| Barbara Fuller | Regional Services Manager | JBS International, Inc. |
| Laurie Barger Sutter | Prevention Specialist | JBS International, Inc. |

# Appendix C

## Sources of Information Reviewed

| Sources of Prevention Information | |
|---|---|
| 2013 SABG Behavioral Health Report | 2012–2013 SABG Behavioral Health Assessment and Plan Application |
| 2013 SABG Application | Kansas NOMs Summary Report |
| Kansas Substance Abuse Prevention and Synar System Review Report FY 2009 August 4–6, 2009 | Kansas Prevention System Assessment Report June 22–24, 2004 |
| TA Report - KANSAS-P-7-15-08-2<br>Kansas-P-07-15-08-1 TA Report<br>Kansas P 04 01 TA Report<br>Kansas-P-03 19 03 TA Report<br>Kansas SIR 2010-5 | Kansas CAPT TA Plans<br>Kansas TTTA Tracker Report<br>Kansas TTTA Tracker Report<br>Kansas TTTA Tracker Report |
| Kansas State Contacts | State Profile of Underage Drinking |
| State and County Quick Facts | Office of Adolescent Health publishes state summaries called Adolescent Mental Health Facts (2007–2011)<br>States In Brief Substance Abuse and Mental Health Issues At-A-Glance<br>samhsa.gov/data/States_In_Brief_Reports.aspx |
| State of Profile of Drug Indicators ONDCP | Grant Awards by State Summaries and Full Detail of Awards FY 2012–2013 |
| Economic Outlook and Overview: Kansas | Kansas Mental Health National Outcome Measures (NOMs): CMHS Uniform Reporting System |
| Public Health Snapshots by State (data assembled by the National Association of Local Boards of Health) | Kansas Wikipedia |
| Kansas Governor Sam Brownback | Kansas Aging and Behavioral Health Profile |
| Kansas Map of Federal Lands and Indian Reservations | Executive Reorganization Order<br>Kansas Statute 65-4006<br>Kansas Statute 65-4007<br>Kansas Statute 75-5375 |
| CSP Org Chart without Contract Staff | CSP Org Chart with Contract Staff |
| Kansas Prevention Infrastructure Diagram | Job Description Summaries |
| BG 403 Expenditures<br>BG 404 Monitoring | SSA Reorganization |
| KBHS Mission and Vision | Kansas Prevention Logic Model<br>Theoretical Framework for Prevention |
| Operational Framework for Prevention | Prevention Definitions |
| Governor's Behavioral Health Membership<br>House Bill 2368 | Safe and Supportive Schools Partnership |
| Block Grant Section P. Tribal Consultation | SEOW Timeline and Milestones<br>SEOW Indicator Ranking<br>SEOW Intangible Prioritization Criteria Definitions<br>SEOW Prioritization Work Kansa sheets – Final<br>Kansas 30-Day Marijuana Use Map 2012<br>Kansas 30-Day Cigarette Use Map 2012<br>Kansas 30-Day Alcohol Use Map 2012 |

| | |
|---|---|
| Kansas Substance Abuse Epidemiological Indicators Profile Revised May 2, 2013 | Assessment Guidance Document |
| Kansas 30-Day Alcohol Use Map 2012<br>Kansas 30-Day Cigarette Use Map 2012<br>Kansas 30-Day Marijuana Use Map 2012 | Prevention Outcomes Progress Summary |
| Workforce Development Plan | Capacity and Collaboration Summary and Work Plan |
| Community Readiness Enhancement Work Plan | K-SPF Collaboration and Capacity Survey |
| Tri Ethnic Community Readiness Handbook | KANSASPF Strategic Plan and Logic Model |
| Kansas Plan To Reduce Suicide | Prevention Team Roles and Responsibilities |
| Sustainment Planning and Processes for Kansas Coalitions Sustainability Plan Template | Multiagency Budget<br>SSA Funding Sources<br>SSA Funding Sources and Amounts<br>Funding Priorities |
| FY 2012 Greenbush Agreement<br>FY 2013 Greenbush Amendment | FY 2012 KFP Agreement<br>FY 2013 KFP Agreement |
| FY 2013 RPC Region 1 Agreement<br>FY 2013 RPC Region 3 Agreement<br>FY 2013 RPC Region 4 Agreement<br>FY 2013 RPC Region 5 Agreement<br>FY 2013 RPC Region 6 Agreement<br>FY 2013 RPC Region 7 Agreement<br>FY 2013 RPC Region 8 Agreement<br>FY 2013 RPC Region 9 Agreement<br>FY 2013 RPC Region10 Agreement | FY 2014 RPC Region 1 Agreement<br>FY 2014 RPC Region 2 Agreement<br>FY 2014 RPC Region 3 Agreement<br>FY 2014 RPC Region 4 Agreement<br>FY 2014 RPC Region 5 Agreement<br>FY 2014 RPC Region 6 Agreement<br>FY 2014 RPC Region 7 Agreement<br>FY 2014 RPC Region 8 Agreement<br>FY 2014 RPC Region 9 Agreement<br>FY 2014 RPC Region 10 Agreement |
| FY 2014 Kansas University Agreement | FY 2014 RPC Region 2 RFP |
| FY 2013 Funding | Kansas KANSASPF Evaluation Plan |
| Subrecipient Monitoring | Community ODSS Training<br>RPC ODSS Codebook |
| County Alcohol Data<br>County Cigarette Data<br>County Marijuana Data<br>K-SPF 2013 Brown County | Bills Presented to the Kansas Legislature in 2013<br>House Bill 2198<br>House Bill 2206<br>Senate Bill 9 |
| Advocacy Toolkit | Kansas State of the State Underage Drinking |
| Kansas Substance Abuse Epidemiological Indicators Profile 2006–2011 | Strategic Directions, Needs, and Challenges PPT (March 17, 2014) |
| Flow Chart Current Prevention System | Reductions in 30-Day Alcohol Use and Past Two-Week Binge Drinking |
| "Hot Spot" maps for :<br>30-Day Marijuana Use in 2012<br>30-Day Alcohol Use in 2012<br>30-Day Cigarette Use in 2012 | Draft Charter Prevention Subcommittee<br>Governor's Behavioral Health Planning Council |
| Kansas Strategic Prevention Framework Collateral Catalogue | |

| Sources of Synar Information | |
|---|---|
| Kansas Annual Synar Report FFY 2014 | Synar Survey Sampling Plan and Inspection Protocol Review Form Final and Initial Versions |
| SSES Tables 1–4 | Kansas Substance Abuse Prevention and Synar System Review Report<br>August 4–6, 2009 |
| Kansas Synar Section 214 Site Visit Report November 18–19, 2008 | Kansas Synar System Assessment Report June 25–27, 2002 |
| Kansas S-April 7, 2005-1 TA Report<br>Kansas-S-April 7, 2005-2 TA Report | SLATI State Information: Kansas |
| Targeted and RVR by State and Year | 79-3321(l) Cigarette Tobacco Tax Laws Regulations |
| Investigations 6 - Controlled Buy Tobacco | Contract with Kansas Department of Revenue |
| KDOR CATE agreement FY 2012 | Synar Protocol Refresher 2013 |
| Consent Document | CATE UCI Handbook |
| FY 2012 Greenbush Agreement<br>FY 2013 Greenbush Agreement<br>FY 2014 Greenbush Amendment | Synar Program Organization |
| Synar Budget | TFKC Strategic Plan Executive Summary |
| TFKC strategic plan | KDOR Synar Agreement |
| Synar Advisory Group Participant List | |

# Appendix D

## Summary of Kansas' Estimated FFY 2013 and Planned FFY 2014 Prevention and Synar Budgets

### *Estimated FFY 2013 and Planned FFY by Program Area and Revenue Source and Amount*

### Estimated FFY 2013 Prevention Budget

| Kansas Community Services and Programs Commission, Behavior Health Services Prevention Expenditures | | | | | | |
|---|---|---|---|---|---|---|
| **Program Area** (e.g., statewide prevention contractors, prevention grants for services, SPF-SIG, SPE grant, EUDL discretionary funding, Partnership for Success grant, Suicide Prevention grants, Drug-Free Schools carryover). | **FTE for Prevention** | **Revenue Source and Amount** | | | | |
| | | SABG Funds | % of SABG | Federal (Other) | State | Total |
| Regional Prevention Centers | | $2,189,000.00 | 17.9% | | | $2,189,000.00 |
| Kansas Family Partnership | | $148,660.00 | 1.2% | | $201,340.00 | $350,000.00 |
| Center For Learning Tree | | $292,110.00 | 2.4% | | $201,341.00 | $493,451.00 |
| Kansas University | | $81,477.00 | 0.7% | | | $81,477.00 |
| Safe Schools | | | | $250,000.00 | | $250,000.00 |
| Partnership For Success | | | | $884,028.00 | | $884,028.00 |
| Uncommitted | | $59,650.00 | 0.5% | | | $59,650.00 |
| Other | | $48,083.00 | 0.4% | | | $48,083.00 |
| | Total | **$2,818,980.00** | | **$1,134,028.00** | **$402,681.00** | **$4,355,689.00** |

# Planned FFY 2014 Prevention Budget

| Program Area (e.g., statewide prevention contractors, prevention grants for services, SPF-SIG, SPE grant, EUDL discretionary funding, PFS grant, Suicide Prevention grants, Drug Free Schools carryover). | FTE for Prevention | Revenue Source and Amount | | | | |
|---|---|---|---|---|---|---|
| | | SABG Funds | % of SABG | Federal (Other) | State | Total |
| Regional Prevention Centers | | $2,189,000.00 | 18.2% | | | $2,189,000.00 |
| Kansas Family Partnership | | $350,000.00 | 2.9% | | $94,000.00 | $444,000.00 |
| Center For Learning Tree | | $236,131.00 | 2.0% | | $297,608.000 | $533,739.00 |
| Kansas University | | $81,477.00 | 0.7% | | | $81,477.00 |
| Total | | **$2,856,608.00** | **23.8%** | | **$391,608.00** | **$3,248,216.00** |

# Estimated FFY 2013 Synar Budget

| Synar Category | Responsible Agency | Revenue Source and Amount | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | State Funds | Licensing Fees | Fines | SABG | Foundations | Retailer Associations | Tobacco Industry or Settlement | Other | Total |
| Management/ Staffing | | | | | | | | | | |
| Sample Design | KDADS through contract with Greenbush | $5,000 | | | | | | | | $5,000 |
| Coverage Study | | | | | | | | | | |
| Inspections | | | | | | | | | | |
| Merchant Education | | | | | | | | | | |
| Training | | | | | | | | | | |
| Community Education & Support | | | | | | | | | | |
| Data Analysis To Determine RVR | KDADS through contract with Greenbush | $15,000 | | | | | | | | $15,000 |
| Enforcement | KDADS through MOU with KDOR | $33,700 | | | | | | | | $33,700 |
| Other (please describe) | KDADS through MOU with KDOR | $400,000 | | | | | | | | $400,000 |
| | **Total** | **$453,700** | | | | | | | | **$453,700** |

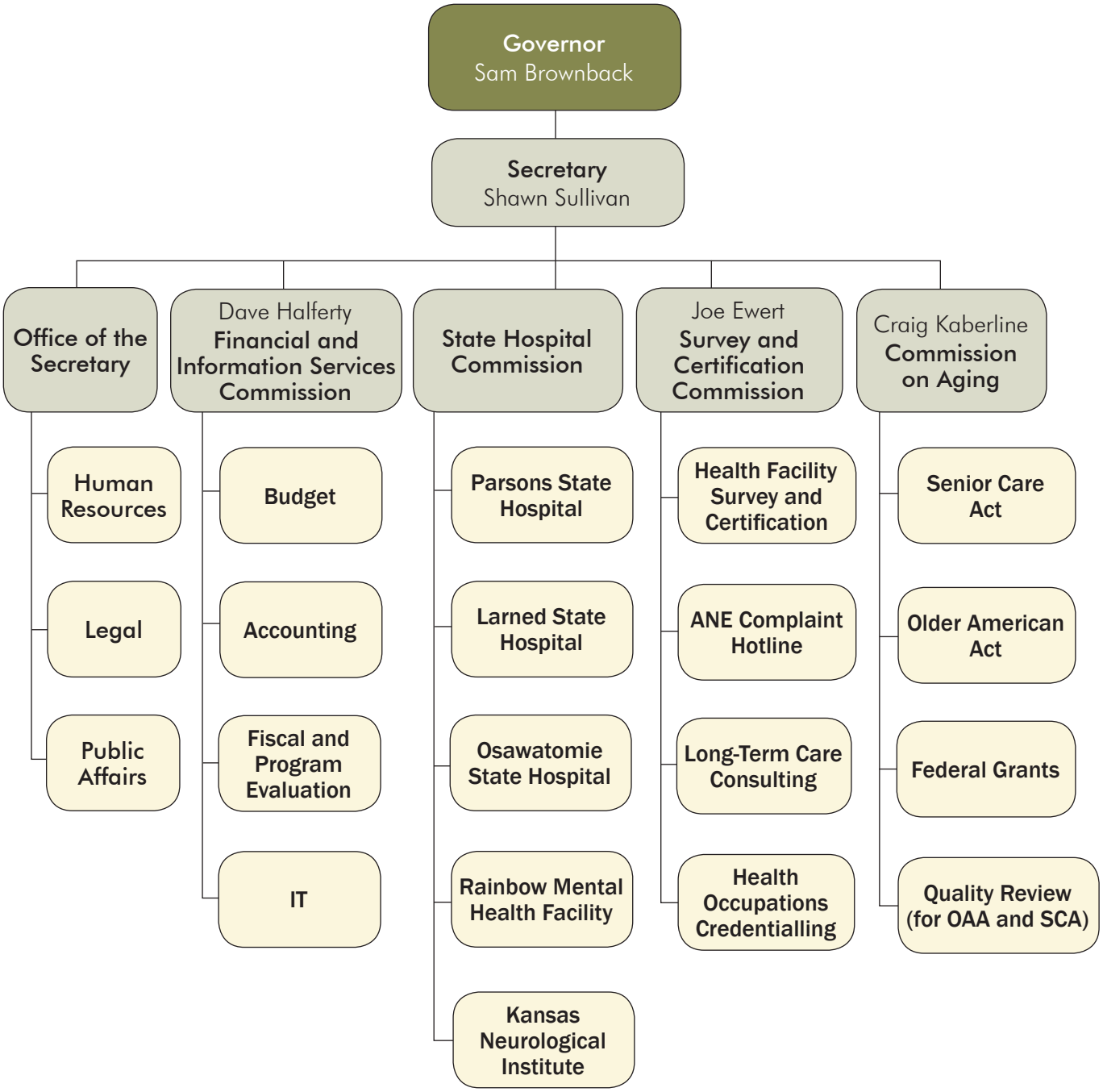
# Planned FFY 2014 Synar Budget

| Synar Category | Responsible Agency | Revenue Source and Amount | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | State Funds | Licensing Fees | Fines | SABG | Foundations | Retailer Associations | Tobacco Industry or MSA Settlement | Other | Total |
| Management/ Staffing | | | | | | | | | | |
| Sample Design | KDADS through contract with Greenbush | $5,000 | | | | | | | | $5,000 |
| Coverage Study | | | | | | | | | | |
| Inspections | | | | | | | | | | |
| Merchant Education | | | | | | | | | | |
| Training | | | | | | | | | | |
| Community Education & Support | | | | | | | | | | |
| Data Analysis To Determine RVR | KDADS through contract with Greenbush | $15,000 | | | | | | | | $15,000 |
| Enforcement | KDADS through MOU with KDOR | $13,100 | | | | | | | | $13,100 |
| Other (please describe) | KDADS through MOU with KDOR | $400,000 | | | | | | | | $400,000 |
| | **Total** | **$433,100** | | | | | | | | **$433,100** |

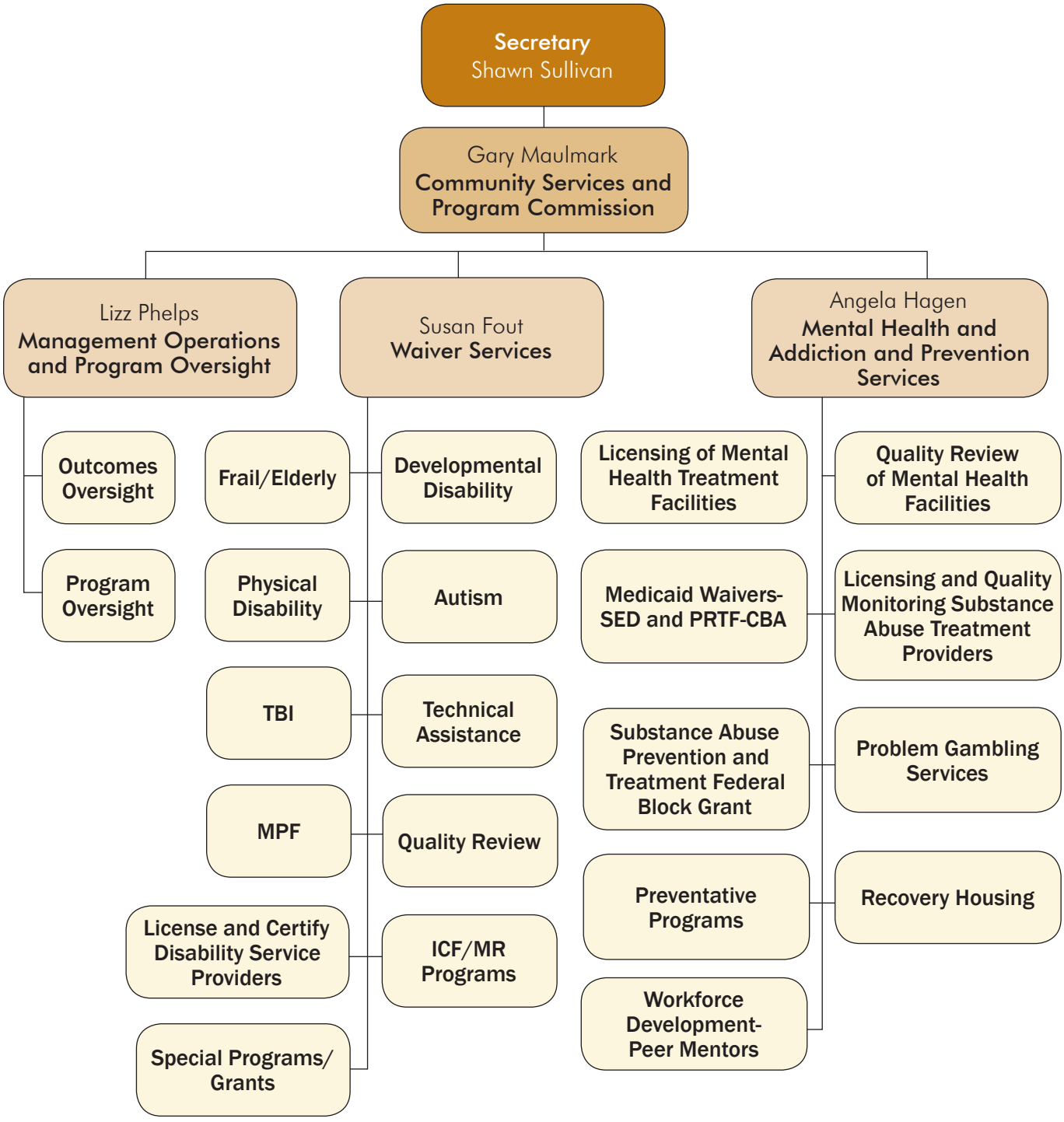
# Appendix E

## SSA Organizational Charts

### Kansas Department for Aging and Disability Services



## Kansas Department for Aging and Disability Services (*continued*)



# Appendix F

## State Laws and Policies

| State AOD Policies Snapshot | | |
|---|---|---|
| Alcohol | Is state an alcohol control state? | Yes |
| | What is the minimum age for bartenders to serve alcohol on-premise? | 21 years |
| | What is the minimum age for servers to serve alcohol on-premise? | 21 years |
| | What is the minimum age for servers to serve alcohol off-premise? | 21 years |
| | Does state mandate beverage service training? | No |
| | ■ If so, what are the requirements? | |
| | ■ Who administers the training? | |
| | ■ Does completion of beverage server training establish an affirmative defense? | |
| | What is the minimum age for purchase of alcohol? | 21 years |
| | What is the minimum age for possession of alcohol? | 21 years |
| | What is the penalty for selling alcohol to underage persons or to a straw purchaser? | Penalties include a fine of $200 to $1,000, and up to 6 months in county jail. (K.S.A. 21-3610) |
| | Are retailers required to post signs warning of dangers of alcohol use by pregnant women? | No |
| | Does state law allow municipalities and/or other substate jurisdictions to pass laws that are more stringent than state laws with regard to alcohol? | Yes |
| | ■ If so, are there applicable conditions or exceptions? | No |
| | Are the following laws/policies in place?<br>■ Social host legislation | Yes |
| | ■ Dram shop laws (making it possible for bar owners and alcohol servers to be held financially liable if a customer becomes obviously intoxicated on their premises and subsequently injures someone or causes property damage, typically by driving drunk) | No |
| | ■ Keg registration | Yes |
| | ■ Open container laws | Yes |
| | ■ "Use and lose" or other provisions associated with the use of false ID or other aspects of underage drinking | Yes |
| | ■ Laws to address alcohol use during pregnancy (e.g., priority treatment, mandatory reporting, warning signs, civil commitments, limitations on criminal prosecution of substance-abusing pregnant women). | No |
| | What is the blood alcohol content that constitutes DUI/DWI? | .02 per se law for DUI for persons under 21 |
| | Does state law permit the use of sobriety checkpoints? | Yes |
| | Does state have other key alcohol laws and policies in place (e.g., ignition interlock, "Happy Hour" prohibitions)? If so, what are they? | Cereal malt beverage sold at retail separately from sales of alcoholic liquor at retail |

| State AOD Policies Snapshot (*continued*) | | |
|---|---|---|
| Drugs | Do state laws decriminalize, in whole or part, marijuana? | No |
| | Do state laws legalize medical marijuana? | No |
| | Do state laws decriminalize any illicit drugs other than marijuana? | No |
| | Do state laws contain provisions intended to prevent the manufacturing and distribution of illicit drugs (e.g., restrictions on over-the-counter sales of precursor drugs used in the manufacture of illicit drugs)? | No |
| | Does state have drugged driving laws? | Yes |
| | Does state restrict sales of prescription drugs? | Yes |
| | Does state have a prescription monitoring program (to prevent "doctor shopping")? | Yes |
| | Does state have alternative sentencing/Drug Court provisions? | No |

# Appendix G

## Kansas Employment Data*

| County | Weekly Wages 2013 | Unemployment Rate 2012 |
|---|---|---|
| Allen | 596 | 6.4 |
| Anderson | 534 | 6.6 |
| Atchison | 617 | 6.8 |
| Barber | 578 | 3.7 |
| Barton | 661 | 4.2 |
| Bourbon | 581 | 6.3 |
| Brown | 606 | 5.0 |
| Butler | 650 | 6.6 |
| Chase | 460 | 4.7 |
| Chautauqua | 516 | 6.1 |
| Cherokee | 623 | 7.3 |
| Cheyenne | 575 | 3.2 |
| Clark | 547 | 3.4 |
| Clay | 566 | 4.4 |
| Cloud | 542 | 3.9 |
| Coffey | 1161 | 6.0 |
| Comanche | 474 | 3.6 |
| Cowley | 624 | 5.7 |
| Crawford | 579 | 6.3 |
| Decatur | 452 | 3.8 |
| Dickinson | 558 | 5.5 |
| Doniphan | 616 | 6.1 |
| Douglas | 662 | 5.3 |
| Edwards | 623 | 3.7 |
| Elk | 456 | 6.0 |
| Ellis | 660 | 3.1 |
| Ellsworth | 610 | 3.3 |
| Finney | 663 | 4.4 |
| Ford | 649 | 3.6 |
| Franklin | 632 | 7.6 |
| Geary | 726 | 6.8 |
| Gove | 528 | 2.7 |
| Graham | 596 | 3.1 |
| Grant | 742 | 3.8 |

| County (continued) | Weekly Wages 2013 | Unemployment Rate 2012 |
|---|---|---|
| Gray | 600 | 3.0 |
| Greeley | 547 | 3.3 |
| Greenwood | 561 | 5.5 |
| Hamilton | 588 | 3.7 |
| Harper | 647 | 3.7 |
| Harvey | 668 | 5.6 |
| Haskell | 663 | 3.5 |
| Hodgeman | 589 | 3.6 |
| Jackson | 591 | 6.4 |
| Jefferson | 608 | 6.4 |
| Jewell | 553 | 3.5 |
| Johnson | 950 | 5.0 |
| Kearny | 598 | 3.8 |
| Kingman | 639 | 4.8. |
| Kiowa | 570 | 3.4 |
| Labette | 609 | 8.0 |
| Lane | 612 | 3.8 |
| Leavenworth | 811 | 6.9 |
| Lincoln | 525 | 4.6 |
| Linn | 855 | 8.7 |
| Logan | 565 | 3.0 |
| Lyon | 571 | 5.5 |
| Marion | 531 | 5.0 |
| Marshall | 649 | 4.0 |
| McPherson | 722 | 4.0 |
| Meade | 614 | 3.3 |
| Miami | 622 | 6.3 |
| Mitchell | 607 | 3.1 |
| Montgomery | 599 | 7.7 |
| Morris | 520 | 6.6 |
| Morton | 629 | 3.9 |
| Nemaha | 607 | 3.5 |
| Neosho | 616 | 7.2 |
| Ness | 740 | 2.8 |

* U.S. Bureau of Labor Statistics

| County (continued) | Weekly Wages 2013 | Unemployment Rate 2012 |
|---|---|---|
| Norton | 596 | 3.7 |
| Osage | 496 | 7.1 |
| Osborne | 515 | 4.1 |
| Ottawa | 540 | 5.1 |
| Pawnee | 597 | 4.2 |
| Phillips | 600 | 4.2 |
| Pottawatomie | 661 | 4.8 |
| Pratt | 658 | 4.0 |
| Rawlins | 568 | 3.0 |
| Reno | 617 | 5.2 |
| Republic | 502 | 3.6 |
| Rice | 586 | 4.0 |
| Riley | 659 | 4.5 |
| Rooks | 594 | 4.7 |
| Rush | 615 | 4.7 |
| Russell | 615 | 4.2 |
| Saline | 645 | 5.8 |
| Scott | 623 | 2.9 |
| Sedgwick | 843 | 6.9 |
| Seward | 668 | 4.0 |
| Shawnee | 784 | 6.2 |
| Sheridan | 647 | 2.5 |
| Sherman | 555 | 3.1 |
| Smith | 504 | 3.9 |
| Stafford | 500 | 4.7 |
| Stanton | 642 | 3.1 |
| Stevens | 797 | 4.1 |
| Sumner | 598 | 6.4 |
| Thomas | 593 | 3.7 |
| Trego | 620 | 3.4 |
| Wabaunsee | 496 | 5.4 |
| Wallace | 565 | 3.9 |
| Washington | 463 | 4.1 |
| Wichita | 639 | 5.4 |
| Wilson | 612 | 8.6 |
| Woodson | 561 | 6.3 |
| Wyandotte | 832 | 8.6 |

# Appendix H
## Abbreviations

| | |
|---|---|
| ABC | Division of Alcoholic Beverage Control |
| AOD | alcohol and other drugs |
| ATOD | alcohol, tobacco, and other drugs |
| BHS | Behavioral Health Services |
| BRFSS | Behavioral Risk Factor Surveillance System |
| CATE | Cigarette and Tobacco Enforcement |
| CDC | Centers for Disease Control and Prevention |
| CSAP | Center for Substance Abuse Prevention |
| CSPC | Community Services and Programs Commission |
| CTC | Communities That Care |
| DFC | Drug Free Communities (grant) |
| DUI | driving under the influence |
| FFY | federal fiscal year |
| FTE | full-time equivalent |
| HIDTA | High Intensity Drug Trafficking Area |
| IC&RC | International Certification and Reciprocity Consortium |
| IOM | Institute of Medicine |
| KAAP | Kansas Association of Addiction Professionals |
| KBHDS | Kansas Behavioral Health and Disability Services |
| KCC | Kansas Citizens' Council |
| KDADS | Kansas Department of Aging and Disability Services |
| KDHE | Kansas Department of Health and Environment |
| KDOE | Kansas Department of Education |
| KDOR | Kansas Department of Revenue |
| KFP | Kansas Family Partnership |
| KSAPT | Kansas Substance Abuse Profile Team |
| K-TRACS | Kansas Tracking and Reporting of Controlled Substances System |
| KU | University of Kansas |
| LACIE | Lewis and Clark Information Exchange |
| LAUNCH | Linking Actions for Unmet Needs in Children's Health |
| NOMs | National Outcome Measures |
| NPN | National Prevention Network |
| NREPP | National Registry of Evidence-based Programs and Practices |

| | |
|---|---|
| NSDUH | National Survey of Drug Use and Health |
| ODSS | Online Documentation and Support System |
| PDMS | prescription drug monitoring system |
| KTRCSS | Kansas Tracking and Reporting of Controlled Substances System |
| PFS | Partnership for Success (grant) |
| QA | quality assurance |
| RADAR | Regional Alcohol and Drug Awareness Resource |
| RFP | request for proposals |
| RPC | Regional Prevention Center |
| RVR | retailer violation rate |
| S3 | Safe and Supportive Schools |
| SABG | Substance Abuse Prevention and Treatment Block Grant |
| SAC | Synar Advisory Council |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SAPST | Substance Abuse Prevention Specialist Training |
| SEOW | State Epidemiological Outcomes Workgroup |
| SFY | state fiscal year |
| SPF | Strategic Prevention Framework |
| SPF SIG | Strategic Prevention Framework State Incentive Grant |
| SSA | Single State Authority |
| SSES | Synar Survey Estimation System |
| SUD | Substance Use Disorder |
| TA | technical assistance |
| T/TA | training and technical assistance |
| UCI | underage cooperating individual |
| YLinK | Youth Leaders in Kansas |

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