

Kansas

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND
PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 12/17/2017 10.40.41 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 878195098

Expiration Date

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

Agency Name Kansas Department for Aging and Disability Services

Organizational Unit Behavioral Health Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

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

First Name Kimberly

Last Name Reynolds

Agency Name Kansas Department for Aging and Disability Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

Telephone 785-296-0649

Fax 785-296-0256

Email Address kimberly.reynolds@ks.gov

State CMHS DUNS Number

Number 878195098

Expiration Date

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

Agency Name Kansas Department for Aging and Disability Services

Organizational Unit Behavioral Health Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

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

First Name Kimberly

Last Name Reynolds

Agency Name Kansas Department for Aging and Disability Services

Mailing Address 503 S. Kansas

City Topeka

Zip Code 66603

Telephone 785-296-0649

Fax 785-296-0256

Email Address kimberly.reynolds@ks.gov

III. Third Party Administrator of Mental Health Services

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date 9/1/2017 10:01:52 AM

Revision Date 11/6/2017 6:02:29 PM

VI. Contact Person Responsible for Application Submission

First Name Kimberly

Last Name Reynolds

Telephone 785-296-0649

Fax 785-296-0256

Email Address kimberly.reynolds@ks.gov

Footnotes:

Kansas does not have a third party administrator for MHBG funds.

State Information

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
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Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
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Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Tim Keck

Signature of CEO or Designee¹: _____

Title: Secretary

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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

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

Timothy E. Keck

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee¹:



Secretary

Title:

Date Signed: 08/30/2017

mm/dd/yyyy

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

Footnotes:

Behavioral Health Services Commission
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404



Phone: (785) 296-6807
Fax: (785) 296-0256
wwwmail@kdads.ks.gov
www.kdads.ks.gov

Timothy Keck, Interim Secretary
Susan Fout, Commissioner

Sam Brownback, Governor

February 13, 2017

Gilbert Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 13N 14-C
Rockville, MD 20857

RE: Delegation of Single State Authority for Kansas

Dear Mr. Rose:

On behalf of the Kansas Department for Aging and Disability Services (KDADS), I am writing to inform you of the following change. From this date on, the Single State Authority for the Substance Abuse Prevention and Treatment Block Grant and the Single State Authority for the Mental Health Services Block Grant for the State of Kansas shall be Kimberly Reynolds, SUD Block Grant Program Manager.

Kimberly may be reached by phone at 785-296-0649 or by mail 503 S. Kansas Ave. Topeka, Kansas 66603. Her email address is Kimberly.Reynolds@ks.gov.

Should you have any questions regarding this delegation, please do not hesitate to contact me directly at 785-368-7228 or Susan.Fout@ks.gov.

Sincerely,

A handwritten signature in cursive script that reads "Susan Fout".

Susan Fout
Commissioner Behavioral Health Services

State Information

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

Fiscal Year 2018

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Section	Title	Chapter
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Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Tim Keck

Signature of CEO or Designee¹: _____

Title: Secretary

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Timothy E. Keck

Signature of CEO or Designee¹:  _____

Title: Secretary

Date Signed: 08/30/2017

mm/dd/yyyy

Footnotes:

State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name

Title

Organization

Signature:

Date:

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

In July of 2012, several state agencies in Kansas were re-organized. The mental health and addictions-prevention and treatment programs, previously administered by the Kansas Department of Social and Rehabilitation Services, were moved into the newly formed Kansas Department for Aging and Disability Services. These programs became part of the agency's Community Services and Programs Commission, which administered both behavioral health and home- and community-based services. In June of 2015, a separate Behavioral Health Commission was established and a Commissioner was appointed to oversee management of the behavioral health services provided by the state. The state's two psychiatric hospitals were situated under the BH Commission as well.

The Director of Behavioral Health Services reports to the Commissioner for BH. The Behavioral Health Services Director is designated as the State Mental Health Authority (SMHA), and supervises the majority of the BH staff. The Block Grant Manager is the Single State Authority (SSA) for community mental health services ("MHS"), substance abuse prevention ("SAP"), and substance abuse treatment ("SAT"). Five BH staff oversee SAT programs; six oversee SAP programs; and 11 oversee MHS programs (three of which focus on programs for children and adolescents.) In 2016, KDADS staff responsible for licensing and certifying MH services and SAT providers moved from the Behavioral Health Commission to the newly established KDADS Commission on Survey, Certification and Credentialing. This reorganization has enabled BH staff to focus on program planning and management rather than the enforcement of regulations, which is now the work of staff on the Survey, Certification and Credentialing Commission

The Kansas Department of Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority. KDHE administers KanCare, the program through which the state administers Medicaid and its seven home- and community-based services 1915 (c)waivers. Currently Kansas has a contract with three managed care organizations (MCOs), Amerigroup of Kansas, Inc., Sunflower Health Plan, and United Healthcare Community Plan of Kansas, to coordinate health care (including MHS and SAT) for all people enrolled in Medicaid. The current KanCare 1115 waiver demonstration program expires on December 31, 2017. KDHE has requested a one-year extension, through December 2018, and intends to submit a waiver renewal request on November 1, 2017, for a new 1115 waiver that would take effect January 1, 2019.

Mental Health Services

Criterion 1: Comprehensive Community-Based Mental Health Service Systems: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring M/SUD. States must have available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Under Kansas Statutes Annotated (KSA) 19-4001 et. seq., and KSA 65-211 et. seq., 26 licensed Community Mental Health Centers (CMHCs) currently operate in the state. These Centers have a combined staff of over 4,000 providing mental health services in every county of the state in over 120 locations. Together they form an integral part of the total mental health system in Kansas. The independent, locally owned centers are dedicated to fostering a quality, free standing system of treatment and programs for the benefit of citizens needing mental health care and treatment. Each of the 26 licensed CMHCs operating in Kansas has a separate, duly elected and/or appointed board of directors. Each of these boards is accountable to the citizens served, its county officials, the state legislature, and the governor; and all have reporting responsibilities to the national level of government. The CMHCs provide recovery and treatment services to Kansans who are covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured.

CMHCs are the counties' legally delegated authorities to manage mental health care in Kansas, and function as the local mental health authorities. Outcome performance measures have been specifically delineated in contracts with the State of Kansas since Mental Health Reform was commenced. The CMHCs operate under extensive state licensing regulations; are subject to licensure site reviews; and routinely provide extensive required data to the Kansas Department for Aging and Disability Services (KDADS). The CMHCs also conform to Medicaid and Medicare standards and audits.

The primary goal of the CMHCs is to provide quality care, treatment and rehabilitation to individuals with mental health problems in the least restrictive environment. CMHCs provide services to all those needing it, regardless of economic

level, age or type of illness. Services provided include: evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education, consultation, treatment and rehabilitation services, 24-hour emergency services. Community-based mental health services also include assistance in securing employment services, housing services, medical and dental care, and other supports. Kansas CMHCs provide care to more than 100,000 citizens per year. The number of consumers served has doubled over the past 10 years, largely as a result of deinstitutionalization. Many of these former hospital patients now rely on CMHCs for mental health treatment to maintain their ability to live in their own community. CMHCs provide services and treatment to these persons in the priority target populations as defined by K.S.A. 39-1602, which are adults with severe and persistent mental illness (SPMI), children and adolescents experiencing a serious emotional disturbance (SED), and other individuals at risk of requiring institutional care. An estimated 18,000 patients are seriously emotionally disturbed children that are being served in the community, and over 18,000 are severe and persistently mentally ill adults. Services that are key to ensuring individuals are able to remain in their own communities include: 24-hour, 7 days a week emergency treatment and first response services; crisis responsiveness; evaluation, assessment, and treatment; screening for admission to a state psychiatric hospital, when applicable and required by K.A.R. 30-61-10; follow-up with any consumer seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services and/or referral to any services; basic outpatient treatment services; basic case management services for adults; and basic community-based support services for children, adolescents, and their families. Currently, 23 of the CMHCs also offer Substance Use Disorder (SUD) treatment in their areas of the state.

Kansas has built an infrastructure of Consumer Run Organizations (CROs) to promote recovery through peer recovery supports to consumers or former consumers of mental health services, especially people with severe and persistent mental illness (SPMI). CROs are legally incorporated, nonprofit, consumer-governed and operated organizations using a peer recover model built on self-direction, empowerment, peer support and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. Typically, a CRO provides an array of services to its members that include leadership, education, training and research opportunities; peer support groups, drop-in centers, self-help groups, employment support, life skills training, health and wellness activities; bridge supports from state institutions to life in the community; and education about Medicaid and other community resources to connect Members to services.

CROs:

- Provide leadership, education, training and research opportunities for members;
- Offer a range of peer support groups, drop-in centers, self-help groups, employment support, life skills training, health and wellness activities;
- Often provide a bridge from state institutions to life in the community; and
- Educate consumers of mental health services about Medicaid and other community resources and connect them to these programs.

Recovery-oriented services typically include self-help groups, activities and resources to empower members to work, volunteer, attend school or further enrich their lives as members work towards recovery. Three of the CROs are regional centers for CRO leadership and administration purposes. Called Regional Recovery Resource Centers, these CROs are dedicated Certified Peer Support Specialists that offer resources, technical assistance and support development of recovery supports and peer support programs in communities and populations statewide. The RRRC provides support to build capacity within the other CROs in their Kansas regions as well recovery supports in communities not having established a CRO or peer support group.

The RRRC connects with Community Mental Health Center's for crisis prevention and intervention, the State Mental Health Hospitals to bridge supports prior to the consumer discharge, Homeless shelters to assist with a referral process, Police Departments to expand the CIT program, and NFMH's to bring hope and recovery resources to the people they serve. KDADS funds 13 Consumer-Run Organizations (CROs) to provide nontraditional peer supports to consumers or former consumers of mental health services to support recovery and improve quality of life, such as helping

people achieve employment, housing and greater social connectedness. The Kansas Consumer Advisory Council for Adult Mental Health, Inc. (CAC) is a consumer organization serving the geographical area of Kansas and dedicated to improving the lives of people with psychiatric disabilities. The organization is comprised of people who self-identify as current or former consumers of mental health services. The Kansas Consumer Advisory Council hosts a variety of programs throughout the year. These include:

- Leadership Academy – A two-month course consisting of two, three-day sessions, held in Wichita and a service project carried out in the participant’s community.
- Annual Kansas Recovery Conference – a three-day conference held each June in Wichita. This conference is one of the largest consumer conferences in the nation, hosting more than 800 attendees in 2009. It presents nationally recognized keynote speakers, a wide variety of workshops, and many related activities.
- Trauma Informed Care – “Recovery For Real” is a CAC project funded by SAMHSA for the development of a Trauma Informed Care (TIC) model. The CAC was instrumental in Trauma Informed Care being introduced in Australia in May, 2015.

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

Criterion 2: Mental Health System Data Epidemiology: Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Target Population (A)	Statewide Prevalence (B)	Statewide Incidence (C)
1. Adults with SMI	4.08	4.05
2. Children with SED	See below	See below

2. Children with SED: According to the report, “Overview and Analysis of Kansas Public Health System,” dated June 1, 2009, developed by the Kansas Department of Social and Rehabilitation Services Division of Disability and Behavioral Health Services Mental Health Services Program, approximately 5 percent to 9 percent of children and adolescents ages nine through 17 experience more severe functional mental health limitations, known as “serious emotional disturbance” (SED). Based on this estimate, using Census data, between 29,000 to 52,300 children and adolescents in Kansas have an SED. In SFY 2018, KDADS will submit a formal request to the Kansas Department of Health and Environment (KDHE) Epidemiology work group to collect this particular statistic for the state.

Criterion 3: Children’s Services: Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

One mechanism for ensuring that Kansas children receive integrated services for their multiple needs is through the SAMHSA-funded System of Care for Mental Health Services for Children and Their Families. The goal of is to improve behavioral health outcomes for Kansas children and youth (birth-21) experiencing serious emotional disturbances (SED), and their families. Partnerships between KDADS, Wichita State University (WSU) and four local jurisdictions will, in the first year of the program, offer the following mental health services to youth to obtain the outcomes of improved behavioral health status and functionality of participants: (1) diagnostic and evaluation services; (2) outpatient services; (3) 24-hour emergency services; (4) intensive home-based services for the children and their families when the child is at risk of out-of-home placement; (5) intensive day treatment services; (6) respite care; (7) therapeutic foster care services, services in therapeutic foster family homes or individual therapeutic residential homes, and group homes caring for not more than 10 children; (8) assisting the child in making the

transition from services received as a child to the services to be received as an adult; and (9) other recovery support services (e.g., supported employment) and focus efforts to provide early treatment for those youth with early onset of SED/SMI to children and youth.

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

Another mechanism for ensuring that Kansas children receive integrated services for their multiple needs is the KDADS Home and Community Based (HCBS) 1915 (c) waiver program. Kansas administers Medicaid waivers for both children and youth who have a severe emotional disturbance (SED) and for those with autism (which is also covered under the Medicaid State Plan). Children who meet eligibility requirements will receive a medical card and are eligible for Medicaid physical and behavioral health services. The SED waiver program serves children aged 4-18 who are experiencing SED and who are at risk of inpatient psychiatric treatment. SED waiver services provide children with special intensive support so they may remain in their homes and communities. Children with a diagnosis of Autism, Asperger's Syndrome, or Pervasive Developmental Disorder NOS will be able to apply for the Autism waiver until their sixth birthday. Autism waiver services are typically limited to three years.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults: Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

The Kansas Department for Aging and Disability Services currently offers four programs to assist individuals who are homeless or at risk of homelessness and experiencing an SMI: Supported Housing Funds, Interim Housing, Projects for Assistance in Transitioning from Homelessness (PATH) and Cooperative Agreements to Benefit Homeless Individuals (CABHI).

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

Cooperative Agreements to Benefit Homeless Individuals (CABHI) is a three-year federal agreement with SAMHSA that assists individuals who experience chronic homelessness and veterans who experience homelessness/chronic homelessness with co-occurring mental and substance use disorders. CABHI's primary goal is to ensure that the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment, and recovery support services.

Supported Housing Funds is a state-funded program that provides assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and/or maintain housing in the least restrictive environment possible. This is accomplished by providing temporary financial assistance for their housing needs. The goal is to provide persons with SPMI/SMI the help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives. The SHF program supports eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible.

Interim Housing (IH) projects is a state-funded program that involves short-term (up to six months) project-based housing that provides immediate community-based housing for persons who meet HUD's definition of homeless; who are homeless and being

discharged from inpatient or residential mental health or substance use treatment facility (e.g., a state mental health hospital, nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program). There are currently seven CMHCs that have Interim Housing Projects.

In addition, the state requires CMHCs to employ Housing Specialists, who are responsible for increasing the array of housing options available to consumers. The CMHC Housing Specialists assist persons with behavioral health issues, including co-occurring mental health and substance use disorders, to access safe and affordable housing of their choice and to provide the necessary supports and services that ensure the person lives a safe, healthy, self-determined life in their own homes. CMHC Housing Specialists actively participate in and assist with local, regional and/or statewide efforts to decrease homelessness and to address situations where individuals are precariously housed.

KDADS' Behavioral Health Services Commission and the Commission on Aging are jointly responsible for programming and funding statewide. In addition, while all CMHCs serve individuals regardless of age, multiple CMHCs provide services that target older adults. Currently, the Governor's Behavioral Health Services Planning Council (GBHSPC) is reinstating an Aging Subcommittee that will have representation from a diverse group of stakeholders, including providers, consumers, and state agency representatives.

In 2015, the University of Kansas Institute for Policy and Social Research found that of Kansas' 105 counties, 36 were frontier (less than 6 persons per square mile), and 33 were rural (6-19.9 persons per square mile). According to the President's New Freedom Commission on Mental Health, the vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in the availability of mental health services. Rural issues are sometimes misunderstood, minimized and not taken into consideration when national and state mental health policy is formed.

The Rural and Frontier Subcommittee of the GBHSPC has identified unique needs/gaps for those living in rural/frontier counties. They include: 1) lack of urban/semi-urban resources in 89 of 105 counties; 2) disproportionate share of the older population; 3) rural legacy of depopulation that has continued over the past decade; and 4) high percentage per capita of Hispanic residents in rural/frontier counties, particularly in the southwest region. Over the next two years, the Subcommittee plans to make recommendations to the GBHSPC and KDADS to address these issues.

Criterion 5: Management Systems: States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved. To ensure that emergency health staff and first responders are able to train others in their arenas of work, KDADS supports Mental Health First Aid training for trainers. CMHCs also offer Mental Health First Aid training within their communities for educators, families, clergy, health care professionals and other stakeholders. Each CMHC also participates in disaster planning and training at both the local and state levels.

KDADS has taken a comprehensive approach to train law enforcement, first responders, and other personnel in the area of mental health issues throughout the state. They have provided grant funding to enable emergency health responders including law enforcement, mental health providers, those who work with veterans, and others, to receive Crisis Intervention Training (CIT). CIT training programs include instruction, classroom materials, and student room and board. Law enforcement officers trained will earn continuing education hours through the Kansas Law Enforcement Training Center (KLETC). KLETC will also produce an online training video and testing instrument for use by law enforcement agencies that are unable to send staff to the training center. More than 1,000 first responders have been trained to date. There are plans to provide a series of six one-day mental health awareness training sessions throughout the state, which will lay the ground work for more specialized behavioral health training in the future. Regional training events will target smaller, rural law enforcement agencies that do not have the local mental health resources to provide such training.

SAP

Over the past two years Kansas has made great strides in its system re-design, which

began in earnest following our most recent CSAP site visit that took place in 2014. Following that site visit the prevention and promotion team developed priorities for the development of more robust and streamlined infrastructure. The two main priorities identified were: 1) the development of a more integrated approach that would allow the state and communities to address both substance use, mental health promotion, suicide prevention and problem gambling education and awareness, and 2) to make the state's support network more agile and efficient thus creating an increased level of funding for the implementation of community level, comprehensive strategic plans.

The previous Kansas prevention system was rooted in tradition and resistant to change. This created significant challenges when working to develop a new system that would be most efficient and effective given the established priorities. The previous system was comprised of a statewide evaluation contract, a statewide communication and resource dissemination contract, and 10 regional prevention centers primarily tasked with providing training and technical assistance (T/TA). Nearly all of the set-aside prevention funding was used to pay for this system, leaving little funding for strategy implementation at the local level. In order to create an integrated system with adequate local-level funding, a Request for Proposal (RFP) process was developed; the new infrastructure was to include one statewide data collection, analysis, and evaluation contract, a statewide T/TA contract, as well as a statewide communication, collaboration, and connection contract. Three providers were identified as a result of reviewing the applications that were submitted. Additionally, there were two mental health promotion contractors who received non-block grant funding, but were still considered a part of the newly developed Kansas Prevention Collaborative, the state's new prevention infrastructure. This new infrastructure created a significant cost savings that could be utilized to make community grants; the initial community grants awarded in SFY 16 focused on the planning step of the strategic prevention framework (SPF). This new system has been expanded and enhanced over the previous two years, and the agency was able to add a new partner organization as a member of the newly established prevention infrastructure; the new partner, also non-block grant funded, provides suicide prevention subject matter expertise and T/TA for community work.

During FFYS 18 and 19, Kansas will continue to strengthen working relationships among the Kansas Prevention Collaborative Partners and expand the use of the SPF framework, increasing the implementation of evidence-based prevention strategies (both programmatic and environmental), and sustaining outcomes. A current organizational chart of the system partners is provided below:

Figure 1 Kansas Prevention Collaborative-Org Chart

Problem gambling education and awareness is also managed by the Prevention and Promotion Services team; during FY18 and 19, the four regional taskforces and one statewide coalition that receive funding under the Problem Gambling and Addictions Grant Fund will begin utilizing the strategic prevention framework to develop plans, including the identification of specific needs, assessing readiness and capacity, and implementing strategies that are based on research in order to achieve greater more impactful outcomes. Additionally, work will continue to provide education and training around co-occurring behavioral health concerns as well as shared risk and protective factors in an effort to increase mental health promotion and suicide prevention efforts across the state.

SAT

Beginning in 2007, KDADS contracted with a managed care entity to oversee its SAT provider network. At the time of implementation, the Administrative Service Organization (ASO) oversaw: funds for the uninsured/underinsured (SAT Block Grant, State General Funds, and State Fee Funds), Kansas Department of Corrections (KDOC) funds for their Third Time DUI Program, State funds dedicated to the Problem Gambling and Other Addictions Program, and Medicaid reimbursement for SAT services. In 2013, when KanCare was implemented, responsibility for Medicaid oversight shifted to the three KanCare MCOs; the same ASO continued to manage the remaining funds. In FY 17, a request for proposals was issued regarding the management of these funds; the same contractor (Beacon Health Options, formerly Value Options) was selected to continue in this role. (Results from a June, 2017 provider satisfaction survey of the ASO indicated that 92percent of Block Grant-funded Kansas SAT providers were either "Very Satisfied" or "Satisfied" with the ASO.)

There are currently nearly 300 licensed providers of SAT throughout the State; of those, 42 receive SAT Block Grant funding to provide services at 136 locations. Of those 42 providers, 11 are designated to provide services to pregnant women and women with dependent children (PWDC), and one is a Federally Recognized Tribe. To ensure continuity of care, all providers are dually approved to provide Medicaid-funded services, as well. A number of providers are dually licensed as Community Mental Health Centers (CMHCs), enabling them to coordinate both mental health and SUD care for those with co-occurring diagnoses. Many providers are partnering with Federally Qualified Health Centers (FQHCs) and other primary medical providers to offer early screening and intervention, integrated treatment, and facilitated access to ongoing medical care. SAT providers offer a comprehensive continuum of care of BG-funded services including: assessment, peer mentoring, outpatient, intensive outpatient, reintegration, social detox, and intermediate. All SAT services are based on clinical need/medical necessity.

Contracts with the current SAT provider network will end on June 30, 2017. Kansas has maintained the same provider network since the 2007 implementation of an ASO to manage funding; in the fall of 2017, a request for proposals will be issued to identify providers who comprise the new network. All licensed Kansas SUD treatment providers who are KanCare providers will be eligible to apply. As part of this initiative, Kansas is currently exploring potential enhancements to the rate structure that will improve the quality of services provided to consumers. SAT needs in Kansas continue to be identified by data collected by the ASO and then reviewed by KDADS and other stakeholders. Until recently, a State Quality Committee (SQC) comprised of KDADS staff and Block Grant funded providers met quarterly to review data related to service utilization, consumer demographic and diagnostic characteristics, and related information. In 2016, when the licensing staff were moved from KDADS BHS Commission to the Survey, Certification and Credentialing Commission, BHS SAT program staff decided to revisit the composition of the SQC membership, and to update the data requested from the ASO to ensure that the data provided best assist them in assessing the needs, strengths, and gaps of the system. The newly designed quality committee will begin meeting by the second quarter of FFY 18. KDADS staff have also begun attending monthly internal quality meetings held by the ASO. Additional data about the wait for services continues to be compiled and provided to KDADS by the ASO, as well.

Recently, a task force of the Governor's Behavioral Health Services Planning Council (GBHSPC) has begun a review of the service continuum for consumers seeking SAT. The information gathered will inform the work of the GBHSPC and KDADS in addressing service gaps/needs.

The Kansas SAT provider network possesses many strengths. Increasingly, providers offer services utilizing evidence-based models of care. A number are also offering counseling that specifically addresses trauma experienced by consumers. Coordination among SAT providers has become more common. Strong ASO oversight of Block Grant-funded SAT providers and extensive data collection processes help to ensure that providers offer effective services that consumers need.

KDADS has fostered strong partnerships with other State agencies who also serve with individuals with SUDs, including Community Corrections and Court Services. KDADS staff meets monthly with the Kansas Association of Addiction Professionals (KAAP), as well as the two Regional Alcohol and Drug Assessment Centers (RADACs), and are active with regional and national organizations including the Addiction Technology Transfer Center Network (ATTC) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). One provider who gave public comment noted that, "There currently exists a positive relationship between providers, state program staff, and the administering block grant managed care organization. This allows for effective decision making for the citizens of Kansas." He also remarked that, "Kansas embraces and promotes a Recovery Oriented System of Care approach and is committed to many other evidenced based practices." Another SAT provider stated that our SUD system's strengths included that we are: "Supporting programs with a collaborative spirit and mutuality;" "Requesting feedback from providers and consumers on a regular basis;" "Continuing to fight stigma and fund prevention programs to offset the enormous social pressure to use drugs in primary grades;" "Creating training and support for Peer Mentoring services including advocating for recovery oriented systems of care;" "Advocating for programs to develop their own collaborative relationships with mainstream resources in order to aid the consumer to be successful, healthy and have a greater quality of life;" "Continuing to fund

grass roots community based services, to meet the consumer where they live, grow and play;" and, "Providing state wide meetings and quarterly meetings to enhance provider relations." She also noted that we have an "Effective reimbursement system with strategies for accountability in place;" and that we are "Providing an electronic payment system that is effective."

Kansas is fortunate to have 11 designated women's programs that serve pregnant women and women with children. Programs are monitored via a report from the ASO. The 11 programs utilize a gender-specific, evidence-based curriculum that supports women and their families in treatment and helps them to move into recovery. Some providers offer additional services that include housing for homeless individuals, family case management, therapy for individuals with co-occurring SUD and mental illness, and Medication Assisted Treatment. Providers who assess priority women are required to make three referrals for treatment, one of which must be to a designated women's program. Providers are monitored to ensure that this priority population is admitted within 48 hours of initial contact.

KDADS provides a combination of Block Grant and State General Funds to enable the nonprofit Friends of Recovery Association (FORA) to establish Oxford Houses throughout the state. The term "Oxford House" refers to any house operating under the Oxford House Model, a community-based approach to addiction treatment, which provides an independent, supportive, and sober living environment. Oxford House members help themselves by helping each other abstain from alcohol and drug use one day at a time. Residents assume and learn responsibility for their recovery. Additionally, there are no time limits. This allows an individual to focus on establishing a new set of personal values that center around sobriety. It allows the individual to practice the skills of responsible family and community living with their new Oxford House family.

The State of Kansas has supported the efforts of FORA for more than 15 years. In 2001, there were 19 Oxford houses in Kansas; currently, there are 105. This provides a total of 896 beds for persons seeking recovery from substance use disorders. Oxford Houses in Kansas include men only, women only, men with children, and women with children.

In May of 2017, KDADS was awarded \$3,114,402 by SAMHSA for the 2017 State Targeted Response to the Opioid Crisis Grant (STR). The purpose of the Kansas STR program is to address the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose-related deaths through provision of prevention, treatment, and recovery activities for opioid use disorder (OUD), including prescription opioids as well as illicit drugs such as heroin. Four regional sub-awardees will use data to demonstrate critical gaps in availability of treatment for OUDs in geographic, demographic, and service-level terms; address the critical gaps in availability of treatment for OUDs in geographic, demographic, and service-level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly address the gaps in their systems of care; deliver evidence-based treatment intervention, including medication and psychosocial interventions; and report progress toward increasing availability of treatment for OUD and reducing opioid-related overdose deaths.

Kansas was one of eight states selected to attend the National Governors' Association Center for Best Practices Learning Lab, "Expanding Access to Opioid Use Disorder Treatment for Justice-involved Populations." The Kansas team included two members from the Kansas Department of Corrections (KDOC) reentry programs, two regional contactors who provide care coordination and peer support under contract with the KDOC, a representative from the Attorney General's office, and the KDADS NTN. Under the guidance of the Learning Lab consultants, the workgroup has begun to address the following goals: 1) Identify all incoming offenders with a history of opioid, alcohol, and heroin misuse; 2) Increase the ability of offenders to access Medicaid benefits upon release to assist them with access to Medication Assisted Treatment (MAT); 3) Identify ways to remove barriers to offenders' willingness to participate in MAT; 4) KDOC and KDADS collaborate to identify providers in Kansas who will more to more effectively treat returning offenders and who will use MAT as a treatment component; 5) Position Kansas to leverage existing resources to increase funding for treatment and medication for opioid, alcohol, and heroin misuse; 6) Engage local drug courts through the Kansas Judicial Administration's State Drug Court Coordinator to identify ways to reduce probation revocations caused by opioid, alcohol, or heroin misuse; 7) Design a plan to track, trend, and analyze data to reflect the impact of the MAT initiative in KDOC, as well as other project goals.

Planning Steps

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

Narrative Question:

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

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

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's population- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Please see attachments for SPMI services definition.

MHS

The Governor's Behavioral Health Services Planning Council (GBHSPC) has identified the need for services that target non-English speaking consumers. They do not currently have a plan in place to address this need, but will maintain a focus on this issue over the next FY.

Children's mental health needs that have been identified by the GBHSPC's Children's Subcommittee include: inconsistency in services, lack of relationships with families, little mental health training, stigma, lack of assistance to children transitioning to/from out of home placements, and access to services. They reported that 84 percent of educators agreed or strongly agreed that further professional development training is needed, including information on mental health disorders, behavioral management techniques, specialized skill training, positive behavioral supports, and trauma. Strong, cross-system collaboration between schools and community providers should be developed to meet the needs of children and adolescents in Kansas.

The Justice Involved Youth and Adults Subcommittee of the GBHSPC convened multiple workgroups within their Subcommittee to examine particular issues of concern. Needs/gaps that the subcommittee identified included: the need for screening for mental illness in jails, the need for communities across Kansas and for agencies within those communities to partner to work on how to address mental illness in criminal justice settings, the need for those working with incarcerated youth and adults to have access to data relevant to their behavioral and physical health and involvement with community agencies.

The Housing and Homeless Subcommittee of the GBHSPC understands the integral part that having safe affordable housing plays in the recovery of persons with serious mental illness. Current housing resources are not sufficient for the needs across the State of Kansas. The most effective housing system offers an array of housing options from crisis facilities to adequate, affordable, independent living, including individual evidenced-based supports that help to ensure that individuals obtain and retain housing in the least restrictive environment.

The Vocational Subcommittee of the GBHSPC identified the need for the integration of peers into employment services at the Community Mental Health Centers (CMHCS). They also noted the lack of a statewide educational campaign to dispel the myth that working is equated with losing public benefits.

As stated above, the Rural and Frontier Subcommittee of the GBHSPC has identified unique needs/gaps for those living in rural/frontier counties. They include: 1) lack of urban/semi-urban resources 89 of the 105 counties; 2) disproportionate share of the older population; 3) rural legacy of depopulation that has continued over the past decade; and 4) higher percentage per capita of Hispanic residents in rural/frontier counties, particularly in the southwest region.

SAP

Much change has occurred within the state's prevention system in the last two years; the state infrastructure is much stronger now and our epidemiological data collection has been enhanced with the creation of an online data dashboard (www.kbhid.org), additionally for the first time a survey of young adults (18-25) has been completed with plans for a repeat survey in state FY 19. While we have enhanced our ability to collect statewide data, gaps that relate to local level data availability have been identified.

Generally, there is little data on young adults available at the community level, the exception being data that is collected by colleges and universities, though that data is oftentimes not reliable when used to measure outcomes for an intervention targeted to that age range. As many more communities are now recognizing the need to implement strategies targeted to that age group, the need for local data is more important than ever. Our evaluation team continues to work with individual communities to consider data collection strategies but a more consistent data collection effort is needed.

As we have reported previously, the Kansas Legislature passed active-consent legislation in SFY15 that initially hindered the state's ability to sustain participation in our Communities That Care (CTC) Student Survey. For the first time

in more than 20 years, in 2016, statewide data was not available. Since the new statute became law, prevention contractors have been working diligently with community coalitions and local school districts to create strategies to ensure consents are provided in enrollment packets making the process much easier for schools. The enhanced efforts have led to increased participation in the last two years, but participation is still about 20 percent less than it was prior to the legislation. This challenge is another gap in our system that we are working to overcome.

Despite those challenges, Kansas has a strong and robust epidemiological data workgroup. The workgroup's efforts have led to many data enhancements over the past two years, including the creation of an online data dashboard to share behavioral health data (www.kbhid.org). The epidemiological workgroup reviewed multiple data source before determining block grant priorities for FY18 and FY19

Summary of relevant data:

Review of youth substance use data indicates that alcohol is by far the most prevalent substance used by students in grades 6, 8, 10 and 12 in Kansas. Alcohol is followed by use of marijuana, e-cigarettes, and misuse of prescription drugs. Similar to what has been seen at a national level, youth substance use in Kansas has demonstrated a downward trend over the past five years. While use of alcohol has shown the largest percentage decrease in the past five years compared to other substance use, its prevalence (16.3 percent) and impact (estimated 42,998 students in 6th-12th grade) warrants prioritization by Kansas' prevention system particularly for this vulnerable population and at its stage of brain development.

While reported youth substance use is on a downward trend, students reporting there is no risk of harm from substance use is on the rise for alcohol, cigarettes, marijuana and prescription drug misuse. For the past five years, the largest percentage of students reported that there was no risk of harm from regular marijuana use. This disproportion to reported use is likely an access issue as 61 percent of youth indicated it would be 'very hard' to get marijuana if they wanted to, compared to 43 percent saying the same for alcohol. Changes in surrounding states' legislation and the public acceptance of marijuana use as normative adult behavior, as witnessed in television and movies and other media, may be linked to increases in youth perception that regular marijuana use is not harmful.

National data lags two years behind current Kansas data but provides the only estimate of comparable use for young adults aged 18-25. A much smaller percentage (18.95 percent) of Kansas young adults report smoking cigarettes than the national average (26.7 percent), where larger percentages of Kansas young adults report alcohol and marijuana use than the national average. Methamphetamine use is notably different with Kansas reporting a much larger percentage of use. The second table reflects community mental health treatment admissions by primary substance for this age group. For most substances, Kansas admissions are relatively similar to national average for treatment admissions per 100,000; however, there is a very large discrepancy for methamphetamine. Kansas has more than double the treatment admissions for methamphetamine than the national average for young adults aged 18-25.

SAT

To identify unmet services needs and critical gaps within the current SAT system, KDADS relies upon data reported by the Administrative Service Organization (ASO) with whom they contract to administer SAT Block Grant funds to providers. KDADS also utilizes the Treatment Episode Data Set (TEDS). During the next two years, KDADS will review data reported in the annual State and National Behavioral Health Barometers, and utilize information that identifies unmet needs/gaps as part of strategic planning.

The Governor's Behavioral Health Services Planning Council (GBHSPC) is another mechanism used by KDADS to identify needs/gaps in the SAT. To assist KDADS in developing the FFY 18-19 Block Grant, a workgroup was developed that consisted of representatives from: the GBHSPC's Continuum of Care Task Force and the Kansas Citizen's Committee on Alcohol and Other Drug Abuse Subcommittee (KCC), as well as from the Kansas Association of Addiction Professionals (KAAP) and other SAT providers. Themes from their input, other public comment, and the KCC's FY 17 Annual Report are included, below:

SAT Access/Consumer Choice: Some rural and frontier areas of the state have proportionately fewer available block grant-funded SAT providers than the rest of the state, particularly for residential, social/medical detox, peer support, and

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adolescent services. This limitation may adversely impact Kansas' ability to address the opioid epidemic, as may the lack of Medication Assisted Treatment (MAT). In addition, even in more urbanized areas, there can be waiting periods for services, particularly for men.

There are sometimes delays in getting services approved for the SAT population, particularly when a consumer is being transferred from one provider to the other, or, there is a change in funding source. The current state SAT data system, the KCPC, can hamper providers' ability to efficiently transfer consumers from one provider to another.

The lack of available providers impacts consumer choice. In addition, one public comment reported that, "Consumers continue to be 'told' where to go rather than given options, especially in regard to consumers that are assessed by entities that have contracts with other referral agents. This is also true of consumers that prefer a faith-based choice (Charitable Choice), that are not given the option." SAT Access for Subpopulations: In some communities, SAT providers report that there is a lack of access to mental health treatment and medication management for their consumers with co-occurring SUD and mental illness. This may be due in part to a lack of availability of concurrent mental health care and SUD treatment to consumers. There is also currently inadequate access to treatment for those who use tobacco. One provider stated that, "The most important treatment aspect that should be implemented in order to receive Block Grant money is that the treatment program have Tobacco Treatment Cessation as part of their curriculum in order to be considered. Most alcoholics, amphetamine, cocaine, opiate, sedative, gambling etc patients die of complications of tobaccoism, not the substance use disorder they present with. If programs aren't treating tobacco substance use disorders they should not be receiving grant funding. The health care cost associated with tobacco use are staggering. The primary reason many patients are not able to achieve abstinence is due to continued use of tobacco."

A member of the workgroup notes that, "A growing number of children in the child welfare system were removed from their homes due to parental substance use as a primary or contributing factor to the substantiated abuse or neglect. These parents are, more often than not, uninsured. Expectations of the treatment system and child welfare often conflict, delaying permanency for the child." Another member of the workgroup observed that, "There seems to be the need for training resources for treating the LGBT clients as well as recognizing support systems for the LGBT population." And another workgroup member reported a need for provider training related to: trauma awareness, older adults, and opioid users.

Related Service Needs: Providers have indicated the need for access to other services, including: affordable housing, transportation, primary care, mental health care, education, childcare, etc. One SAT provider commented that, "...HUD is eliminating emergency shelter funding in favor of permanent housing programs which leaves many addicts in very precarious situations. There are waiting periods and other application requirements the most seriously disabled are not able to navigate. As you know, many women, couples, families and men may have a serious co-occurring disability but have so precariously housed and avoidant of medical professionals they are unable to work but have no disability application in process." One public comment stated that, "Coordination of admission, discharge, and follow-up services can often take hours of a provider's and/or support staff's time. There are no codes to support this type of care like there are in the mental health system. A model should be considered that allows for coordination of care through an outcome based platform." Another noted that, "It seems like many clients go to inpatient and return to the same environment. More case management could help them find employment, new housing, and support that a therapist might not be able to. If the system can prevent as many people needing inpatient treatment than their [sic] will be shorter wait times."

SAT Workforce Shortage: According to the KCC's FY 17 Annual Report, "The workforce crisis means that some agencies are forced to terminate effective, cost-saving programs because there aren't enough qualified professionals to staff them. Current professionals in the field are stretched too thin, creating a risk for poorer quality services and attrition. In some cases, agencies must resort to hiring staff that are technically eligible to perform the work but have very little specific training in addiction counseling, which is a highly demanding field with specialized treatments and challenges. Under-prepared staff creates substantial training demands and attrition problems."

In 2016, a workgroup was formed to strategize responses to the Kansas workforce shortage. This workgroup, which was comprised of SAT providers and representatives from: KDADS, the Behavioral Sciences Regulatory Board, Wichita State University, Emporia State University, the Kansas Department for Children and Families, University of Kansas Medical Center, Newman University, the University of Kansas School of Social Welfare, Mid-America Addiction Technology Center, HRSA, and SAMHSA. They met monthly from February to October, and produced a "Summary and Recommendations" document that addressed the critical needs regarding recruitment and retention, as well as continuing education.

Specifically, they identified recruitment and retention recommendations to: 1) Collect data regarding staff turnover to identify contributing factors; 2) Create a map of where licensed professionals are located across the state; 3) Create incentives for Kansas graduates to remain in Kansas post-graduation; 4) Increase reimbursement rates to keep pace with other disciplines and cost of living; 5) Enforce Mental Health and Addiction Equality Act (parity) law violations (specifically reimbursement rates which are related to starting salaries); 6) Education private insurance companies as to the value added by licensed addiction counselors (return on investment, outcomes); 7) Education for funders as to the importance of measuring behavioral health outcomes along with health outcomes; 8) Review results of pending Mid-America Addiction Technology Center's workforce study; 9) Identify statutory changes regarding licensure that could enhance reciprocity with other states; and, 10) Dedicate resources toward leadership development, specifically supervisory and business skills. Continuing education recommendations identified were: 1) Enhance higher education curriculums to include the value of telehealth services; 2) Provide telehealth trainings to current practitioners; 3) Support proposed legislation that defines and promotes the use of telehealth; 4) Make funding available to rural areas to develop broadband to expand the use of telehealth; 5) Offer interdisciplinary training (primary care, mental health and addictions) to current practitioners to improve client outcomes; and, 6) Convene educators of higher learning to discuss ways to prepare students for interdisciplinary practice.

Use of Evidence-Based Practices:

While many network providers utilize evidence-based and promising practices in their treatment, increasing this utilization will be a consideration when making decisions about selecting the new SAT provider network. One public specifically recommended, "Incorporation of a strengths based model into the existing site visit reporting model to highlight the positive aspects of a particular program."

SAT Funding Constraints: Because of consumer demand for SUD services, providers frequently expend their allotment of block grant and state funding before the end of the fiscal year; because of this, they are not able to be reimbursed for all services provided. In addition, some consumer utilizing block grant funds to pay for their services would meet medical necessity for reintegration treatment; however, lower reimbursement rates for these services result in limited access to them. One Block Grant workgroup participant suggested that KDADS, "Review SAT reimbursement rates and billing requirements. Explore increased investment in technology resources that break down geographical barriers. Explore use of a global payment model to allow providers to define the appropriate care for each consumer while managing per member per month funds while tracking quality outcomes. Explore initiatives that allow professions with specialty training in addiction counseling to provide more integrative services to clients with co-occurring conditions." One provider recommended that, "Peer mentoring services be funded in the form of a grant (with increased supportive funding) rather than as it is now which is fee for service. The reimbursement for peer mentoring services is very minimal and the billing is intensive. This is the reason that few programs provide much peer mentoring...the cost of providing the service and billing is cost prohibitive." The same provider also recommended funding for, "Crisis Centers such as the Community Crisis Center here in Wichita where COMCARE and SACK provide Crisis Mental Health Services and SACK provides Sobering and Detoxification services in one facility."

Other SAT needs/gaps identified by KDADS and its stakeholders include: for adolescents, an exploration of the use nontraditional treatment methods such as those utilizing social media; for pregnant women and women with dependent children (PWDC), increased access to SAT services; for PWDC, increased access to prenatal care; for men with dependent children, increased access to SAT services; increased access to trauma-informed care; for priority populations, increased access to public

benefits; treatment uniquely targeted to older adults; increased provider; exploration of ways to enhance provider knowledge about communicable diseases; and the need for screening for and addressing problem gambling in the SAT population. MHS/SAT Integration

As stated, above, for the past five years, the Kansas departments of mental health and substance use disorders have been housed within the same Commission. Further integration within the Commission includes:

- Prevention staff who work on state and community initiatives that address both mental health and substance use disorders;
- Housing, homeless, and vocational staff who manage the SAMHSA MHS-funded ESEK, CABHI, and PATH grants, as well as substance use disorder programs such as Oxford Houses;
- Partnerships with the Kansas Department of Corrections and local law enforcement that address both mental health and substance use disorders;
- A dedicated Block Grant Planner to develop a combined Block Grant Assessment and Plan and Report; and,
- An integrated Governor's Behavioral Health Services Planning Council (GBHSPC).

The GBHPC is currently conducting a review of existing services and resource gaps for children and youth across the behavioral health services continuum. In recent months, they've also invited presenters from providers who are integrating their mental health and substance use disorder services.

Kansas' FFY 16-17 Block Grant Plan reported that the GBHSPC and KDADS had identified the goal to, "Establish integrated SUD/MH peer services that support individuals in their recovery." The objective was, "To review, identify, research, and align peer services," with the outcome of, "creation of [an] implementation plan." In SFY 17, Kansas applied for and was awarded technical assistance in the form of a Policy Academy facilitated by BRSS TACS. The Academy, which began in May, 2017, and will end in September, 2017, is comprised of ten members that include: state decision-makers, stakeholders such as consumers and service providers, and representatives from one Kansas Medicaid Managed Care Organization (MCO) and from the Administrative Service Organization (ASO) that oversees and authorizes SAT funded by the Block Grant. The team's goal is to "develop a strategic plan to train and credential 'Recovery Support Specialists' to build recovery capacity for persons new to recovery by connecting them to naturally occurring resources in the community, assist in reduction of barriers to fully engaging in recovery, and providing support in skill development for maintaining a recovery lifestyle." Expected outcomes include: 1) expanded peer support workforce for providers throughout the Kansas behavioral health services continuum; 2) improved efficacy of peer supports for individuals with co-occurring mental illnesses and substance use disorders and other addictions; and, 3) improved consumer outcomes based upon a process of continuous quality improvement utilizing standardized data and enhanced program evaluation. An analysis conducted with the team has identified that current critical weaknesses of the Kansas system include: 1) limited workforce in frontier and rural Kansas; 2) budget decisions not always informed by program need, resulting in lack of funding; 3) lack of integrated behavioral health model for peer support training and certification. Please see Attachments for BRSS TACS Action Plan.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

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

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

Footnotes:

Kansas Block Grant Responses for FY18/19

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

The Kansas Client Placement Criteria (KCPC) system is used at the facility and assessment center level for client information and treatment tracking. Statistical State and Federal (TEDS/NOMS) data is gathered in these systems and automatically provided to the state.

The Automated Information Management System (AIMS) is a succession of processes that result in a comprehensive data set comprised of 85 data fields that reflect demographic, client status, and encounter data for mental health consumers served by local Community Mental Health Centers (CMHCs) in Kansas.

To collect mental health data we rely on our AIMS database which is populated through our community mental health centers that provide outpatient services to our mental health population. Substance abuse treatment episodes are collected in our KCPC system.

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

These two systems are specific to SA and MH respectively, collecting data throughout the entire state.

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

We are able to report down to the client level detail.

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

N/A

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Provide access to community based services for adults with severe mental illness allowing them to remain in their homes and communities with services and supports.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

Adults with severe mental illness receive peer support and treatment that is timely, appropriate, and adequate.

Strategies to attain the objective:

Identify opportunities to increase access to services for SMI.

Examine adequacy of SMI-related service rates.

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

Explore potential partnership opportunities with the Kansas Department of Corrections to increase referrals and to address barriers related to stigma of mental illness and treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SPMI served with Block Grant funds

Baseline Measurement: Number of SPMI served with Block Grant funds in SFY 17.

First-year target/outcome measurement: 1 percent increase in number of SPMI served with Block Grant funds since SFY 17

Second-year target/outcome measurement: 1 percent increase in number of SPMI served with Block Grant funds since SFY 18

Data Source:

KDADS' Automated Information Management System (AIMS)

Description of Data:

Proportion of total number of SMI in a given SFY

Data issues/caveats that affect outcome measures::

Individuals not correctly identified as SPMI

Priority #: 2

Priority Area: Provide access to community based services for children with serious emotional disturbance, allowing them to remain in their homes and communities with services and supports.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Children with SED are offered treatment needed to ensure they can maintain in the community and improve their education, family and quality of life.

Objective:

Children with SED receive treatment and supports that are timely, appropriate, and adequate.

Strategies to attain the objective:

Build awareness of the SED diagnosis and service availability for families of children with SED who are in need of treatment and services, and for other systems that have contact with children.

Identify opportunities to increase access to services for SED.

Examine adequacy of SED-related service rates.

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

Coordinate care and build partnerships with Kansas Department of Children and Families and Kansas Department of Education to increase referrals and to address barriers related to SED children's access to needed treatment and support in schools, child welfare and other locations.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: SED served with Block Grant funds
Baseline Measurement: Number of SED served with Block Grant funds in SFY 17
First-year target/outcome measurement: 1 percent increase in number of SED served with Block Grant funds since SFY 17
Second-year target/outcome measurement: 1 percent increase in number of SED served with Block Grant funds since SFY 18

Data Source:

KDADS' Automated Information Management System (AIMS)

Description of Data:

Proportion of total number of SED in a given SFY

Data issues/caveats that affect outcome measures::

Individuals not correctly identified as SED

Priority #: 3

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

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Identify opportunities to increase access to services for ESMI.

Examine adequacy of ESMI-related service rates.

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: ESMI served with Block Grant funded-intervention
Baseline Measurement: Number of youth experiencing ESMI served with Block Grant funded-intervention in SFY 17
First-year target/outcome measurement: 5 percent increase in number of youth experiencing ESMI served with Block Grant funded-intervention in SFY 17
Second-year target/outcome measurement: 5 percent increase in number of youth experiencing ESMI served with Block Grant funded-intervention in SFY 18

Data Source:

KDADS' Automated Information Management System (AIMS)

Description of Data:

Proportion of total number of youth experiencing ESMI served with Block Grant funded-intervention in a given SFY

Data issues/caveats that affect outcome measures::

Individuals not correctly identified as being ESMI, funding cuts to overall Block Grant

Priority #: 4
Priority Area: Reduce underage drinking in Kansas
Priority Type: SAP
Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Question: On how many occasions, if any, have you had beer, wine, or hard liquor in the past 30 days?
Baseline Measurement: Question: On how many occasions, if any, have you had beer, wine, or hard liquor in the past 30 days? Baseline year 16.31percent (2017)
First-year target/outcome measurement: 15.17 percent
Second-year target/outcome measurement: 14.03 percent

Data Source:

Kansas Communities That Care Student Survey

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Indicator #: 2

Indicator: Total number of aggregate program, policy, practice and service activities related to implementation of evidence-based strategies designed to reduce underage drinking

Baseline Measurement: Total number of aggregate program, policy, practice and service activities related to implementation of evidence-based strategies designed to reduce underage drinking – 12 (2017 communities were in SPF assessment and planning phase)

First-year target/outcome measurement: 24 (per three funded communities); 8 community activities per funded community

Second-year target/outcome measurement: 36 (per three funded communities); 12 community activities per funded community

Data Source:

Community Check Box

Description of Data:

Community Check Box is a smart, helpful, easy-to-use web-based tool to capture and display data that shows where and how well communities are progressing toward their goals. This process helps support meaningful evaluations, promote accountability, and encourage continual improvements in work. The CheckBox is provided per our evaluation contract by the University of Kansas, Workgroup for Community Health and Development, this tool has been utilized in our state for over 10 years.

Data issues/caveats that affect outcome measures::

Data is entered into the Community CheckBox system by communities themselves, so much of the data collection is depended upon accurate data entry; that being said the state provides training and on-going technical support to all communities and the Workgroup for Community Health and Development does provide reliability reports to each community on a regular bases. Additionally all grant awards require weekly documentation in the system.

Priority #: 5

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

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce percentage of students in grades 6, 8, 10, and 12 that report there is “No risk” of harm from regular marijuana use.

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Question: How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly?

Baseline Measurement: Question: How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly? (No risk) - Baseline year 16.78 percent (2017)

First-year target/outcome measurement: 16.28 percent

Second-year target/outcome measurement: 15.78 percent

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Indicator #: 2

Indicator: Total number of aggregate program, policy, practice and service activities related to the implementation of evidence-based strategies targeting perceived risk of harm associated with regular marijuana use.

Baseline Measurement: Total number of aggregate program, policy, practice and service activities related to the implementation of evidence-based strategies targeting perceived risk of harm associated with regular marijuana use. Baseline year: 1 (2017 communities were in SPF assessment and planning phase)

First-year target/outcome measurement: 5 community level activities per funded community

Second-year target/outcome measurement: 10 community level activities per funded community

Data Source:

Community Check Box

Description of Data:

Community Check Box is a smart, helpful, easy-to-use web-based tool to capture and display data that shows where and how well communities are progressing toward their goals. This process helps support meaningful evaluations, promote accountability, and encourage continual improvements in work. The CheckBox is provided per our evaluation contract by the University of Kansas, Workgroup for Community Health and Development. This tool has been utilized in our state for over 10 years.

Data issues/caveats that affect outcome measures::

Data is entered into the Community CheckBox system by communities themselves, so much of the data collection is depended upon

accurate data entry. However, the State provides training and on-going technical support to all communities and the Workgroup for Community Health and Development does provide reliability reports to each community on a regular basis. Additionally, all grant awards require weekly documentation in the system.

Priority #: 6
Priority Area: Reduce methamphetamine use among young adults
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Increase the number of young adults (age 18-25) receiving treatment for methamphetamine.

Objective:

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

Strategies to attain the objective:

Kansas will utilize the SPF process to identify communities of high need and significant capacity to address the issue. Funding will allow local communities to create a strategic plan that is guided by the SPF elements and identify appropriate evidence-based strategies that directly correlate to their individual needs identified after completion of a comprehensive needs assessment.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Question: Have you used methamphetamines in the last 30 days?
Baseline Measurement: Question: Have you used methamphetamines in the last 30 days? Baseline year: 1.7 percent (2017)
First-year target/outcome measurement: 1.5 percent
Second-year target/outcome measurement: 1.0 percent

Data Source:

Kansas Young Adult Survey (KYAS)

Description of Data:

The new Kansas Young Adult Survey measures behavioral health among Kansans aged 18-25. In addition to asking about use of alcohol, tobacco, and other drugs, this survey addresses major sources of stress, general health, mental health and depression, and perceived risk of harm from substance use. It also includes questions related to prescription drug misuse, knowledge of proper disposal of unused drugs, gambling, and driving safety.

Data issues/caveats that affect outcome measures::

The survey utilized a representative sample and was conducted for the first time in 2017; currently, funding is only available to conduct second survey in 2019, although the state plans to seek additional resources to enhance the availability of data for the target population.

Indicator #: 2
Indicator: Total number of aggregate program, policy, practice and service activities related to the implementation of evidence-based strategies targeting young adult methamphetamine use
Baseline Measurement: Total number of aggregate program, policy, practice and service activities related to the implementation of evidence-based strategies targeting young adult methamphetamine use. Baseline year: 0 communities were in SPF assessment and planning phase) (2017)
First-year target/outcome measurement: 3 community-level activities per funded community

Second-year target/outcome measurement: 6 community level activities per funded community

Data Source:

Community Check Box

Description of Data:

Community Check Box is a smart, helpful, easy-to-use web-based tool to capture and display data that shows where and how well communities are progressing toward their goals. This process helps support meaningful evaluations, promote accountability, and encourage continual improvements in work. The CheckBox is provided per our evaluation contract by the University of Kansas, Workgroup for Community Health and Development. This tool has been utilized in our state for over 10 years.

Data issues/caveats that affect outcome measures::

Data is entered into the Community CheckBox system by communities themselves, so much of the data collection is depended upon accurate data entry. The State provides training and on-going technical support to all communities and the Workgroup for Community Health and Development does provide reliability reports to each community on a regular bases. Additionally, all grant awards require weekly documentation in the system.

Priority #: 7
Priority Area: Behavioral Health Prevention and Promotion
Priority Type: SAP
Population(s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Educate, increase awareness, promote, advocate, and disseminate resources to support suicide prevention, mental health promotion, and the reduction of co-occurring risk factors.

Objective:

Increase collaborations and initiatives that promote awareness of behavioral health co-occurring risk and protective factors and use of evidence-based strategies that address multiple behavioral health issues.

Strategies to attain the objective:

- Provide training to the community and state level workforce to increase the knowledge around co-occurring risk and protective factors, suicide prevention, Adverse Childhood Experiences
- Compile and disseminate a list of strategies that have demonstrated effectiveness at addressing both SUD and mental health concerns.
- Continue data collection that encompasses a more holistic understanding of behavioral health needs

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Kansas school districts participating in the systematic data collection of youth depression, suicidal thoughts, plans, attempts, and co-occurring risk factors
Baseline Measurement: Number of Kansas school districts participating in the systematic data collection of youth depression, suicidal thoughts, plans, attempts, and co-occurring risk factors. Baseline year: KCTC 190 districts; KCTC Depression/Suicide Module 134 districts (2017)
First-year target/outcome measurement: 195/140
Second-year target/outcome measurement: 198/145

Data Source:

Kansas Communities That Care (KCTC) Student Survey participation rate and KCTC Optional Depression/Suicide Module participation rate

Description of Data:

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

community levels. It provides a measurable level of risk and protective factors that influence behavior, attitudes, and opinions of Kansas teens.

Data issues/caveats that affect outcome measures::

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

Indicator #: 2
Indicator: Gambling and Behavioral Health survey
Baseline Measurement: Number of surveys completed Baseline year: 0 participants (2017)
First-year target/outcome measurement: 1,600
Second-year target/outcome measurement: 2,100

Data Source:

2017 Kansas Gambling and Behavioral Health Survey

Description of Data:

Kansas will complete Gambling and Behavioral Health survey in the summer of 2017. This survey was initially conducted in 2012; the 2017 version will include some enhancements and will ask additional behavioral health related questions.

Data issues/caveats that affect outcome measures::

The survey is conducted on a random sample, so achieving the desired participation rate may be a challenge.

Priority #: 8
Priority Area: Pregnant women and women with dependent children receive treatment that targets the PWWDC population
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Pregnant women and women with dependent children are free from the adverse effects of substance use disorders that they have experienced.

Objective:

Increase proportion of pregnant women and women with dependent children who receive SAT at designated women's facilities

Strategies to attain the objective:

Require assessors to document in the KCPC that the designated women's facility where they have referred PWWDC has no available beds.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: PWWDCs served with Block Grant funds
Baseline Measurement: Proportion of total PWWDCs served with Block Grant funds in SFY 17 by designated women's facilities
First-year target/outcome measurement: 10 percent increase in proportion of total PWWDCs served with Block Grant funds in SFY 17 by designated women's facilities in compared to number of PWWDC served with Block Grant funds since SFY 17

Second-year target/outcome measurement: 10 percent increase in proportion of total PWWDCs served with Block Grant funds in SFY 17 by designated women's facilities in compared to number of PWWDC served with Block Grant funds since SFY 18

Data Source:

KDADS' Kansas Client Placement Criteria (KCPC) system

Description of Data:

Proportion (percent) of total PWWDCs in a given SFY served by designated women's facilities

Data issues/caveats that affect outcome measures::

Individuals not correctly identified as being PWWDCs

Priority #: 9

Priority Area: Increase timely access to services for PWID

Priority Type:

Population(s): PWID

Goal of the priority area:

PWID are free from the adverse effects of substance use disorders that they have experienced.

Objective:

Increased proportion of PWID access treatment within the required timeframe

Strategies to attain the objective:

Identify opportunities to increase access to services for PWID.

Examine adequacy of PWID-related service rates.

Reinstated Statewide Quality Committee (SQC) reviews reports indicating PWID treatment access timeframes generated by ACO. Data are analyzed and trends identified.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: PWID admission to treatment within required timeframes

Baseline Measurement: Proportion of PWIDs who were not admitted to treatment within required timeframes who were utilizing Block Grant funds in SFY 17

First-year target/outcome measurement: 10percent decrease in proportion of PWIDs who were not admitted to treatment within required timeframes utilizing Block Grant funds compared to SFY 17

Second-year target/outcome measurement: 10 percent decrease in proportion of PWIDs who were not admitted to treatment within required timeframes utilizing Block Grant funds compared to SFY 18

Data Source:

KDADS' Kansas Client Placement Criteria (KCPC) system

Description of Data:

Proportion (percent) of total PWIDs who were not admitted to treatment within required timeframes utilizing Block Grant funds in a given SFY

Data issues/caveats that affect outcome measures::

Individuals not correctly identified as being PWIDs, PWIDs voluntarily choosing delay in treatment admission dates

Priority #: 10
Priority Area: Referrals for TB screening
Priority Type: SAT
Population(s): TB

Goal of the priority area:

Individuals at risk for TB know their TB status

Objective:

PWWDC, PWID, HIV + and individuals otherwise identified as being at risk are referred for TB screening.

Strategies to attain the objective:

Charts reviewed in accordance with Block Grant monitoring procedure.

Providers who are found deficient in referring individuals for TB screening are identified, and ACO develops corrective action plan.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Priority population charts indicate that they are referred fro TB screening

Baseline Measurement: Not established due to new Block Grant monitoring procedure.

First-year target/outcome measurement: Representative sample of the charts of 95 percent of all individuals identified as a member of the priority populations (PWWDC, PWID, HIV) indicate that they are referred for TB screening.

Second-year target/outcome measurement: Representative sample of the charts of 100 percent of all individuals identified as a member of the priority populations (PWWDC, PWID, HIV) indicate that they are referred for TB screening.

Data Source:

SUD Treatment Block Grant Monitoring Tool

Description of Data:

Proportion of data collected on SUD Treatment Block Grant Monitoring Tools indicating that priority populations were referred for TB screening.

Data issues/caveats that affect outcome measures::

Individuals who choose not to disclose their at-risk status, individuals not correctly identified as being members of the priority population.

Priority #: 11
Priority Area: Referrals for HIV screening
Priority Type: SAT
Population(s): EIS/HIV

Goal of the priority area:

Individuals at risk for HIV know their HIV status

Objective:

PWWDC, PWID, TB and individuals otherwise identified as being at risk are referred for HIV screening

Strategies to attain the objective:

Charts reviewed in accordance with Block Grant monitoring procedure.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Chart review indicates that priority populations and others at risk are referred fro HIV screening

Baseline Measurement: Not established due to new Block Grant monitoring procedure

First-year target/outcome measurement: Representative sample of the charts of 95 percent of all individuals identified as a member of the priority populations (PWWDC, PWID, TB) indicate that they are referred for HIV screening

Second-year target/outcome measurement: Representative sample of the charts of 100 percent of all individuals identified as a member of the priority populations (PWWDC, PWID, TB) indicate that they are referred for HIV screening

Data Source:

SUD Treatment Block Grant Monitoring Tool

Description of Data:

Proportion of data collected on SUD Treatment Block Grant Monitoring Tools indicating that priority populations were referred for HIV screening

Data issues/caveats that affect outcome measures::

Individuals who choose not to disclose their at-risk status, individuals not correctly identified as being members of the priority population

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$17,783,480		\$27,982,260	\$0	\$38,102,862	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$4,100,622		\$0	\$0	\$1,899,380	\$0	\$0
b. All Other	\$13,682,858		\$27,982,260	\$0	\$36,203,482	\$0	\$0
2. Primary Prevention	\$5,422,494		\$0	\$1,770,000	\$1,563,414	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$593,630		\$644,430	\$112,098	\$810,281	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$23,799,604	\$0	\$28,626,690	\$1,882,098	\$40,476,557	\$0	\$0

* Prevention other than primary prevention

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

Footnotes:

It appears that line 2 is not included in the Subtotal calculations.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$16,000,000	\$6,000,000	\$172,425,500	\$0	\$0
6. Other 24 Hour Care		\$0	\$42,209,332	\$0	\$81,186,924	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$5,030,706	\$244,114,152	\$4,980,000	\$286,273,188	\$0	\$0
8. Mental Health Primary*		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$591,844	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$295,922	\$3,903,546	\$0	\$266,924	\$0	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$5,918,472	\$306,227,030	\$10,980,000	\$540,152,536	\$0	\$0

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

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	10010	0
Women with Dependent Children	14032	0
Individuals with a co-occurring M/SUD	65520	0
Persons who inject drugs	4368	0
Persons experiencing homelessness	28560	0

Please provide an explanation for any data cells for which the stats does not have a data source.

"Aggregate in Need" data were calculated using the estimate provided by SAMHSA of the proportion of Kansans who reported "needing but not receiving" SAT during 2009-2014 (168,000 Kansans). According to the 2010 Census, there were 2,125,581 adults living in Kansas. Therefore, approximately 13% of Kansans were in need but not received SAT. This percentage was then applied to the following data to report the numbers, above: According to the Guttmacher Institute, in 2010, 77,000 Kansas women were pregnant. According to the 2010 Census, 107,941 households were headed by women. According to SAMHSA's Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, 8% of the US adult population had an SUD, and 39% of those had a co-occurring mental illness. According to the 2014 article in PLoS One, "Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections," by Lansky et al., 2.6% Americans inject drugs at some point in their lives. Finally, according to HUD 2016 Continuum of Care data provided by SAMHSA, 17% (94,496 of the total 549,928) of Kansans who identified as homeless experienced chronic substance abuse.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$8,788,962
2 . Primary Substance Abuse Prevention	\$2,494,164
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV *	
5 . Administration (SSA Level Only)	\$593,846
6. Total	\$11,876,972

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	\$874,581
	Total	\$874,581
Education	Universal	
	Selective	
	Indicated	
	Unspecified	\$397,537
	Total	\$397,537
Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	\$53,005
	Total	\$53,005
Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	\$26,502
	Total	\$26,502

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	\$795,074
	Total	\$795,074
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	\$477,044
	Total	\$477,044
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$2,623,743
Total SABG Award*		\$11,876,972
Planned Primary Prevention Percentage		22.09 %

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	\$0
Total SABG Award*	\$11,876,972
Planned Primary Prevention Percentage	0.00 %

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

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

Footnotes:

Young adults aged 18-25 is the target for the methamphetamine population.

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems			\$283,588	
2. Infrastructure Support			\$754,750	
3. Partnerships, community outreach, and needs assessment			\$275,848	
4. Planning Council Activities (MHBG required, SABG optional)			\$0	
5. Quality Assurance and Improvement			\$113,435	
6. Research and Evaluation			\$453,741	
7. Training and Education			\$404,283	
8. Total	\$0	\$0	\$2,285,645	\$0

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102?123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52?77

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

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³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

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

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

In July of 2012, several state agencies in Kansas were re-organized. The mental health and addictions-prevention and treatment programs, previously administered by the Kansas Department of Social and Rehabilitation Services, were moved into the newly formed Kansas Department for Aging and Disability Services. These programs became part of the agency's Community Services and Programs Commission, which administered both behavioral health and home- and community-based services. In June of 2015, a separate Behavioral Health Commission was established and a Commissioner was appointed to oversee management of the behavioral health services provided by the state. The state's two psychiatric hospitals were situated under the BH Commission as well.

The Director of Behavioral Health Services reports to the Commissioner for BH. The Behavioral Health Services Director is designated as the State Mental Health Authority (SMHA), and supervises the majority of the BH staff. The Block Grant Manager is the Single State Authority (SSA) for community mental health services ("MHS"), substance abuse prevention ("SAP"), and substance abuse treatment ("SAT"). Five BH staff oversee SAT programs; six oversee SAP programs; and 11 oversee MHS programs (three of which focus on programs for children and adolescents.) In 2016, KDADS staff responsible for licensing and certifying MH services and SAT providers moved from the Behavioral Health Commission to the newly established KDADS Commission on Survey, Certification and Credentialing. This reorganization has enabled BH staff to focus on program planning and management rather than the enforcement of regulations, which is now the work of staff on the Survey, Certification and Credentialing Commission. The Kansas Department of Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority. KDHE administers KanCare, the program through which the state administers Medicaid and its seven home- and community-based services 1915 (c)waivers. Currently Kansas has a contract with three managed care organizations (MCOs), Amerigroup of Kansas, Inc., Sunflower Health Plan, and United Healthcare Community Plan of Kansas, to coordinate health care (including MHS and SAT) for all people enrolled in Medicaid. The current KanCare 1115 waiver demonstration program expires on December 31, 2017. KDHE has requested a one-year extension, through December 2018, and intends to submit a waiver renewal request on November 1,

2017, for a new 1115 waiver that would take effect January 1, 2019.

Mental Health Services

Criterion 1: Comprehensive Community-Based Mental Health Service Systems: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring M/SUD. States must have available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Under Kansas Statutes Annotated (KSA) 19-4001 et. seq., and KSA 65-211 et. seq., 26 licensed Community Mental Health Centers (CMHCs) currently operate in the state. These Centers have a combined staff of over 4,000 providing mental health services in every county of the state in over 120 locations. Together they form an integral part of the total mental health system in Kansas. The independent, locally owned centers are dedicated to fostering a quality, free standing system of treatment and programs for the benefit of citizens needing mental health care and treatment. Each of the 26 licensed CMHCs operating in Kansas has a separate, duly elected and/or appointed board of directors. Each of these boards is accountable to the citizens served, its county officials, the state legislature, and the governor; and all have reporting responsibilities to the national level of government. The CMHCs provide recovery and treatment services to Kansans who are covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured.

CMHCs are the counties' legally delegated authorities to manage mental health care in Kansas, and function as the local mental health authorities. Outcome performance measures have been specifically delineated in contracts with the State of Kansas since Mental Health Reform was commenced. The CMHCs operate under extensive state licensing regulations; are subject to licensure site reviews; and routinely provide extensive required data to the Kansas Department for Aging and Disability Services (KDADS). The CMHCs also conform to Medicaid and Medicare standards and audits.

The primary goal of the CMHCs is to provide quality care, treatment and rehabilitation to individuals with mental health problems in the least restrictive environment. CMHCs provide services to all those needing it, regardless of economic level, age or type of illness. Services provided include: evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education, consultation, treatment and rehabilitation services, 24-hour emergency services. Community-based mental health services also include assistance in securing employment services, housing services, medical and dental care, and other supports. Kansas CMHCs provide care to more than 100,000 citizens per year. The number of consumers served has doubled over the past 10 years, largely as a result of deinstitutionalization. Many of these former hospital patients now rely on CMHCs for mental health treatment to maintain their ability to live in their own community.

CMHCs provide services and treatment to these persons in the priority target populations as defined by K.S.A. 39-1602, which are adults with severe and persistent mental illness (SPMI), children and adolescents experiencing a serious emotional disturbance (SED), and other individuals at risk of requiring institutional care. An estimated 18,000 patients are seriously emotionally disturbed children that are being served in the community, and over 18,000 are severe and persistently mentally ill adults. Services that are key to ensuring individuals are able to remain in their own communities include: 24-hour, 7 days a week emergency treatment and first response services; crisis responsiveness; evaluation, assessment, and treatment; screening for admission to a state psychiatric hospital, when applicable and required by K.A.R. 30-61-10; follow-up with any consumer seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services and/or referral to any services; basic outpatient treatment services; basic case management services for adults; and basic community-based support services for children, adolescents, and their families. Currently, 23 of the CMHCs also offer Substance Use Disorder (SUD) treatment in their areas of the state.

Kansas has built an infrastructure of Consumer Run Organizations (CROs) to promote recovery through peer recovery supports to consumers or former consumers of mental health services, especially people with severe and persistent mental illness (SPMI). CROs are legally incorporated, nonprofit, consumer-governed and operated organizations using a peer recover model built on self-direction, empowerment, peer support and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. Typically, a CRO provides an array of services to its members that include leadership, education, training and research opportunities; peer support groups, drop-in centers, self-help groups, employment support, life skills training, health and wellness activities; bridge supports from state institutions to life in the community; and education about Medicaid and other community resources to connect Members to services.

CROs:

- Provide leadership, education, training and research opportunities for members;
- Offer a range of peer support groups, drop-in centers, self-help groups, employment support, life skills training, health and wellness activities;
- Often provide a bridge from state institutions to life in the community; and
- Educate consumers of mental health services about Medicaid and other community resources and connect them to these programs.

Recovery-oriented services typically include self-help groups, activities and resources to empower members to work, volunteer, attend school or further enrich their lives as members work towards recovery. Three of the CROs are regional centers for CRO leadership and administration purposes. Called Regional Recovery Resource Centers, these CROs are dedicated Certified Peer Support Specialists that offer resources, technical assistance and support development of recovery supports and peer support programs in communities and populations statewide. The RRRRC provides support to build capacity within the other CROs in their Kansas regions as well recovery supports in communities not having established a CRO or peer support group. The RRRRC connects with Community Mental Health Center's for crisis prevention and intervention, the State Mental Health Hospitals to bridge supports prior to the consumer discharge, Homeless shelters to assist with a referral process, Police Departments to expand the

CIT program, and NFMH's to bring hope and recovery resources to the people they serve. KDADS funds 13 Consumer-Run Organizations (CROs) to provide nontraditional peer supports to consumers or former consumers of mental health services to support recovery and improve quality of life, such as helping people achieve employment, housing and greater social connectedness.

One consumer of CRO services provided the following public comment: "I am a Stanford University Graduate and a Fulbright Scholar, I also have a severe mental illness, Schizo-affective Bipolar Type. I was delusional for four years, had many false beliefs that ruled my life, and was basically a noted 'crazy' person around town, I was notorious. I would go into bars and restaurants and scream about the CIA and FBI, I got arrested and went to jail, I was hospitalized six times for weeks and weeks at a time. I basically lost those years of my life. After I came out of delusions I was suicidal and deeply depressed, and couldn't believe what had happened to my life. I am sure I would have killed myself if it hadn't been for the support and hope provided by Morning Star Inc., our local Consumer Run Organization. I joined Morning Star's groups and received peer-to-peer support and the center saved my life. They taught me I could have a life worth living even with my diagnosis, and today I have a job, a boyfriend and most importantly, a great feeling of optimism for the future. I learned to have a sort of healthy pride about myself, and came to internalize that a mental illness is like any other disease and nothing to feel guilty or embarrassed about. I have not been hospitalized or incarcerated since coming to Morning Star Inc. CRO. Thank you for your support of consumer run organizations and peer-to-peer support!"

Another consumer of CRO services provided the following public comment:

"I started coming to the cro about a year ago when I got hired on as the driver Before I came to Morning star I was in and out of the hospital about every six months. There were weeks at a time when I wouldn't get out of bed to shower or take care of my personal hygiene. I rarely ate I went from 250 pounds to 180 pounds. Don't get me wrong, Im glad I lost weight but not that way. It is a very personal and a source of embarrassment for me. I have been in and out of county jails and spent 2.5 years in the penitentiary. Im not proud of my past but it is part of my story. Since I've been coming to morning star I take a shower every day and change my clothes daily. For most people this is not a major accomplishment but for me it is. I haven't been to the hospital or to jail I started coming to the cro."

And a third consumer commented: "I have been a regular member of my local CRO. I led a very lonely life and isolated a lot. I have better work and social skills since my involvement. I have made several friends and enjoy groups and celebrations. I see the CRO as a regular part of my recovery and encourage others to attend."

The Kansas Consumer Advisory Council for Adult Mental Health, Inc. (CAC) is a consumer organization serving the geographical area of Kansas and dedicated to improving the lives of people with psychiatric disabilities. The organization is comprised of people who self-identify as current or former consumers of mental health services. The Kansas Consumer Advisory Council hosts a variety of programs throughout the year. These include:

- Leadership Academy – A two-month course consisting of two, three-day sessions, held in Wichita and a service project carried out in the participant's community.
- Annual Kansas Recovery Conference – a three-day conference held each June in Wichita. This conference is one of the largest consumer conferences in the nation, hosting more than 800 attendees in 2009. It presents nationally recognized keynote speakers, a wide variety of workshops, and many related activities.
- Trauma Informed Care – "Recovery For Real" is a CAC project funded by SAMHSA for the development of a Trauma Informed Care (TIC) model. The CAC was instrumental in Trauma Informed Care being introduced in Australia in May, 2015.

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

KDADS has also contracted with the National Alliance for the Mentally Ill (NAMI) – Kansas to develop a process for consumers, families, and communities to request information, resources, and assistance in accessing behavioral health services, as well as other community supports and services. NAMI is also developing a plan to train and provide technical assistance to consumers, families, communities, stakeholders, and professionals on how to address behavioral health concerns.

Criterion 2: Mental Health System Data Epidemiology: Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Target Population (A) Statewide Prevalence (B) Statewide Incidence (C)

1. Adults with SMI 4.08 4.05

2. Children with SED See below See below

2. Children with SED: According to the report, "Overview and Analysis of Kansas Public Health System," dated June 1, 2009, developed by the Kansas Department of Social and Rehabilitation Services Division of Disability and Behavioral Health Services Mental Health Services Program, approximately 5 percent to 9 percent of children and adolescents ages nine through 17 experience more severe functional mental health limitations, known as "serious emotional disturbance" (SED). Based on this estimate, using Census data, between 29,000 to 52,300 children and adolescents in Kansas have an SED. In SFY 2018, KDADS will submit a formal request to the Kansas Department of Health and Environment (KDHE) Epidemiology work group to collect this particular statistic for the state.

Criterion 3: Children's Services: Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services,

including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services. One mechanism for ensuring that Kansas children receive integrated services for their multiple needs is through the SAMHSA-funded System of Care for Mental Health Services for Children and Their Families. The goal of is to improve behavioral health outcomes for Kansas children and youth (birth-21) experiencing serious emotional disturbances (SED), and their families. Partnerships between KDADS, Wichita State University (WSU) and four local jurisdictions will, in the first year of the program, offer the following mental health services to youth to obtain the outcomes of improved behavioral health status and functionality of participants: (1) diagnostic and evaluation services; (2) outpatient services; (3) 24-hour emergency services; (4) intensive home-based services for the children and their families when the child is at risk of out-of-home placement; (5) intensive day treatment services; (6) respite care; (7) therapeutic foster care services, services in therapeutic foster family homes or individual therapeutic residential homes, and group homes caring for not more than 10 children; (8) assisting the child in making the transition from services received as a child to the services to be received as an adult; and (9) other recovery support services (e.g., supported employment) and focus efforts to provide early treatment for those youth with early onset of SED/SMI to children and youth. Within each CMHC catchment area, the SOC is establishing collaborations across child-serving agencies (e.g., substance use, child welfare, juvenile justice, primary care, education, early childhood) and among critical providers and programs to build bridges among partners, including relationships between community and residential treatment settings. Families and youth are integrally involved in the planning, governance, implementation, evaluation, and oversight of grant activities and in the system planning efforts to expand and sustain the SOC. Mechanisms such as: peer support, youth leadership development, youth-guided activities, parent support services and family advisory bodies, and self-help programs will be used to promote and sustain youth and family participation. SOC also implements an integrated crisis response strategy that creates a continuum of community-based crisis services and supports to reduce the unnecessary use of inpatient services by children and youth with SED.

Another mechanism for ensuring that Kansas youth receive integrated services for their multiple needs is through the SAMHSA-funded Transforming Lives through Supported Employment project currently in year three. The goal is to support and enhance employment opportunities for adults (including employment age youth) with a severe mental illness. Partnerships between KDADS, Kansas State University (KU) and two local jurisdictions are strengthening our current Supported Employment infrastructure and enhancing the implementation of the evidence based practice, Individual Placement and Support (IPS) throughout the state. IPS youth service outcomes include improved behavioral health status and functionality, along with the addition of employment as part of their recovery. Creation of the Supported Employment Coordinating Committee to coordinate activities across state departments and consult the grantee on statewide infrastructure measures is promoting supported employment and working toward sustainability.

In addition, Kansas ensures that children receive integrated services for their multiple needs is the KDADS Home and Community Based (HCBS) 1915 (c) Waiver program. Kansas administers Medicaid waivers for both children and youth who have a severe emotional disturbance (SED) and for those with autism (which is also covered under the Medicaid State Plan). Children who meet eligibility requirements will receive a medical card and are eligible for Medicaid physical and behavioral health services. The SED Waiver program serves children aged 4-18 who experiencing SED and who are at risk of inpatient psychiatric treatment. SED waiver services provide children with special intensive support so they may remain in their homes and communities. Children with a diagnosis of Autism, Asperger's Syndrome, or Pervasive Developmental Disorder NOS will be able to apply for the Autism Waiver until their sixth birthday. Autism Waiver services are typically limited to three years.

KDADS contracts with Keys for Networking to serve as a behavioral health communication hub for children and their families. They support families and consumers in crisis, and provide guidance to assist them in accessing services.

Kansas is fortunate to have two foundations working within the state as change-agents on identified issues. The United Methodist Health Ministries Fund has a focus on creating a "Foundation for Success: Healthy Social & Emotional Development in Early Childhood" that stresses the importance of early brain development. Approaches include universal screening and access to timely and appropriate services to support success in life. The Fund is continuing work on developing systematic, universal social and emotional health screenings for Kansas children six and under. Twelve coalitions working in regional areas covering much of western Kansas have provided thousands of screenings for children, using the Ages and Stages Questionnaire: Social Emotional (ASQ:SE) and several coalition projects have also successfully promoted the Edinburgh Depression screening for prospective and newly-delivered mothers. Mental health centers and other providers have significantly improved their capacity to do work with very young children through trainings and awareness developed through these coalitions.

The Sunflower Foundation focuses on "Healthy Living" projects that emphasize the importance of the built environment as a means to promote lifelong healthy behaviors such as increased physical activity and improved food choices; "Health Care" projects that focus on improving access to health care for growing numbers of uninsured and underinsured, with an emphasis on community-based health services and health disparities; and "Advocacy" projects that help nonprofits become engaged in the public policy process and more effectively promote the populations that they serve.

The Tower Mental Health Foundation of Kansas created as a result of an agreement between the Attorney General's office and the Menninger Foundation in 2007, offers support to organizations that provide mental health services in Kansas. Developing collaborative efforts that focus on child and youth mental health, including substance abuse and suicide prevention were the Foundation's focus for FY 17.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults: Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

The Kansas Department for Aging and Disability Services currently offers four programs to assist individuals who are homeless or at risk of homelessness and experiencing an SMI: Supported Housing Funds, Interim Housing, Projects for Assistance in Transitioning from Homelessness (PATH) and Cooperative Agreements to Benefit Homeless Individuals (CABHI).

Projects for Assistance in Transitioning from Homelessness (PATH) is a SAMHSA-funded program designated to support the delivery of eligible services to persons who have a SMI and may also have a co-occurring disorder, are homeless or at risk of

becoming homeless. Through outreach services provided by CMHCs, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive services. Collectively these efforts help homeless individuals with serious mental illness secure safe and stable housing, improve their health, and live a self-directed, purposeful life.

Cooperative Agreements to Benefit Homeless Individuals (CABHI) is a three-year federal agreement with SAMHSA that assists individuals who experience chronic homelessness and veterans who experience homelessness/chronic homelessness with co-occurring mental and substance use disorders. CABHI's primary goal is to ensure that the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment, and recovery support services.

Supported Housing Funds is a state-funded program that provides assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and/or maintain housing in the least restrictive environment possible. This is accomplished by providing temporary financial assistance for their housing needs. The goal is to provide persons with SPMI/SMI the help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives. The SHF program supports eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible.

Interim Housing (IH) projects is a state-funded program that involves short-term (up to six months) project-based housing that provides immediate community-based housing for persons who meet HUD's definition of homeless; who are homeless and being discharged from inpatient or residential mental health or substance use treatment facility (e.g., a state mental health hospital, nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program). There are currently seven CMHCs that have Interim Housing Projects.

In addition, the state requires CMHCs to employ Housing Specialists, who are responsible for increasing the array of housing options available to consumers. The CMHC Housing Specialists assist persons with behavioral health issues, including co-occurring mental health and substance use disorders, to access safe and affordable housing of their choice and to provide the necessary supports and services that ensure the person lives a safe, healthy, self-determined life in their own homes CMHC Housing Specialists actively participate in and assist with local, regional and/or statewide efforts to decrease homelessness and to address situations where individuals are precariously housed.

KDADS' Behavioral Health Services Commission and the Commission on Aging are jointly responsible for programming and funding statewide. In addition, while all CMHCs serve individuals regardless of age, multiple CMHCs provide services that target older adults. Currently, the Governor's Behavioral Health Services Planning Council (GBHSPC) is reinstating an Aging Subcommittee that will have representation from a diverse group of stakeholders, including providers, consumers, and state agency representatives.

In 2015, the University of Kansas Institute for Policy and Social Research found that of Kansas' 105 counties, 36 were frontier (less than 6 persons per square mile), and 33 were rural (6-19.9 persons per square mile). According to the President's New Freedom Commission on Mental Health, the vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in the availability of mental health services. Rural issues are sometimes misunderstood, minimized and not taken into consideration when national and state mental health policy is formed.

The Rural and Frontier Subcommittee of the GBHSPC has identified unique needs/gaps for those living in rural/frontier counties. They include: 1) lack of urban/semi-urban resources in 89 of 105 counties; 2) disproportionate share of the older population; 3) rural legacy of depopulation that has continued over the past decade; and 4) high percentage per capita of Hispanic residents in rural/frontier counties, particularly in the southwest region. Over the next two years, the Subcommittee plans to make recommendations to the GBHSPC and KDADS to address these issues.

Criterion 5: Management Systems: States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

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

KDADS has taken a comprehensive approach to train law enforcement, first responders, and other personnel in the area of mental health issues throughout the state. They have provided grant funding to enable emergency health responders including law enforcement, mental health providers, those who work with veterans, and others, to receive Crisis Intervention Training (CIT). CIT training programs include instruction, classroom materials, and student room and board. Law enforcement officers trained will earn continuing education hours through the Kansas Law Enforcement Training Center (KLETC). KLETC will also produce an online training video and testing instrument for use by law enforcement agencies that are unable to send staff to the training center. More than 1,000 first responders have been trained to date. There are plans to provide a series of six one-day mental health awareness training sessions throughout the state, which will lay the ground work for more specialized behavioral health training in the future. Regional training events will target smaller, rural law enforcement agencies that do not have the local mental health resources to provide such training.

SAP

Over the past two years Kansas has made great strides in its system re-design, which began in earnest following our most recent CSAP site visit that took place in 2014. Following that site visit the prevention and promotion team developed priorities for the development of more robust and streamlined infrastructure. The two main priorities identified were: 1) the development of a more integrated approach that would allow the state and communities to address both substance use, mental health promotion, suicide prevention and problem gambling education and awareness, and 2) to make the state's support network more agile and efficient thus creating an increased level of funding for the implementation of community level, comprehensive strategic plans.

The previous Kansas prevention system was rooted in tradition and resistant to change. This created significant challenges when working to develop a new system that would be most efficient and effective given the established priorities. The previous system was comprised of a statewide evaluation contract, a statewide communication and resource dissemination contract, and 10 regional prevention centers primarily tasked with providing training and technical assistance (T/TA). Nearly all of the set-aside prevention funding was used to pay for this system, leaving little funding for strategy implementation at the local level. In order to create an integrated system with adequate local-level funding, a Request for Proposal (RFP) process was developed; the new infrastructure was to include one statewide data collection, analysis, and evaluation contract, a statewide T/TA contract, as well as a statewide communication, collaboration, and connection contract. Three providers were identified as a result of reviewing the applications that were submitted. Additionally, there were two mental health promotion contractors who received non-block grant funding, but were still considered a part of the newly developed Kansas Prevention Collaborative, the state's new prevention infrastructure. This new infrastructure created a significant cost savings that could be utilized to make community grants; the initial community grants awarded in SFY 16 focused on the planning step of the strategic prevention framework (SPF). This new system has been expanded and enhanced over the previous two years, and the agency was able to add a new partner organization as a member of the newly established prevention infrastructure; the new partner, also non-block grant funded, provides suicide prevention subject matter expertise and T/TA for community work.

During FFYs 18 and 19, Kansas will continue to strengthen working relationships among the Kansas Prevention Collaborative Partners and expand the use of the SPF framework, increasing the implementation of evidence-based prevention strategies (both programmatic and environmental), and sustaining outcomes. A current organizational chart of the system partners is provided below:

Figure 1 Kansas Prevention Collaborative-Org Chart

Problem gambling education and awareness is also managed by the Prevention and Promotion Services team; during FY18 and 19, the four regional taskforces and one statewide coalition that receive funding under the Problem Gambling and Addictions Grant Fund will begin utilizing the strategic prevention framework to develop plans, including the identification of specific needs, assessing readiness and capacity, and implementing strategies that are based on research in order to achieve greater more impactful outcomes. Additionally, work will continue to provide education and training around co-occurring behavioral health concerns as well as shared risk and protective factors in an effort to increase mental health promotion and suicide prevention efforts across the state.

SAT

Beginning in 2007, KDADS contracted with a managed care entity to oversee its SAT provider network. At the time of implementation, the Administrative Service Organization (ASO) oversaw: funds for the uninsured/underinsured (SAT Block Grant, State General Funds, and State Fee Funds), Kansas Department of Corrections (KDOC) funds for their Third Time DUI Program, State funds dedicated to the Problem Gambling and Other Addictions Program, and Medicaid reimbursement for SAT services. In 2013, when KanCare was implemented, responsibility for Medicaid oversight shifted to the three KanCare MCOs; the same ASO continued to manage the remaining funds. In FY 17, a request for proposals was issued regarding the management of these funds; the same contractor (Beacon Health Options, formerly Value Options) was selected to continue in this role. (Results from a June, 2017 provider satisfaction survey of the ASO indicated that 92percent of Block Grant-funded Kansas SAT providers were either "Very Satisfied" or "Satisfied" with the ASO.)

There are currently nearly 300 licensed providers of SAT throughout the State; of those, 42 receive SAT Block Grant funding to provide services at 136 locations. Of those 42 providers, 11 are designated to provide services to pregnant women and women with dependent children (PWDC), and one is a Federally Recognized Tribe. To ensure continuity of care, all providers are dually approved to provide Medicaid-funded services, as well. A number of providers are dually licensed as Community Mental Health Centers (CMHCs), enabling them to coordinate both mental health and SUD care for those with co-occurring diagnoses. Many providers are partnering with Federally Qualified Health Centers (FQHCs) and other primary medical providers to offer early screening and intervention, integrated treatment, and facilitated access to ongoing medical care. SAT providers offer a comprehensive continuum of care of BG-funded services including: assessment, peer mentoring, outpatient, intensive outpatient, reintegration, social detox, and intermediate. All SAT services are based on clinical need/medical necessity.

Contracts with the current SAT provider network will end on June 30, 2017. Kansas has maintained the same provider network since the 2007 implementation of an ASO to manage funding; in the fall of 2017, a request for proposals will be issued to identify providers who comprise the new network. All licensed Kansas SUD treatment providers who are KanCare providers will be eligible to apply. As part of this initiative, Kansas is currently exploring potential enhancements to the rate structure that will improve the quality of services provided to consumers.

SAT needs in Kansas continue to be identified by data collected by the ASO and then reviewed by KDADS and other stakeholders. Until recently, a State Quality Committee (SQC) comprised of KDADS staff and Block Grant funded providers met quarterly to review data related to service utilization, consumer demographic and diagnostic characteristics, and related information. In 2016, when the licensing staff were moved from KDADS BHS Commission to the Survey, Certification and Credentialing Commission, BHS SAT program staff decided to revisit the composition of the SQC membership, and to update the data requested from the ASO to ensure that the data provided best assist them in assessing the needs, strengths, and gaps of the system. The newly designed quality committee will begin meeting by the second quarter of FFY 18. KDADS staff have also begun attending monthly internal quality meetings held by the ASO. Additional data about the wait for services continues to be compiled and provided to KDADS by the ASO, as well.

Recently, a task force of the Governor's Behavioral Health Services Planning Council (GBHSPC) has begun a review of the service continuum for consumers seeking SAT. The information gathered will inform the work of the GBHSPC and KDADS in addressing service gaps/needs.

The Kansas SAT provider network possesses many strengths. Increasingly, providers offer services utilizing evidence-based models of care. A number are also offering counseling that specifically addresses trauma experienced by consumers. Coordination among SAT providers has become more common. Strong ASO oversight of Block Grant-funded SAT providers and extensive data collection processes help to ensure that providers offer effective services that consumers need.

KDADS has fostered strong partnerships with other State agencies who also serve with individuals with SUDs, including Community Corrections and Court Services. KDADS staff meets monthly with the Kansas Association of Addiction Professionals (KAAP), as well as the two Regional Alcohol and Drug Assessment Centers (RADACs), and are active with regional and national organizations including the Addiction Technology Transfer Center Network (ATTC) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). One provider who gave public comment noted that, "There currently exists a positive relationship between providers, state program staff, and the administering block grant managed care organization. This allows for effective decision making for the citizens of Kansas." He also remarked that, "Kansas embraces and promotes a Recovery Oriented System of Care approach and is committed to many other evidenced based practices." Another SAT provider stated that our SUD system's strengths included that we are: "Supporting programs with a collaborative spirit and mutuality;" "Requesting feedback from providers and consumers on a regular basis;" "Continuing to fight stigma and fund prevention programs to offset the enormous social pressure to use drugs in primary grades;" "Creating training and support for Peer Mentoring services including advocating for recovery oriented systems of care;" "Advocating for programs to develop their own collaborative relationships with mainstream resources in order to aid the consumer to be successful, healthy and have a greater quality of life;" "Continuing to fund grass roots community based services, to meet the consumer where they live, grow and play;" and, "Providing state wide meetings and quarterly meetings to enhance provider relations." She also noted that we have an "Effective reimbursement system with strategies for accountability in place;" and that we are "Providing an electronic payment system that is effective."

Kansas is fortunate to have 11 designated women's programs that serve pregnant women and women with children. Programs are monitored via a report from the ASO. The 11 programs utilize a gender-specific, evidence-based curriculum that supports women and their families in treatment and helps them to move into recovery. Some providers offer additional services that include housing for homeless individuals, family case management, therapy for individuals with co-occurring SUD and mental illness, and Medication Assisted Treatment. Providers who assess priority women are required to make three referrals for treatment, one of which must be to a designated women's program. Providers are monitored to ensure that this priority population is admitted within 48 hours of initial contact.

KDADS provides a combination of Block Grant and State General Funds to enable the nonprofit Friends of Recovery Association (FORA) to establish Oxford Houses throughout the state. The term "Oxford House" refers to any house operating under the Oxford House Model, a community-based approach to addiction treatment, which provides an independent, supportive, and sober living environment. Oxford House members help themselves by helping each other abstain from alcohol and drug use one day at a time. Residents assume and learn responsibility for their recovery. Additionally, there are no time limits. This allows an individual to focus on establishing a new set of personal values that center around sobriety. It allows the individual to practice the skills of responsible family and community living with their new Oxford House family.

The State of Kansas has supported the efforts of FORA for more than 15 years. In 2001, there were 19 Oxford houses in Kansas; currently, there are 105. This provides a total of 896 beds for persons seeking recovery from substance use disorders. Oxford Houses in Kansas include men only, women only, men with children, and women with children.

KDADS has also awarded a grant to support the efforts of Central Kansas Foundation's (CKF) Pathfinder Program. Pathfinder is a peer recovery program that offers access to life skills groups, as well as individual sessions with a Kansas Certified Peer Mentor. It is open six days per week from 7 a.m. to 9 p.m.; it is a walk in center and no appointment is necessary. Many individuals experiencing substance use disorders have been willing to access the Pathfinder program prior to seeking traditional SUD counseling and treatment. Pathfinder also supports individuals who have completed other treatment, but continue to benefit from peer support.

In May of 2017, KDADS was awarded \$3,114,402 by SAMHSA for the 2017 State Targeted Response to the Opioid Crisis Grant (STR). The purpose of the Kansas STR program is to address the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose-related deaths through provision of prevention, treatment, and recovery activities for opioid use disorder (OUD), including prescription opioids as well as illicit drugs such as heroin. Four regional sub-awardees will use data to demonstrate critical gaps in availability of treatment for OUDs in geographic, demographic, and service-level terms; address the critical gaps in availability of treatment for OUDs in geographic, demographic, and service-level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly address the gaps in their systems of care; deliver evidence-based treatment intervention, including medication and psychosocial interventions; and report progress toward increasing availability of treatment for OUD and reducing opioid-related overdose deaths.

Kansas was one of eight states selected to attend the National Governors' Association Center for Best Practices Learning Lab, "Expanding Access to Opioid Use Disorder Treatment for Justice-involved Populations." The Kansas team included two members from the Kansas Department of Corrections (KDOC) reentry programs, two regional contactors who provide care coordination and peer support under contract with the KDOC, a representative from the Attorney General's office, and the KDADS NTN. Under the guidance of the Learning Lab consultants, the workgroup has begun to address the following goals: 1) Identify all incoming offenders with a history of opioid, alcohol, and heroin misuse; 2) Increase the ability of offenders to access Medicaid benefits upon release to assist them with access to Medication Assisted Treatment (MAT); 3) Identify ways to remove barriers to offenders' willingness to participate in MAT; 4) KDOC and KDADS collaborate to identify providers in Kansas who will more to more effectively treat returning offenders and who will use MAT as a treatment component; 5) Position Kansas to leverage existing resources to increase funding for treatment and medication for opioid, alcohol, and heroin misuse; 6) Engage local drug courts through the Kansas Judicial Administration's State Drug Court Coordinator to identify ways to reduce probation revocations caused by opioid, alcohol, or heroin misuse; 7) Design a plan to track, trend, and analyze data to reflect the impact of the MAT initiative in KDOC, as

well as other project goals.

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

KanCare, the State's managed care system for Medicaid, contracts with three Managed Care Organizations (MCOs). All three MCOs employ Care Coordinators who ensure that consumers' care needs are addressed in an integrated manner. Funding streams for mental health and SUD services for the uninsured and underinsured remain separate so that utilization data can be reported following SAMHSA's data collection and reporting requirements.

In addition to the System of Care (SOC) SAMHSA-funded initiative discussed above, for individuals with co-occurring disorders, the community mental health centers (CMHCs) provide access to both mental health and substance use disorder treatment. If the CMHC does not offer SAT onsite, they are required to partner with local SAT provider that they refer to.

Health information technology, including EHRs and telehealth, are ways that treatment is integrated in Kansas. All 26 CMHCs have electronic health records and nearly all have access to telehealth systems. They offer intake, therapy, psychiatric and other services via telehealth systems. In one CMHC catchment area that serves 20 rural and frontier counties, they have co-located tele-video systems in each applicable county court and/or jail to be able to provide intake, medication management and therapy services to those in the judicial system.

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

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

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

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

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education Yes No

b) Health risks such as

i) heart disease Yes No

ii) hypertension Yes No

viii) high cholesterol Yes No

ix) diabetes Yes No

c) Recovery supports Yes No

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

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

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

Issues include communication with state providers on the requirements, understanding legal ramifications to the state and providers, deadlines for implementation, and lack of federal technical assistance.

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

Currently, we have two coordinated care SAT initiatives. One is in partnership with the Kansas Department for Children and Families (DCF), serving recipients of their TANF program. Another is in partnership with the Kansas Department of Corrections (KDOC), and services individuals who have received their third DUIs. It includes barrier reduction through coordination with recovery-oriented systems within the community and treatment as needed. (The block grant does not fund either program.) KDOC also has a separate contract with the State's two Regional Alcohol and Drug Assessment Centers (RADACs) to provide care coordination and peer services for the re-entry population identified with SUD and/or co-occurring mental health issues. In addition, Kansas has a certification for both person-centered case management and peer support that providers are able to access for ongoing care coordination.

Please indicate areas of technical assistance needed related to this section

Footnotes:

BRSS TACS 2017 Policy Academy Action Plan

Team Name	Kansas
Team Vision Statement	Through shared experience and peer support, we empower communities to promote and encourage healthy, hopeful individuals & families to lead: Self-directed Interdependent Resilient Lives.
Overall Goal of the Action Plan	Expand the peer support workforce to meet the needs of all Kansas Behavioral Health systems.
Action Plan Objectives <i>Please list each objective succinctly; each will be described in detail in Part II. Use as much space as needed.</i>	<ol style="list-style-type: none"> 1. Develop, fund, and support an integrated peer training and related credential. 2. Identify, collect, and analyze data to support integrated peer services, policy, programs, and practice. 3. Facilitate organizational cultural change to meet the demand for integrated peer support.

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Action Plan

Objective 1	Develop, fund, and support an integrated peer training and related credential.
Description of Objective 1	<ul style="list-style-type: none"> - Core training and a test - Specialization in MH, youth, parent, problem gambling, SUD, etc. - Supervision training - CEU's and field placement - Ethics training (on-going basis), trauma training, competencies, documentation - Specific timeline for credentialing with credential tracking portal - Lived experience as a prerequisite - Open door training - Multiple funding streams, cross-sector - Policy and procedure framework solidified and written down - Evaluation and fidelity component
Resources <i>Please list the resources to be utilized to achieve this objective (e.g., new partnerships, TA consultations, consultants, training curricula, etc.).</i>	<ul style="list-style-type: none"> - Contractors, universities, MCO's, providers, etc. - Existing curricula that we can draw from - Access to multiple TA opportunities (funding streams, curricula, etc.) from other states and/or organizations. - Identify KDAD program & IT staff - Fidelity materials - Policy framework - Cost analysis of training - Other materials related to CEU's - Peer review and input (existing peer mentors and specialists) - Provider and stakeholder review and input

<p>Outcomes <i>Describe what you will accomplish by March 8, 2018 and how you will measure your progress and accomplishments.</i></p>	<ul style="list-style-type: none"> - Stakeholder meeting and report out from this - Tight draft of the core training (by November) - Tight draft of MH/SUD/Parent Specialties - Rough draft of gambling and youth specialties - Policy and procedure manual - IT training portal - First pass at fidelity and on-going education standards - Draft plan of funding/revenue stream work plan 		
<p>OBJECTIVE 1: ACTION STEPS <i>(Add additional lines as needed)</i></p>		<p>Person Responsible <i>(Primary and Secondary)</i></p>	<p>Timeline <i>(start and end dates)</i></p>
<p>1.1 Hold a stakeholder meeting about core training, post-training test, CEU's, evaluation and supervision.</p>		<p>Randy/Kim</p>	<p>8/9 - 9/30</p>
<p>1.2 Synthesize meeting information with existing curriculum.</p>		<p>Randy/Charles Carrie/ Sam P.</p>	<p>9/30 – 10/15</p>
<p>1.3 Develop rough draft of core training and post-training test.</p>		<p>Randy/Lael with BH input</p>	<p>10/15 – 11/1</p>

1.4 Stakeholder review of rough draft.	Randy	11/1 – 11/6
1.5 Develop revised draft	Randy/Lael with BH input	11/1 – 11/15
1.6 KDADS review of revised draft	Michelle	11/15 – 12/1
1.7 Use TA supports to review fidelity state of the field for White Paper	Kelsee	8/14 – 3/8/18
1.8 Determine how to grandfather in existing Peer Support Workforce	Randy/KDADS Staff	8/9 – 9/30
1.9 Determine whether to allow open door enrollment in training.	Randy/KDADS Staff	8/9 – 9/30

1.10 Complete cost analysis of training needs	Randy/KDADS Staff	10/1 – 12/31
1.11 Pilot the core training	Randy	11/1– 11/30
1.12 Develop rough drafts of specialty trainings (along with stakeholders)	Carrie/KDADS Staff	10/1 – 1/31/18
1.13 KDADS review of revised version of specialty training	Michelle	2/1 – 2/15/18

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Action Plan

Objective 2	Identify, collect, and analyze data to support integrated peer services, policy, programs, and practice.
Description of Objective 2	<ul style="list-style-type: none"> - Through identifying, collecting and analyzing data, we will determine what data supports could assist with policy development and implementation for integrated peer services.
Resources <i>Please list the resources to be utilized to achieve this objective (e.g., new partnerships, TA consultations, consultants, training curricula, etc.).</i>	<ul style="list-style-type: none"> - Beacon (non-Medicaid data), Medicaid encounter data, KCPC (SUD data & authorization system), KAMIS (Kansas Assessment Management Information System – portal for Medicaid encounter data), AIMS (Automated Information Management System), input from stakeholders, family members, consumers.
Outcomes <i>Describe what you will accomplish by March 8, 2018 and how you will measure your progress and accomplishments.</i>	<p>Data questions developed</p> <p>Data needs identified</p> <p>Data analysis conducted</p> <p>Data report developed</p> <p>Norm the data by stakeholders, consumers, and family members</p> <p>Current screen (NODS CLiP) tool to identify at-risk populations for gambling population (changed for the SUD and added for the MH)</p>

<p style="text-align: center;">OBJECTIVE 2: ACTION STEPS <i>(Add additional lines as needed)</i></p>	<p style="text-align: center;">Person Responsible <i>(Primary and Secondary)</i></p>	<p style="text-align: center;">Timeline <i>(start and end dates)</i></p>
<p>2.1 Poll stakeholder groups to identify what data elements needed to support integrated peer services including, but not limited to: Adult consumers, parents, NAMI, State MCO's (IT knowledge), and trade associations.</p>	<p>Steve/Fran/Carrie</p>	<p>8/9 – 10/1</p>
<p>2.2 Select who/what entity will be responsible for analyzing data and writing the report.</p>	<p>KDADS/Kim</p>	<p>10/1 – 11/15</p>
<p>2.3 Define who messages the data in a simple, consistent, reader friendly manner.</p>	<p>Michelle</p>	<p>11/15 – 1/1/18</p>

Bringing Recovery Supports to Scale 2017 Policy Academy

Action Plan

<p>Objective 3</p>	<p>Facilitate organizational cultural change to meet the demand for integrated peer support.</p>
<p>Description of Objective 3</p>	<p>Engage all stakeholders (consumers, partners, peers, providers) at the same level to inform, educate, and collaborate for integrated peer support</p>
<p>Resources <i>Please list the resources to be utilized to achieve this objective (e.g., new partnerships, TA consultations, consultants, training curricula, etc.).</i></p>	<ul style="list-style-type: none"> - Focus groups including CRO's, parents, consumers/members, stakeholders - Marketing/media blitz/public awareness campaign (providers, public, corrections, veterans groups, NFMH, PRTF's, SMHH's, etc.) - BSRB (Behavioral Science Regulatory Board) - RFP's - KAAP (Kansas Association Addiction Professionals) - ACMH-CK (trade association for MHA's) - Information and collection (shared resources & ideas)
<p>Outcomes <i>Describe what you will accomplish by March 8, 2018 and how you will measure your progress and accomplishments.</i></p>	<ul style="list-style-type: none"> - Direct providers to offer peer support as a primary option during intake - Measures will include RFP content, AIMS, KCPC - Data via all measurement systems

<p style="text-align: center;">OBJECTIVE 3: ACTION STEPS <i>(Add additional lines as needed)</i></p>	<p style="text-align: center;">Person Responsible <i>(Primary and Secondary)</i></p>	<p style="text-align: center;">Timeline <i>(start and end dates)</i></p>
<p>3.1 Garner public input from various stakeholders pursuant to one set of questions prefaced by a brief introduction including positive anecdotes and outcomes data.</p>	<p>(see 2.1)</p>	
<p>3.2 Follow-up with regional, in-person public focus groups to include available stakeholders.</p>	<p>Michelle</p>	<p>10/1 – 10/31</p>
<p>3.3 Once the input is collated and approved, develop an action plan to create a message to disseminate in as many venues, and by as many means as possible once identified.</p>	<p>Michelle</p>	<p>11/1 – 1/1/18</p>
<p>3.4 Work to insure KDADS & KDHE institutionalize peer support services in all behavioral health systems.</p>	<p>Michelle</p>	<p>8.9 - On-going</p>
<p>3.5 Follow-up to the extent possible.</p>	<p>BRSS-TACS Team</p>	<p>On-going</p>

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
 - a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? Yes No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?
No
Please indicate areas of technical assistance needed related to this section

Footnotes:

METHOD TO DEFINE ADULTS WITH SPMI

PURPOSE: To insure that adults with Severe and Persistent Mental Illness (SPMI), or who are most at risk of developing SPMI, are promptly and accurately identified.

To insure that those most in need are offered the full array of community- based mental health services necessary to successfully manage their illness, support their recovery process, and live meaningful lives in their community.

APPROACH: Apply two main areas of assessment to determine an individual's status as meeting criteria for SPMI: (1) diagnostic criteria, and (2) functional and risk criteria.

STEP ONE: Apply diagnostic criteria to determine an individual's identification as meeting initial criteria for the Community Support Services (CSS) target population. To meet diagnostic criteria for SPMI, individuals must be assessed to determine whether they have a principle diagnosis in either Category A or Category B not solely related to an intellectual/developmental disability or induced by a substance.

Category A Diagnoses:

- 295.70 **(F25.0)** Schizoaffective Disorder, Bipolar type
 (F25.1) Schizoaffective Disorder, Depressive type
- 295.90 **(F20.9)** Schizophrenia
- 296.34 **(F33.3)** Major Depressive Disorder, Recurrent, Severe, with Psychotic Features
- 296.44 **(F31.2)** Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior
- 296.54 **(F31.5)** Bipolar I disorder, most recent episode (or current) depressed, specified as with psychotic behavior
- 298.9 **(F28)** Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

Category B Diagnoses:

All Other Bipolar I Disorders, moderate to severe not listed in Category A: **(F31.12) (F31.13) (F31.32) (F31.4)**

- 296.23 **(F32.2)** Major Depressive Disorder, Single Episode, Severe
- 296.24 **(F32.3)** Major Depressive Disorder, Single Episode, With Psychotic Features
- 296.32 **(F33.1)** Major Depressive Disorder, Recurrent, Moderate
- 296.43 **(F33.2)** Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
- 296.35 **(F33.41)** Major Depressive Disorder, Recurrent, In Partial Remission

- 296.89 (F31.81) Bipolar II Disorder
- 297.10 (F22) Delusional Disorder

- 300.01 (F41.0) Panic Disorder
- 300.22 (F40.00) Agoraphobia
- 300.3 (F42) Obsessive-Compulsive Disorder
- 300.3 (F42) Hoarding Disorder
- 301.83 (F60.3) Borderline Personality Disorder
- 309.81 (F43.10) Posttraumatic Stress Disorder

Category C Diagnoses: Removed

STEP TWO: To meet functional criteria for SPMI, persons with a primary diagnosis in Category A or B must, as a result of their qualifying diagnosis, demonstrate impaired functioning through use of the following assessment. For those with a primary diagnosis in Category A who **do** meet the functional criteria listed below, no further assessment is needed to determine eligibility for CSS. Those with a primary diagnosis in Category B must meet these criteria as well as criteria outlined in Step 3.

Impaired functioning¹ is evidenced by meeting at least one (1) of the first three criteria, and at least three (3) of the criteria numbered 4 through 9 that have occurred on either a continuous or intermittent basis over the last two years:

- 1. Required inpatient hospitalization for psychiatric care and treatment more intensive than outpatient care at least once in her/his lifetime;
- 2. Experienced at least one episode of disability requiring continuous, structured supportive residential care, lasting for at least two months (e.g. a nursing facility, group home, half-way house, residential mental health treatment in a state correctional facility);
- 3. Experienced at least one episode of disability requiring continuous, structured supportive care, lasting at least two months, where the family, significant other or friend of the consumer provided this level of care in lieu of the consumer entering formalized institutional services. (In this case, the Qualified Mental Health Professional (QMHP) must fully document the consumer's level of severe disability and lack of functioning that required the family or other person to provide this level of care).

- 4. Has been unemployed, employed in a sheltered setting, or has markedly limited skills and a poor work history;
- 5. Requires public financial assistance for their out-of-institutional maintenance and is unable to procure such financial assistance without help;
- 6. Shows severe inability to establish or maintain a personal support system, evidenced by extreme withdrawal and social isolation;

¹ Adults that would have met functional impairment criteria during the referenced time period without the benefit of treatment or other support services are included here.

- 7. Requires help in instrumental activities of daily living such as shopping, meal preparation, laundry, basic housekeeping, and money management;
- 8. Requires help in attending to basic health care regarding hygiene, grooming, nutrition, medical and dental care, and taking medications. *(Note: this refers to the lack of a basic skill to accomplish the task, not to the appropriateness of dress, meal choices, or personal hygiene);*
- 9. Exhibits inappropriate social behavior not easily tolerated in the community, which results in demand for intervention by the mental health or judicial systems (e.g. screaming, self-abusive acts, inappropriate sexual behavior, verbal harassment of others, physical violence toward others).

STEP THREE: Risk Assessment

DIRECTIONS: For each item listed below: (1) determine with the person being assessed whether the item applies to her/his life situation; (2) circle the correct number for the item, based on the time period that applies; and (3) enter the number in the box labeled “Score”.

Risk Factor	Circle a number if the item applies		Score
	Within the past 30 days	Between 31 and 180 days	
1. Has been discharged from inpatient psychiatric hospitalization.	5	3	
2. History of suicide attempts/life threatening self harm	5	5	
3. Documented threats of physical harm to others without follow through	2	1	
4. Has been released from jail or prison due to a crime involving physical harm to self or others that was related to psychiatric symptoms	3	1	
5. Experienced severe to extreme impairment due to physical health status (Impairment may be due to chronic health problems and/or frequency and severity of acute illnesses)	2	1	
6. Experienced severe to extreme impairment in thought processes (as evidenced by symptoms such as hallucinations, delusions, tangentiality, loose associations, response latencies, incoherence)	5	3	
7. Experienced moderate to severe impairment due to use of drugs and/or alcohol.	3	2	
8. Experienced severe to extreme impairment due to significantly insufficient finances and/or access to healthcare.	3	2	
9. Experienced severe to extreme impairment due to significant loss of or conflict with primary support group member(s).	3	2	
10. History of activity of self-mutilating behavior	3	2	

NOTE: You may mark only <u>ONE</u> of the following housing statuses, if one applies:	Within the past 30 days	Between 31 and 180 days	<u>Score</u>
11. Currently homeless or had an incident of homelessness (defined as lack of an overnight, fixed address resulting in sleeping in places not fit for human habitation, i.e. streets, cars, etc., or sleeping in a homeless shelter) Meets the HUD definition of homelessness.	4	2	
12. Currently residing in a RCF or has resided in an RCF (RCF's are state-licensed Residential Care Facilities providing congregate living to adults with mental illness. These include Nursing Facilities for Mental Health, group homes, Adult Care Homes, etc.)	3	1	
13. Currently at imminent risk of homelessness (reference current HUD definition) and/or placement in an RCF.	2	1	
	TOTAL SCORE:		

Circle Score:

12 or higher

11 or less

Risk Assignment:

High Risk

Low Risk

CSS Eligibility Status:

YES

NO

This tool is meant as a screening device, not the final and only assessment of risk. Should a worker or consumer rank him/her at a higher level of risk than is indicated, the score should be changed to reflect that level of risk and the change and rationale for it be documented below:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

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

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

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

SAT's MCO contract with providers includes language about the use of evidence-based practices in our contract with providers. While providers are not currently required to implement evidence-based practices, some are voluntarily utilizing EBPs such as Cognitive Behavioral Therapy, Motivational Enhancement Therapy, Strengths-Based Case Management, Wellness Recovery Action Plans, and Motivational Interviewing. The use of evidence-based practices will be a component of the Request for Proposals that prospective FY 19 SUD providers will complete.

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No
2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? Yes No

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

The two funded MHS providers have developed specialized teams to provide services and supports to individuals with an early serious mental illness (ESMI). Eligible individuals are those with early psychotic disorders, specifically first episode psychosis, between the ages of 15 to 25. This project includes the use of multiple EBPS, among them: "Recovery After First Schizophrenia Episode" (RAISE), NAVIGATE, and Cognitive Behavioral Therapy for Psychotic Disorders (CBTp).

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

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

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

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

The two funded programs provide education and outreach in their communities via: hospitals, schools, colleges, and a large social media campaign.

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

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

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

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

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

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

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8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

Education by the two funded programs for mental health professionals across the state is the highest priority, as it should increase the number of providers who are offering similar interventions. Over the next two years, providers will present at State conferences, as well as the Governor's Behavioral Health Services Planning Council (GBHSPC).

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

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

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

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

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

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

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

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

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

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
Kansas continues to engage consumers in the decision-making processes, providing the opportunity for individuals to be active participants in their health care plans through four general steps: 1) consumers receive clear and unbiased information that describes their overall health conditions, providing them the opportunity to envision how their life may change based on their own decisions; 2) provider and stakeholder support of consumers' decision making processes; 3) provider encouragement of consumers in asking questions about their health conditions; and, 4) provider recognition of consumers as the decision-makers regarding health care.

In addition, Kansas has a network of Consumer Run Organizations (CROs) dedicated to improving the lives of adults with SPMI using Peer Support as the cornerstone of its programs and services. CROs are legally incorporated nonprofit consumer governed and operated organizations using a peer recovery model built on self-direction, empowerment, peer support, and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. CROs provide an array of services to its members which include: one on one peer support, peer support groups, self-help groups, employment support, life skills training, health and wellness activities; act as bridge supports from state institutions to life in the community, and education about Medicaid and other community resources to connect members to services.

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

In the 1980s, researchers at the University of Kansas' School of Social Welfare developed the Strengths Model, which empowers individuals to focus on their strengths and set goals for recovery instead of fixating on a problem or diagnosis. For several decades, Kansas community mental health center (CMHC) case managers have received training in how to use the Strengths Model in their work. The Kansas network of Consumer Run Organizations (CROs) also utilizes Wellness Recovery Action Plans (WRAP) with their members. According to the website for this model, WRAP is a "self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be. It was developed in 1997 by a group of people who were searching for ways to overcome their own mental health issues and move on to fulfilling their life dreams and goals."

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

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

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? Yes No
2. Are there any concretely planned initiatives in our state specific to self-direction? Yes No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed:
KDADS Behavioral Health Services funds 13 Consumer-Run Organizations (CROs) to provide nontraditional peer supports to consumers or former consumers of mental health services to support recovery and improve quality of life, such as helping people achieve employment, housing and greater social connectedness. CROs receive a combination of Block Grant and State General Funds which are award through a grant/RFP process, allowing each organization to identify the services, training, self-direction and choice opportunities they would like to offer their local members.
- b) What are the eligibility criteria?
CROs are legally incorporated nonprofit consumer-governed and operated organizations. CROs' only eligibility criteria for service are that individuals have lived experience that they are willing to share. CROs are in the process of developing a program of intervention and outreach to other consumers who have been admitted to state psychiatric hospitals (there are two in Kansas) within the first 24-48 hours of admission, and also close to time of discharge. Once implemented, they will develop a similar project with individuals residing in Nursing Facilities for Mental Health (NFMHs).
- c) How are budgets set, and what is the scope of the budget?
CRO funding allocations in Kansas are developed in a unique system that provides for full control of individual grant funding of the CROs to be completely consumer controlled from the point that the state identifies available fund to be allocated. A consumer run State Funding Council is developed with representation from around the state. All members of the Council have to be self-identified as having lived experience with SPMI. They work with the KDADS Adult Consumer Affairs Coordinator, who also self identifies as having lived experience, to develop an RFP for services that are identified as needed from the CROs. Each CRO makes application and the State Consumer Funding Council reviews and score the applications. The Funding Council then allocates the award funds as justified through consciences regarding service delivery ability, community needs and grant scoring. We believe Kansas is the only State in the country that has a funding process that is completely consumer controlled.
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

CROs are overseen and staffed by consumers/former consumers of mental health services.

- e) What, if any, research and evaluation activities are connected to the initiative?
None; however, the grants manager will be collecting data to ensure that outcomes are met.

- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.
n/a

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

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

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

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

Please respond to the following items:

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

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? Yes No

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

KDADS has a program integrity/quality assurance plan in place for monitoring the contracted Administrative Service Organization (ASO) that oversees and authorizes SAT funded by the Block Grant. These requirements are also included in the ASO's contract. KDADS has a policy in place for compliance monitoring of providers to ensure that requirements are met. The ASO is required to include the Block Grant requirements in provider agreements. KDADS reviews and approves this contract. In addition, the contracted ASO is required to submit reports that include: an accumulator (providers' allocations and utilization), timeliness and accuracy, monthly claims and payments to providers, and independent audited financial statements. KDADS staff is assigned to monitor for compliance and report any discrepancies to the staff assigned to oversee the contract. Monthly meetings are held internally between KDADS program and financial staff, who also meet monthly with staff from the ASO.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The Governor's Behavioral Health Services Planning Council (GBHSPC) has a tribal representative who was appointed by the Governor. Currently he is working with Council to establish communication and consultations with Kansas Tribes. In addition, this past year, the Prairie Band Pottawatomi Nation became a licensed SAT provider, and SABG block grant funding was allocated to pay for services that they provided.

2. What specific concerns were raised during the consultation session(s) noted above?

n/a

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

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - Data on consequences of substance using behaviors
 - Substance-using behaviors
 - Intervening variables (including risk and protective factors)
 - Others (please list)Data related to demographic characteristics, gambling, suicide, and depression.
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)

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

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

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

If yes, (please explain)

In addition to supporting the ability to identify trends, locate geographic prevalence and risk/protective factor hotspots, and make data-driven decisions concerning substance abuse prevention priorities at the state and systems level, needs assessment data from the Kansas SEOW Behavioral Health Indicators Profile will also support the ability of the Kansas Prevention System to engage in targeted outreach and mobilization in communities identified as high need while lacking in prevention response capacity (e.g., low readiness, low functioning or non-existent coalition, poor sector involvement or engagement, low or ineffective strategy implementation), which will allow for capacity development in communities demonstrating high need and bolstering their ability to engage in more effective prevention processes. As such, smaller scale funding allocations will be made as funds are available for capacity development in this regard.

Current community-level allocation of SAPTBG prevention funds to local coalitions or other prevention partnerships are based on variables which include: fidelity to the SPF process and submission of deliverables demonstrating completion of milestones and benchmarks associated with each of the steps within the planning phase (assessment, capacity, and planning), completion of a needs assessment process entailing the identification and prioritization of at least 1-2 local prevalence outcomes, and approximately 2-5 targeted local risk and protective factors, completion of a logic model/theory of change and action plans for each primary evidence-based strategy, and creation (in conjunction with the Evaluation Team) of an evaluation framework outlining key process and outcome indicators and corresponding data collection needs for all funded strategies. Upon submission of these SPF deliverables, materials are reviewed by KDADS staff and subject matter experts including the Evaluation Team to ensure accuracy, comprehensiveness, alignment, assessment and prioritization integrity, and alignment, fit, saturation, intensity, and appropriateness of all proposed strategies. Following review and approval (or as needed), requested revisions are completed and resubmitted, and funding allocations are made to support each community's proposed line-item budget for strategy implementation. In this way, needs assessment data at the community level is integral to the process of awarding funding to communities to support local prevention efforts in a manner that is both data-driven, outcome-focused, and maintains fidelity to the SPF process, yet retains local support and ownership.

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

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

Kansas maintains a certification process, standards and requirements, and board to support statewide certification of the state prevention workforce. Kansas ICRC Prevention Specialist standards (updated October 2013) includes 2000 hours of experience across ICRC domains, 120 hours of education across domains, 120 hours of supervision with 10 hours specific to each respective domain, successful completion of the ICRC Prevention Specialist Examination, and adherence to the code of ethics. The Kansas Prevention Certification Board is a member of ICRC, and is responsible for the credentialing of prevention, addiction treatment, and recovery professionals.

The Kansas Department for Aging and Disability Services (KDADS) utilizes four primary sources for making training and technical assistance available to the prevention workforce. In conjunction with the workforce needs assessment and identification of learning needs based upon emerging issues and trends across the spectrum of behavioral health, an annual training schedule is developed and implemented by identified subject matter experts within the system, through the Southwest Resource Team (CAPT), or via technical assistance request through CSAP to ensure foundational knowledge and skill development among contractor organizations and their respective staff members. It is anticipated that while the prevention workforce is comprised of skilled and experienced personnel, it will be of critical importance to engage in more frequent provision of training and learning opportunities to ensure all individuals use and employ the same approaches, resources, tactics, and skill sets as they translate this to the provision of training and technical assistance at the community level. As such, structured and regularly facilitated coaching and feedback opportunities will be provided to ensure appropriate application of knowledge and skills by the prevention workforce, as well as opportunities for engagement and co-learning with the Kansas Prevention Project Team.

As part of the SPF assessment phase, Kansas utilizes the Tri-Ethnic Community Readiness model as the primary measure of community readiness, which is conducted in all funded communities in addition to community collaboration and capacity

assessment, as well as the requisite completion of a comprehensive needs assessment. The Tri-Ethnic Community Readiness Assessment involves the completion of a series of local key informant surveys, with data obtained and scored on the basis of six dimensions of community readiness – that is, community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue of concern, and resources related to the issue. Scoring of data across these six dimensions indicated a range on a nine-point scale, beginning with no awareness, through initiation, to high community ownership. This provides qualitative and quantitative data, collected as part of repeated evaluation measures in funded communities, that enables communities to build into local prevention capacity development plans specific strategies and approaches for increasing and enhancing readiness over time. Kansas has also developed a Coalition Capacity Survey. This tool, also utilized during the assessment phase, helps coalitions identify their own internal capacity.

The Kansas Prevention Collaborative is largely responsible for providing support for community-based prevention education efforts by developing the capacity of coalitions and other prevention partnerships to engage in effective local prevention activities. The Prevention Collaborative staff with DCCCA, Inc. will continue to offer support, technical assistance, training, and other resources to community-based prevention organizations that enable them to engage in prevention education efforts tailored to local needs. Community capacity for the implementation of prevention education initiatives – that is, two-way communication such as trainings, presentations, or other activities intended to affect life or social skills – will be cultivated among prevention staff. This will be accomplished through skill-building activities, training of trainers, demonstration, coaching, and guided instruction for coalitions and other partnerships. Trainings will be presented so that these providers learn essential skill sets and acquire sufficient content expertise to provide prevention education autonomously at the local level.

Additionally, the Kansas Prevention Infrastructure will examine a variety of avenues, strategically and methodologically, to enable prevention practitioners the ability to deliver prevention education through a variety of technological outlets (for example, online facilitation or virtual distance learning). These capacity building efforts will not be limited to existing coalitions, community organizations, and key leaders, but will also be extended to include youth.

Please indicate areas of technical assistance needed related to this section

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

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

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

Capacity Building

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

If yes, please describe

Kansas maintains a certification process, standards and requirements, and board to support statewide certification of the state prevention workforce. Kansas ICRC Prevention Specialist standards (updated October 2013) includes 2000 hours of experience across ICRC domains, 120 hours of education across domains, 120 hours of supervision with 10 hours specific to each respective domain, successful completion of the ICRC Prevention Specialist Examination, and adherence to the code of ethics. The Kansas Prevention Certification Board is a member of ICRC, and is responsible for the credentialing of prevention, addiction treatment, and recovery professionals.

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

If yes, please describe mechanism used

The Kansas Department for Aging and Disability Services (KDADS) utilizes four primary sources for making training and technical assistance available to the prevention workforce. In conjunction with the workforce needs assessment and identification of learning needs based upon emerging issues and trends across the spectrum of behavioral health, an annual training schedule is developed and implemented by identified subject matter experts within the system, through the Southwest Resource Team (CAPT), or via technical assistance request through CSAP to ensure foundational knowledge and skill development among contractor organizations and their respective staff members. It is anticipated that while the prevention workforce is comprised of skilled and experienced personnel, it will be of critical importance to engage in more frequent provision of training and learning opportunities to ensure all individuals use and employ the same approaches, resources, tactics, and skill sets as they translate this to the provision of training and technical assistance at the community level. As such, structured and regularly facilitated coaching and feedback opportunities will be provided to ensure appropriate application of knowledge and skills by the prevention workforce, as well as opportunities for engagement and co-learning with the Kansas Prevention Project Team.

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

If yes, please describe mechanism used

As part of the SPF assessment phase, Kansas utilizes the Tri-Ethnic Community Readiness model as the primary measure of community readiness, which is conducted in all funded communities in addition to community collaboration and capacity assessment, as well as the requisite completion of a comprehensive needs assessment. The Tri-Ethnic Community Readiness Assessment involves the completion of a series of local key informant surveys, with data obtained and scored on the basis of six

dimensions of community readiness – that is, community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue of concern, and resources related to the issue. Scoring of data across these six dimensions indicated a range on a nine-point scale, beginning with no awareness, through initiation, to high community ownership. This provides qualitative and quantitative data, collected as part of repeated evaluation measures in funded communities, that enables communities to build into local prevention capacity development plans specific strategies and approaches for increasing and enhancing readiness over time Kansas has also developed a Coalition Capacity Survey. This tool, also utilized during the assessment phase, helps coalitions identify their own internal capacity.

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

Please indicate areas of technical assistance needed related to this section

Narrative Question

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

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Planning

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

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

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

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

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

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

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

Implementation

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

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

We anticipate multiple communities across the state will continue to implement the 'It Matters' media campaign which was developed in 2008 as part of our SPF- SIG Grant. This campaign which originally focused on underage drinking prevention has been expanded to include messages on marijuana prevention and other substances. Plans are under development to design messages that also target co-occurring shared risk and protective factors and allow us to address suicide prevention and mental health promotion. This will account for the majority of our information dissemination strategies.
 - b) Education:

The Kansas Prevention Collaborative is largely responsible for providing support for community-based prevention education efforts by developing the capacity of coalitions and other prevention partnerships to engage in effective local prevention activities. The Prevention Collaborative staff with DCCCA, Inc. will continue to offer support, technical assistance, training, and other resources to community-based prevention organizations that enable them to engage in prevention education efforts tailored to local needs. Community capacity for the implementation of prevention education initiatives – that is, two-way communication such as trainings, presentations, or other activities intended to affect life or social skills – will be cultivated among prevention staff. This will be accomplished through skill-building activities, training

of trainers, demonstration, coaching, and guided instruction for coalitions and other partnerships. Trainings will be presented so that these providers learn essential skill sets and acquire sufficient content expertise to provide prevention education autonomously at the local level.

Additionally, the Kansas Prevention Infrastructure will examine a variety of avenues, strategically and methodologically, to enable prevention practitioners the ability to deliver prevention education through a variety of technological outlets (for example, online facilitation or virtual distance learning). These capacity building efforts will not be limited to existing coalitions, community organizations, and key leaders, but will also be extended to include youth.

c) Alternatives:

The Kansas Prevention Collaborative will continue to support alternatives. This includes, at the local level, opportunities for children and youth to participate in activities that exclude the use of alcohol, tobacco, and other drugs, and allows for meaningful involvement, leadership development, community service, or positive social engagement and interaction. These activities will be coordinated and implemented via community coalitions through a comprehensive, local assessment process, identifying those activities most appropriate and likely to produce a positive impact, garnering resources to support implementation of the activity, and evaluating efforts. Additionally, mechanisms for increasing youth involvement in the implementation of evidence-based prevention strategies will serve a secondary purpose of enhancing the availability of drug-free alternatives as well as prevention education opportunities for other youth through involvement in prevention programs.

d) Problem Identification and Referral:

Although the greatest proportion of problem identification and referral activities are addressed through the Kansas SAPT Block Grant-funded treatment infrastructure, the Prevention Collaborative will assist in ensuring accurate and timely referrals to treatment facilities. Referrals are provided to individuals throughout the state on an as-needed basis, or upon request.

Given the complexity and interrelated nature of substance abuse and mental illness, along with the growing body of research relating to co-morbidity, methods for increasing the knowledge and capacity of the Kansas Prevention Collaborative to assist community coalitions in addressing these issues will be explored. Capacity development in this area will, in turn, enable more comprehensive and effective community planning, engagement, and educational efforts, including those targeting health service providers, medical professionals, and other key stakeholders.

e) Community-Based Processes:

Kansas has funded thirteen communities through a competitive request for proposal (RFP) process in SFY 18. We have provided awards for planning (utilizing the SPF process), implementation grants, and awards for building readiness and capacity. Communities will be supported by a statewide project team throughout this process enabling them to more effectively implement prevention programming and achieve outcomes.

f) Environmental:

Communities in the implementation phase have completed a strategic plan and identified appropriate evidence-based strategies. They will receive implementation funding that is comprehensive enough to allow for implementation of an array of strategies that include programs, practices, and policy changes. Previously community funding was limited and strategies that were implemented were not comprehensive and the implementation of environmental strategies and education was limited. Our new approach to funding communities will allow for the greater implementation of environmental strategies; in fact, our training and technical assistance will place emphasis on environmental strategies.

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

If yes, please describe

As a required component of the Kansas SPF assessment process, communities are required to complete a comprehensive needs assessment, capacity assessment, readiness assessment, and assessment of existing community resources. This resources assessment, corresponding with the Communities That Care Community Resources Assessment (CRA), is designed to identify the pre-existing evidence-based prevention strategies in place that address prioritized prevalence outcomes and targeted local risk and/or protective factors. SABG funds are not eligible to support these pre-existing strategies, that is, clear parameters are provided during the assessment and planning phase regarding ensuring that SABG funds do no supplant prior sources of funding for prevention services and programming. Additionally, this requirement ensuring non-supplantation is included into funding agreements with communities through which SABG funds are allocated.

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

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

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

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

Evaluation

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

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

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

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use

- Perception of harm
- c)** Disapproval of use
- d)** Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)** Other (please describe):

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community mental health centers (CMHCs) provide a variety of services in order to enable individuals with mental illness and co-occurring disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities. In their contracts with KDADS, there are specific services for the uninsured/underinsured (which is funded by Block Grant and State funds) that must be given first priority for use with individuals who meet SPMI or SED criteria: 1) Case Management, 2) Attendant Care, 3) Peer Support, 4) 24-hour crisis response, triage, stabilization, and treatment services, 5) Psychiatric services, and 6) Psychosocial Rehabilitation Services. These services are prioritized as they have been identified as particularly critical in assisting individuals in maximizing their independence and capabilities.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- | | |
|---|---|
| a) Physical Health | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| b) Mental Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Housing services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| g) Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| h) Medical and dental services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| i) Support services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| k) Services for persons with co-occurring M/SUDs | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

Thirteen of Kansas' community mental health centers (CMHCs) are licensed to provide SAT as well as MHS.

3. Describe your state's case management services

CMHC case managers provide Community Psychiatric Support and Treatment (CPST). CPST provides goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the consumer's individualized treatment plan. CPST is a face-to-face intervention with the consumer present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the consumer lives, works, attends school, and/or socializes. CPST may include the following components: assist the consumer and family members or other collaterals to identify strategies or treatment options associated with the consumer's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the consumer's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration; individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the consumer, with the goal of assisting the consumer to develop and implement social, interpersonal, self-care, daily living, and independent living skills to

restore stability, support functional gains, and adapt to community living; participation in and use of strengths-based planning and treatments, which include assisting the consumer and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; to use personal strengths, resources, and natural supports to address functional deficits associated with the consumer's mental illness; and, assist the consumer with effectively responding to or avoiding identified precursors or triggers that would risk the consumer remaining in a natural community location, including assisting the consumer and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or as appropriate, to seek other supports to restore stability and functioning.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Six services that have been identified by KDADS as being particularly helpful to consumers in maintaining their independence and maximizing their capabilities are: 1) Case Management, 2) Attendant Care, 3) Peer Support, 4) 24-hour crisis response, triage, stabilization, and treatment services, 5) Psychiatric services, and 6) Psychosocial Rehabilitation Services. Case management is described in question 3, above.

Attendant Care involves personal care services provide one-to-one support or supervision for consumers; it also involves identification of needed services and supports. Peer Support (PS) services are consumer-centered services with a rehabilitation and recovery focus. These services are designed to promote skills to cope with and manage psychiatric symptoms while facilitating the use of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the consumer's individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for consumers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. PS is a face-to-face intervention with the consumer present. Services may be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the consumer lives, works, attends school, and/or socializes. Twenty four hour crisis response, triage, stabilization, and treatment services (CI) are provided to a consumer who is experiencing a psychiatric crisis. CI is designed to interrupt and/or ameliorate a crisis experience, including a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and may occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the consumer lives, works, attends school, and/or socializes. Psychiatric services include treatment modalities such as prescribing of medications and diagnostic testing.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	4.08	4.05
2. Children with SED	see below	see below

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

2. Children with SED: According to the report, "Overview and Analysis of Kansas Public Health System," dated June 1, 2009, that was developed by The Department of Social and Rehabilitation Services Division of Disability and Behavioral Health Services Mental Health Services Program, approximately 5 to 9 percent of children and adolescents ages 9 to 17 experience more severe functional mental health limitations, known as "severe emotional disturbance" (SED). Based on this estimate, using Census data, between 29,000 to 52,300 children and adolescents in Kansas have an SED. In SFY 2018, KDADS will submit a formal request to the Kansas Department of Health and Environment (KDHE) Epidemiology work group to collect this particular statistic for the state.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- a) Social Services Yes No
- b) Educational services, including services provided under IDE Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse preventiion and SUD treatment services Yes No
- e) Health and mental health services Yes No
- f) Establishes defined geographic area for the provision of services of such system Yes No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

The Kansas Department for Aging and Disability Services currently offers four programs to assist individuals that are homeless or at risk of homelessness and experiencing an SMI: Supported Housing Funds, Interim Housing, Projects for Assistance in Transitioning from Homelessness (PATH) and Cooperative Agreements to Benefit Homeless Individuals (CABHI).

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

Cooperative Agreements to Benefit Homeless Individuals (CABHI) is a three-year federal agreement with SAMHSA that assists individuals who experience chronic homelessness and veterans who experience homelessness/chronic homelessness with co-occurring mental and substance use disorders. CABHI's primary goal is to ensure that the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment, and recovery support services.

Supported Housing Funds is a state-funded program that provides assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and/or maintain housing in the least restrictive environment possible. This is accomplished by providing temporary financial assistance for their housing needs. The goal is to provide persons with SPMI/SMI the help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives. The SHF program supports eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible.

Interim Housing (IH) projects is a state-funded program that involves short-term (up to six months) project-based housing that provides immediate community-based housing for persons who meet HUD's definition of homeless; who are homeless and being discharged from inpatient or residential mental health or substance use treatment facility (e.g., a state psychiatric hospital (SPH), nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program). There are currently seven CMHCs that have Interim Housing Projects.

In addition, the state requires CMHCs to have Housing Specialists, who are responsible for increasing the array of housing options available to consumers. The CMHC Housing Specialists assist persons with behavioral health issues, including co-occurring mental health and substance use disorders, to access safe and affordable housing of their choice and to provide the necessary supports and services that ensure the person lives a safe, healthy, self-determined life in their own homes. CMHC Housing Specialists actively participate in and assist with local, regional, and/or statewide efforts to decrease homelessness and to address situations where individuals are precariously housed.

KDADS' Behavioral Health Services Commission and the Commission on Aging are jointly responsible for programming and funding statewide. In addition, while all CMHCs serve individuals regardless of age, multiple CMHCs provide services that target older adults. Currently, the Governor's Behavioral Health Services Planning Council (GBHSPC) is reinstating the Aging Subcommittee, which will have representation from a diverse group of stakeholders, including providers, consumers, and state agency representatives.

In 2015, the University of Kansas Institute for Policy and Social Research found that of Kansas' 105 counties, 36 were frontier (less than 6 persons per square mile), and 33 were rural (6-19.9 persons per square mile). According to the President's New Freedom Commission on Mental Health, the vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in mental health services. Rural issues are often misunderstood, minimized and not considered when forming national (and state) mental health policy.

The Rural and Frontier Subcommittee of the GBHSPC has identified unique needs/gaps for those living in rural/frontier counties. They include: 1) lack of urban/semi-urban resources 89 of the 105 counties; 2) disproportionate share of the older population; 3) rural legacy of depopulation that has continued over the past decade; and 4) higher percentage per capita of Hispanic residents in rural/frontier counties, particularly in the southwest region. Over the next two years, the Subcommittee plans to make recommendations to the GBHSPC and KDADS to address these issues.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

To ensure that emergency health staff and first responders are able to train others in their arenas of work, KDADS supports Mental Health First Aid training for trainers. Community Mental Health Centers (CMHCs) also offer Mental Health First Aid training within their communities for educators, families, clergy, health care professionals and other stakeholders. Each CMHC also participates in disaster planning and training at both the local and state levels.

KDADS has taken a comprehensive approach to train law enforcement, first responders, and other personnel in the area of mental health issues throughout the state. They have provided grant funding to enable emergency health responders including law enforcement, mental health providers, those who work with Veterans, and others, to receive Crisis Intervention Training (CIT). CIT training programs include instruction, classroom materials, and student room and board. Law enforcement officers trained will earn continuing education hours through the Kansas Law Enforcement Training Center (KLETC). KLETC will also produce an online training video and testing instrument for use by law enforcement agencies that are unable to send staff to the training center. More than 1,000 first responders have been trained to date. There are plans to provide a series of six one-day mental health awareness training sessions throughout the state, which will lay the ground work for more specialized behavioral health training in the future. Regional training events will target smaller, rural law enforcement agencies that do not have the local mental health resources to provide such training.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening Yes No
- ii) Education Yes No
- iii) Brief Intervention Yes No
- iv) Assessment Yes No
- v) Detox (inpatient/social) Yes No
- vi) Outpatient Yes No
- vii) Intensive Outpatient Yes No
- viii) Inpatient/Residential Yes No
- ix) Aftercare; Recovery support Yes No

b) Are you considering any of the following:

Targeted services for veterans Yes No

c) Expansion of services for:

- (1) Adolescents Yes No
- (2) Other Adults Yes No
- (3) Medication-Assisted Treatment (MAT) Yes No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Are you considering any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, custody issue Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

KDADS has a program integrity/quality assurance plan in place for monitoring the contracted Administrative Service Organization (ASO) that oversees and authorizes SUD treatment services funded with SAPT BG funds. These requirements are also included in the ASO's contract which is monitored closely by BHS staff. BHS has policy in place for the specific requirements and monitors providers to ensure these are met. This ASO is required to include the Block Grant requirements into agreements with each provider in their network who receives BHS funds (a combination of SAPT BG funds, SGF funds, Fee funds, and Problem Gambling and other addiction funds). BHS staff reviews and approves this contract prior to the ASO sending it out to providers. Until recently, Kansas licensing staff followed a procedure for conducting biennial onsite reviews of SAT BG-funded treatment providers. This consisted of a review of: clinical charts, Access to Care tracking, program wait lists, policy and procedure manuals, and client interviews. The result of this review was forwarded to the ASO, who then communicated with the provider. If a corrective action plan was needed, the ASO and KDADS would work together to ensure that the provider became compliant. As a result of the moving the licensing staff to the Survey, Certification, and Credentialing Commission, responsibility for SAT Block Grant monitoring has recently been reassigned to KDADS Behavioral Health Services Commission staff. KDADS Policy # 404 is being revised to outline the new procedure for Block Grant monitoring. It includes that, biannually, KDADS will continue to review provider policies and client documentation to ensure that applicable Block Grant requirements are met. Providers found not in compliance will continue to be referred to the ASO for corrective action planning that will enable the provider to become compliant.

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement Yes No
 - b) 14-120 day performance requirement with provision of interim services Yes No
 - c) Outreach activities Yes No
 - d) Syringe services programs Yes No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Are you considering any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached Yes No
 - b) Automatic reminder system associated with 14-120 day performance requirement Yes No
 - c) Use of peer recovery supports to maintain contact and support Yes No
 - d) Service expansion to specific populations (military families, veterans, adolescents, older adults) Yes No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

KDADS has a program integrity/quality assurance plan in place for monitoring the contracted Administrative Service Organization (ASO) that oversees and authorizes SUD treatment services funded with SAPT BG funds. These requirements are also included in the ASO's contract which is monitored closely by BHS staff. BHS has policy in place for the specific requirements and monitors providers to ensure these are met. This ASO is required to include the Block Grant requirements into each provider in their network who receives BHS funds (a combination of SAPT BG funds, SGF funds, Fee funds, and Problem Gambling and other addiction funds). BHS staff reviews and approves this contract prior to the ASO sending it out to providers. Until recently, Kansas licensing staff followed a procedure for conducting biennial onsite reviews of SAT BG-funded treatment providers. This consisted of a review of: clinical charts, Access to Care tracking, program wait lists, policy and procedure manuals, and client interviews. The result of this review was forwarded to the ASO, who then communicated with the provider. If a corrective action plan was needed, the ASO and KDADS would work together to ensure that the provider became compliant. As a result of the moving the licensing staff to the Survey, Certification, and Credentialing Commission, responsibility for SAT Block Grant monitoring has recently been reassigned to KDADS Behavioral Health Services Commission staff. KDADS Policy # 404 is being revised to outline the new procedure for Block Grant monitoring. It includes that, biannually, KDADS will continue to review provider policies and client documentation to ensure that applicable Block Grant requirements are met. Providers found not in compliance will continue to be referred to the ASO for corrective action planning that will enable the provider to become compliant.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No
2. Are you considering any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

KDADS has a program integrity/quality assurance plan in place for monitoring the contracted Administrative Service Organization (ASO) that oversees and authorizes SUD treatment services funded with SAPT BG funds. These requirements are also included in the ASO's contract which is monitored closely by BHS staff. BHS has policy in place for the specific requirements and monitors providers to ensure these are met. This ASO is required to include the Block Grant requirements into each provider in their network who receives BHS funds (a combination of SAPT BG funds, SGF funds, Fee funds, and Problem Gambling and other

addiction funds). BHS staff reviews and approves this contract prior to the ASO sending it out to providers. Until recently, Kansas licensing staff followed a procedure for conducting biennial onsite reviews of SAT BG-funded treatment providers. This consisted of a review of: clinical charts, Access to Care tracking, program wait lists, policy and procedure manuals, and client interviews. The result of this review was forwarded to the ASO, who then communicated with the provider. If a corrective action plan was needed, the ASO and KDADS would work together to ensure that the provider became compliant. As a result of the moving the licensing staff to the Survey, Certification, and Credentialing Commission, responsibility for SAT Block Grant monitoring has recently been reassigned to KDADS Behavioral Health Services Commission staff. KDADS Policy # 404 is being revised to outline the new procedure for Block Grant monitoring. It includes that, biannually, KDADS will continue to review provider policies and client documentation to ensure that applicable Block Grant requirements are met. Providers found not in compliance will continue to be referred to the ASO for corrective action planning that will enable the provider to become compliant.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? Yes No
2. Are you considering any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas Yes No
 - b) Establishment or expansion of tele-health and social media support services Yes No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? Yes No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No

If yes, please provide a brief description of the elements and the arrangement

Criterion 8,9&10**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement Yes No
2. Are you considering any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of service for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Are you considering any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) Yes No
2. Are you considering any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) Develop an organized referral system to identify alternative providers Yes No
 - a) Develop a system to maintain a list of referrals made by religious organizations Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Are you considering any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No
 - c) Identify workforce needs to expand service capabilities Yes No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? Yes No
2. Are you considering any of the following:
- a) Training staff and community partners on confidentiality requirements Yes No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
 - c) Updating written procedures which regulate and control access to records Yes No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure Yes No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

KDADS staff attrition resulted in a lack of knowledge about this requirement, resulting in no independent peer review being conducted. KDADS is currently establishing a workgroup that includes representatives from: the GBHSPC, its Subcommittee dedicated to SAT (the KCC), the Kansas Association of Addiction Professionals (KAAP), the ASO, and KDADS staff from the Home and Community-Based Services (HCBS) Commission who currently conduct similar peer reviews. The workgroup is charged with developing a peer review tool based upon the Federal requirements, as well as a procedure for implementing peer reviews. We anticipate that peer reviews will begin by no later than the second quarter of FFY 18.

3. Are you considering any of the following:
- a) Development of a quality improvement plan Yes No
 - b) Establishment of policies and procedures related to independent peer review Yes No
 - c) Develop long-term planning for service revision and expansion to meet the needs of specific populations Yes No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If YES, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Are you considering any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Are you considering any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No
 - c) Coordination of Various Activities and Services Yes No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

<http://www.kdads.ks.gov/provider-home/providers/licensing-and-certification>

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? Yes No

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

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

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? Yes No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No

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

SAMHSA-System of Care project has a strong focus on the use of trauma informed evidence based practices, trauma education for providers and community services, and the importance of creating environments that will not trigger or inflict additional trauma.

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

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csjjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? Yes No

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

This past year, KDADS has hired a fulltime employee to manage veterans and CIT programs. As part of these programs, funding has been increased for the Kansas Law Enforcement Training Center to provide additional CIT trainings and to develop training specifically for rural and frontier areas. Support from the Governor's Behavioral Health Services Planning Council (GBHSPC) was critical in securing the additional funding for these initiatives.

KDADS partners with the Kansas Department of Corrections (KDOC) and the Kansas Department of Commerce (KDC) to pilot a program, "Collaboration for Success," that targets offenders with SUD at high risk for recidivism. The program provides care coordination, peer support, and employment assistance.

As part of the SAT peer support certification curriculum, KDADS has incorporated training about KDOC's re-entry process, as well information about the "Thinking for a Change" model. Providers receive training via a KDOC contract about criminal behavior and thought.

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

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No

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

For more than 10 years, KDADS has worked to educate providers about the use of Medication Assisted Treatment (MAT). Most residential treatment providers now collaborate with OTPs to admit those individuals receiving MAT who need their services. Providers awarded Opioid STR funding are expected to coordinate their treatment efforts with OTPs, and to assist the State in developing additional prescriber resources through outreach and education of medical professionals.

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) WRAP Post-Crisis
- b) Peer Support/Peer Bridgers
- c) Follow-up Outreach and Support
- d) Family-to-Family Engagement

- e) Connection to care coordination and follow-up clinical care for individuals in crisis
- f) Follow-up crisis engagement with families and involved community members
- g) Recovery community coaches/peer recovery coaches
- h) Recovery community organization

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
- b) Required peer accreditation or certification? Yes No
- c) Block grant funding of recovery support services. Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
Yes

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Kansas was awarded a System of Care for Children's Mental Health (SOC) cooperative agreement from SAMHSA. Over four years. Kansas will develop a statewide system of services and supports to "wrap" around children in Kansas with mental health needs. The SOC will create, expand, and sustain a trauma-informed care, family-driven and youth-guided SOC approach for addressing the needs of children and youth with SEDs and their families. More than 7,725 children and youth will be impacted over the four years of the Kansas SOC. The System of Care is working with sixteen counties in the state. Eight are frontier (with less than 6 persons per square mile), three are rural (with 6 to 19.9 persons per square mile), three are densely settled rural (with 20 to 39.9 persons per square mile). One county is the largest in the state, and one is the poorest county in the state. All 16 counties will see growth in mental health systems of care for their youth and families through capacity-building activities focused on trauma-informed care, trauma-informed systems of care, and family-driven and youth-guided practices through the System of Care program. Other children and youth focused stakeholders will be engaged to enhance practices across the state. In addition, our diversified Kansas SOC Advisory Council will work on State level programmatic and finance policy changes. Participating CMHCs will provide quality, best-practice oriented and trauma-informed mental health services with cultural and linguistic competence. Services are provided within the family's community recognizing that youth and families do better when they're in a familiar, supportive environment. Youth will be empowered and given support to find their voice and express their ideas and opinions during the service planning process and throughout treatment. Families will have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. Trauma-informed systems and services will be based on an understanding of the vulnerabilities or triggers of trauma survivors working in a collaborative way with family, youth, and with our CMHCs in a manner that will empower children and youth.

Kansas was also awarded a Transforming Lives through Supported Employment (ESEK) cooperative agreement from SAMHSA. Over five years through two evaluation sites, Kansas is strengthening and enhancing services and supports to promote employment as a part of recovery and road towards economic self-sufficiency for employment age youth and adults with mental health needs. The ESEK will strengthen, enhance, expand and sustain an evidence based, participant guided and empowering ESEK approach for addressing the needs of youth and adults with SMI. More than 3,000 youth and adults will be impacted over five years of the Kansas ESEK. Supported Employment is working with fourteen counties in the state. Eight are frontier (with less than 6 persons per square mile), three are rural (with 6 to 19.9 persons per square mile), two are densely settled rural (with 20 to 39.9 persons per square mile), and only one is urban (with over 150 per persons or more per square mile). All fourteen counties will see expansion and enhancement in supported employment opportunities for their youth and adults who want to gain employment as part of their recovery. In addition, use of the Outreach, Access and Recovery (SOAR) model for people experiencing or at risk of homelessness assists individuals in applying for Social Security (SS) benefits. Economic self-sufficiency may occur through employment alone, or be obtained by combining employment with SS assistance.

Kansas has built an infrastructure of Consumer-Run Organizations (CROs) to promote recovery through peer recover supports to consumers or former consumers of mental health services, especially people with severe and persistent mental illness (SPMI). CROs are legally incorporated nonprofit consumer governed and operated organizations using a peer recover model built on self-direction, empowerment, peer support and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. Typically, a CRO provides an array of services to its' members that include leadership, education, training and research opportunities; peer support groups, drop-in centers, self-help groups, employment support, life skills training, health and wellness activities; act as bridge supports from state institutions to life in the community; and education about Medicaid and other community resources to connect members to services.

Recovery oriented services typically include self-help groups, activities and resources to empower members to work, volunteer, attend school or further enrich their lives as members work towards recovery. Three of the CROs are regional centers for CRO

leadership and administration purposes. They are called Regional Recovery Resource CRO (RRRC). These RRRCs are dedicated Certified Peer Support Specialists that offer resources, technical assistance and support development of recovery supports and peer support programs in communities and populations statewide. The RRRC provides support to build capacity within the other CROs in their Kansas regions as well recovery supports in communities not having established a CRO or peer support group. The RRRC connects with Community Mental Health Centers for crisis prevention and intervention, the State Mental Health Hospitals to bridge supports prior to the consumer discharge, Homeless shelters to assist with a referral process, Police Departments to expand the CIT program, and NFMHs to bring hope and recovery resources to the people they serve. KDADS funds 13 Consumer-Run Organizations (CROs) to provide nontraditional peer supports to consumers or former consumers of mental health services to support recovery and improve quality of life, such as helping people achieve employment, housing and greater social connectedness.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The SAMHSA definition of recovery is commonly accepted in practice by KDADS and those who received MHS and/or SAT Block Grant funding. Peer Mentoring services are provided as both MHS and SAT services. Persons who are self-identified as having lived experience and who have established recovery may complete a state approved training process and apply for certification. Additionally, our state recognizes that a large number of our peer mentors have at some point in time come in contact with our state correctional system. In response to this correlation, we are currently working with the Kansas Department of Corrections (KDOC) to increase learning opportunities for our mentors that focus on criminal thinking.

5. Does the state have any activities that it would like to highlight?

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

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :
 - housing services provided. Yes No
 - home and community based services. Yes No
 - peer support services. Yes No
 - employment services. Yes No

2. Does the state have a plan to transition individuals from hospital to community settings? Yes No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Kansas does not have a state Olmstead plan in place. Beginning before the Olmstead decision, Kansas had been and continues to coordinate other activities to ensure persons with behavioral health disorders are served in the least restrictive environment.

Kansas' public behavioral health services are anchored by three groups of agencies, the Community Mental Health Centers (CMHCs), Substance Use Disorder (SUD) providers and the State Mental Health Hospitals (SMHs), which provide publicly-funded (private) community, inpatient, and residential treatment. The behavioral health service system is comprised of an array of critical services and supports; the role that each service fulfills affects the role of other services in the array.

CMHCs are responsible for providing effective and efficient community mental health services to persons with mental illness that result in an improved quality of life for those they serve, especially adults with a severe and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED). CMHCs provide community mental health services to all persons who need them without regard to their ability to pay. Community mental health services include: individual and group therapy, psychiatric medication prescribing and management, psychiatric rehabilitation, support services where the person needs them (e.g. in the home, in the family, in schools, in employment), coordination of all needed services, 24 hour seven day a week mental health crisis response, screening for individuals to determine the need for state and federally funded inpatient or residential psychiatric treatment, and liaison services to ensure effective, efficient, and person-centered transition into and out of the various mental health treatment settings. CMHCs also provide outreach to ensure Kansans with a mental illness know where to access mental health services and community education to inform the public regarding mental illness and the promise of recovery. Many of the Kansas Community Mental Health Centers have implemented evidenced-based, emerging best practices and promising practices to provide a high level of care to their clients. These practices include: IPS Supported Employment, the Strengths Model of Case Management, Integrated Dual Disorders Treatment, Illness Self-Management and Recovery, Common Ground Shared Decision Making, and Peer Support Services.

SUD treatment providers offer a range of services including assessment, outpatient, intensive outpatient, reintegration, social detox, and intermediate. They are also able to provide support services (transportation), person centered case management, and

overnight boarding for children in residential services at the designated women's programs. Several of the programs licensed to provide substance use disorder treatment are also Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs). SUD providers have begun to collaborate with primary care providers and health care facilities to work toward providing more cohesive care across the state. SMHHS provide inpatient psychiatric treatment to all persons approved for admission by a CMHC. Persons approved for admission are determined to be in need of inpatient care and are unable to be safely and effectively served in community settings or other inpatient or residential psychiatric treatment facilities. Individuals receive inpatient services until such time as the symptoms of their mental illness or co-occurring disorder are stabilized and they can be safely and effectively treated in a community setting.

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

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

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁸Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
 - a) The recovery and resilience of children and youth with SED? Yes No
 - b) The recovery and resilience of children and youth with SUD? Yes No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - a) Child welfare? Yes No
 - b) Juvenile justice? Yes No
 - c) Education? Yes No
3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization? Yes No
 - b) Costs? Yes No
 - c) Outcomes for children and youth services? Yes No
4. Does the state provide training in evidence-based:
 - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - b) Mental health treatment and recovery services for children/adolescents and their families? Yes No
5. Does the state have plans for transitioning children and youth receiving services:
 - a) to the adult behavioral health system? Yes No
 - b) for youth in foster care? Yes No
6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The SAMHSA Center for Substance Abuse Treatment and Mental Health Services awarded KDADS the Cooperative Agreement for the Kansas' Systems of Care for Mental Health Services to Children and Their Families (Kansas SOC) to create, expand, and sustain a trauma-informed, family-driven and youth-guided approach for addressing the needs of children and youth with SEDs and their families annually. Kansas' SOC is a partnership including: KDADS, Wichita State University, and four local jurisdictions/Community Mental Health Centers including: Compass Behavioral Health, South Central Mental health Counseling, Center, Inc., Sumner County Mental Health Center and Wyandot Center for Community Behavioral Health. Kansas SOC's CMHCs will provide quality, best practice oriented, trauma informed, mental health services with cultural and linguistic competence. Services are provided within the family's community recognizing that youth and families do better when they're in a familiar, supportive environment. The partners involved in each child's plan of care provide services that are wrapped around the youth for success in the community and home. Juvenile justice, education, primary care, substance use, mental health and child placement agencies are consulted as part of the treatment team for the youth, thereby ensuring that the youth are served by the systems they are part of, and the key service of care coordination gives the youth the best avenue of success in the community.
7. Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

Kansas has made significant strides in building public-private partnerships to develop and accomplish its suicide prevention goals and objectives. In an effort to customize the national strategies to fit the needs of Kansans, several surveys were conducted and meetings were held in 2013 to prioritize and rank suicide prevention efforts. This plan reflects the input from Kansans involved with suicide prevention. Nearly a dozen Kansas communities have established either county or regional suicide prevention coalitions, bringing local resources together to address this serious public health concern. More than half of these coalitions were formed in the two years prior to this plan being revised. Kansas professionals, researchers, advocates and consumers continue to improve the understanding of suicide prevention in Kansas. More than 200 individuals have attended statewide summits on suicide prevention, and more than 3,000 Kansans completed suicide prevention training since 2013. Since the development of the plan, KDADS has developed suicide prevention activities for each step of the SPF framework, increased communication to and with local level suicide prevention coalitions, enhanced partnerships, and enhanced data collection by adding depression and suicide questions to our youth survey which is given annually. These important changes will lead to a more coordinated approach to suicide prevention in the future.

The Tower Mental Health Foundation of Kansas, created as a result of an agreement between the Attorney General's office and the Menninger Foundation, is currently soliciting projects on child and youth mental health, including substance abuse and suicide prevention for this year's grants. Applications must include a combination of two or more entities that will collaborate on innovative and effective community resources to address these issues.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? Yes No

If so, please describe the population targeted.

Zero Suicide strategies have not been formally implemented; however, a greater emphasis on raising awareness and increasing the understanding of the Zero Suicide Principles has taken place in the recent years. While no formal statewide strategies have been implemented several community organizations across the state have implemented strategy elements into their system in more informal ways. We hope to capitalize on these efforts and develop a statewide implementation plan and have sought additional funding from SAMHSA for this purpose. Additionally, training has been provided to many local community coalitions and school districts across the state as a result of increased data collection. In 2015, Kansas piloted an optional depression and suicide module as part of its annual school survey. Participation in the optional module has grown and in 2017 we had enough participation to have statewide data. This awareness has created great momentum for community planning.

Kansas has recently applied for funding from SAMHSA to implement Zero Suicide in state psychiatric hospitals. Should we receive this funding, KDADS will provide: statewide training of the Zero Suicide principles, technical assistance in reaching different providers, as well as conducting standardized assessments that will be beneficial as we move toward more coordinated implementation efforts.

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

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

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

New partners include the Department of Veterans Affairs and Kansas Law Enforcement Training Center (KLETC).

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

KDADS contracts to provide services for children to ensure they are able to access appropriate educational resources such as special education and related services. These partners provide guidance to families and individuals in accessing appropriate services for mental health and treatment in the community, home and education environments. In addition, parents and youth are offered information, education and training with multi-media operations (print, electronic transfer, phone) to learn how to better navigate the education system. These serves are offered for both grade school and college level youth. They provide training to educators as well on mental health, substance use prevention and other behavioral health supports and services that may assist in the education process.

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

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

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
Submitted in footnotes.
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i Yes No
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No
3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

As stated in its By Laws, the Kansas Governor's Behavioral Health Services Planning Council's (GBHSPC) is comprised of at least 51 percent consumers and family members. Kansas was among the first States to integrate its Planning Council to include both MHS and SAP/T foci. Its duties include: 1) To serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, persons affected by substance use disorders, and other individuals with mental illness or emotional problems; 2) Confer, 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; 3) 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; 4) Perform such 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 as may be prescribed by law; 5) Consult with and advise the governor, from time to time, with reference to the management, conduct, and operations of state psychiatric hospitals, community mental health and substance use disorder programs; 6) A member or members of the Governor's Behavioral Health Services Planning Council, at least once each year, shall visit each state psychiatric hospital and shall visit other providers of community-based mental health and substance use disorder services for the purpose of inspecting the state psychiatric hospitals, mental health centers, or the facility of other such providers of community-based mental health and substance use disorder services, including consumer residence, with their permission. Such visits shall be made at such times and in such manner as the council determines at a regular meeting; and, 7) The Governor's Behavioral Health Services Planning Council shall make annual reports to the Governor and members of the Legislature and may make such recommendations as it deems advisable for appropriate legislation.

The GBHSPC and its Subcommittees meet at least quarterly. The Council and all Subcommittees have consumer and family member representatives. (Council member have noted, however, that additional involvement from the Consumer Run Organizations (CROs) would be beneficial, and this issue will be examined in the coming FY.) All Subcommittees have representative liaisons from the

GBHSPC, as well as designated staff from KDADS. Subcommittees provide feedback to the GBHSPC via their liaisons, as well as through annual reports that are presented to the Secretary of KDADS, the Governor, and other State Officials. Subcommittees have educated themselves about the Kansas behavioral health system through inviting speakers to their meetings. They have also toured community service providers, as well as more restrictive settings such as Psychiatric Residential Treatment Facilities and State Mental Health Hospitals, where they interact with staff and consumers informally and through presentations. This past year, the Continuum of Care task force has focused upon identifying service strengths and gaps in the adult mental health system, and has made recommendations to the GBHSPC and the KDADS Secretary. In the coming year, the task force will conduct similar assessments of the children's behavioral health system and the SAT system. In addition, on April 19, 2017, the GBHSPC was host to a Public Comment Session in which members and attendees provided feedback about a communication protocol that KDADS would follow to gather input into the Block Grant (BG). They recommended that KDADS provide education to the GBHSPC about: SAMHSA BG requirements, Kansas requirements of BG providers, Kansas Goals/Objectives/Outcomes, other funding sources that Kansas BG-funded providers access, information about how BG funding is distributed, data about potential gaps in geographic access and other possible service barriers, data about the availability of services and any delays in accessing services, and trends in provider quality. One suggestion was to reinstate multi day, facilitated planning sessions with the entire GBHSPC to assist KDADS in preparing the BG.

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

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

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GOVERNOR'S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL CHILDREN'S SUBCOMMITTEE

PRESENTED TO:

Wes Cole, Chair

Governor's Behavioral Health Services Planning Council

Tim Keck, Secretary

Kansas Department for Aging and Disability Services

Sam Brownback, Governor

State of Kansas

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✓ Kansas Department of Education's School Mental Health Framework

End Notes

* Notes:

- ✓ Materials and presentations referenced in this report are available by request.
- ✓ Presentations and conversations with members of the subcommittee are also available by request.

SUMMARY OF RECOMMENDATIONS:

Below is a summary of the recommendations from the subcommittee. More detail for each of these recommendations can be found in the body of this report.

- ✓ Promote interconnected systems of care that provide an integrated continuum of person and family-centered services
- ✓ Support Coordinated State Data Systems
 - Support the provision of a unique statewide child identifier
 - Link child-level early childhood data with K-12 and other data systems.¹

- ✓ Capitalize on upcoming Managed Care Organization Request for Proposal process to implement opportunities to maximize and provide flexible funding.
 - Support statewide screening, referral and care coordination model.²
 - Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to cover early childhood mental health screening, assessment, and treatment.³
 - Support payment for two-generational services, parent support services, and dyadic therapies.^{4,5}
 - Recognize Diagnostic Classification: Age 0–5 (DC:0-5) for reimbursing early childhood mental health services, including in-home services.⁶

- ✓ Capitalize on upcoming Quality Rating and Improvement System (QRIS) changes to ensure early childhood programs are supported, including funding, to:⁷
 - Use a relationship-based approach,
 - Ensure children and caregivers are screened and assessed at regular intervals,
 - Provide support and education to caregivers, not just the child,
 - Work on transition planning from day one, and
 - Maintain appropriate staffing ratios.

- ✓ Pilot a Pay-for-Success or Social Impact Bond Project to demonstrate and promote early childhood mental health service effectiveness

- ✓ Support early childhood best practices that align with research such as:
 - Focus on prevention^{8, 9, 10,11}
 - Address Adverse Childhood Experiences (ACEs) and sources of toxic stress¹²
 - Invest in family engagement strategies that value parents as experts in their children’s development¹³
 - Promote comprehensive screening and early detection of developmental delays and link to referral, care coordination, and intervention.^{14, 15, 16, 17, 18, 19}
 - Expand access to voluntary, effective home visiting programs and services for new and expectant parents that model relationship building, engage parents in learning, and refer for additional supports as needed.^{20, 21, 22,23}
 - Support flexible work schedules for parents.²⁴

- ✓ Support school-employed and community mental health providers in coordinating behavioral health supports by:
 - Supporting implementation of *Expanded School Mental Health* a foundation of traditional school mental health services through collaboration with other professionals and entities, resulting in an enhanced scope and depth of assistance and outcomes.
 - Supporting *Interconnected Systems Framework* which is based on the premise that a greater array of mental health supports for students and families can become available through school-based intervention systems involving genuine collaboration and mutual support among school and community providers.

- ✓ Continue to promote the education and implementation of trauma-informed practices across all child and family-serving sectors.
 - Identify specific ways to promote the education of trauma-informed practices to all child and family-serving sectors in Kansas.
 - Identify specific ways to support the implementation of trauma-informed practices across all child and family-serving sectors.
 - Request a presentation on West Virginia’s “*Handle With Care Initiative*,” which is aimed at ensuring that children, who are exposed to violence in their home, school or community, receive appropriate interventions to help them achieve academically at their highest levels, despite whatever traumatic circumstances they may have endured.

INTRODUCTION:

A 2013 Centers for Disease Control (CDC) report estimated that 1 in 5 children in the U.S. experience a mental health disorder annually.²⁵ Data for children and adolescents in Kansas reveal a similar trend. In Kansas, 16% of the children between ages 2 and 17, living with a parent, have a diagnosis of Autism, developmental delays, depression or anxiety, Attention-Deficit Disorder (ADD) / Attention-Deficit Hyperactivity Disorder (ADHD), or behavioral/conduct problems.²⁶ Approximately 58.2% of adolescents diagnosed with a major depressive episode, ages 12-17, did not receive treatment.²⁷

Adverse Childhood Experiences (ACEs) in childhood are major risk factors for illness and a poor quality of life. The 2014 Kansas Behavioral Risk Factor Surveillance System, Adverse Childhood Experiences among Kansas adults found that 54.5% reported having experienced at least one ACE, and 1 in 5 Kansas adults reported having experienced three or more ACEs.²⁸ Research further indicates that ACEs can impede the ability of children and adolescents to succeed socially and academically. Students dealing with ACEs are two-and-one-half times more likely to fail a grade, score lower on standardized achievement test scores, have more receptive or expressive language difficulties, be suspended or expelled from school more often, and are designated to special education more frequently.²⁹

Societal and community risk factors can impede child and adolescent mental health. In 2015, 17% of children lived in families with incomes below 100% of the U.S. poverty threshold.³⁰ In 2016, over 27% of Kansas youth were considered at risk, based on questions about community laws and norms regarding topics such as police intervention for underage drug and alcohol use; and 32.08% were considered at risk based on questions regarding community disorganization such as the presence of crime, drugs, fighting, and feelings of safety.³¹ In 2013, 885 youth were residing in Juvenile Detention, Correctional and/or Residential Facilities.³² In 2014, 2.5% of children placed in out-of-home care were placed because of truancy.³³ In 2016, over 34% of Kansas youth were at risk for academic failure, based on questions about their grades, and 42.12% were at risk for low

commitment to school, based on questions regarding course interest, perceived effort, and days missed.³⁴

A recent report compiled by the Center for Children and Families at the University of Kansas, on behalf of the Kansas Department for Aging and Disability Services (KDADS), found that certain barriers exist in addressing these needs. Barriers identified include consistency in services, relationships with families, little mental health training, stigma, and access to services. 84% of educators agreed or strongly agreed that further professional development training is needed, including information on mental health disorders, behavioral management techniques, specialized skill training, positive behavioral supports, and trauma.³⁵ This report indicates the need for strong, cross-system collaboration between schools and community providers, to meet the needs of children and adolescents. Barrett, Eber & Weist have concluded the following:

Several epidemiological studies of children's mental health needs and services have led to the conclusion that, in this country, school is the de facto mental health system for children. This conclusion is based on the finding that for children, who do receive any type of mental health service, over 70% receive the service from their school. The finding further elucidates this situation, that 20% of children and youth have a clearly identified need for mental health service but only about one-third of these children receive any help at all.³⁶

2016-17 GOALS AND ACCOMPLISHMENTS:

Our subcommittee worked to identify specific, effective practices to facilitate collaboration, coordination and the use of evidence-based practices across all child and family-serving sectors, to address the behavioral and mental health needs of all children across the continuum of care statewide.

We also look for opportunities to champion and inform a Kansas children's Continuum of Care (CoC)/birth through school age service system consistent with our mission and vision:

- ✓ Identify overlap between the early/childhood groups our members serve.
- ✓ Invite presenters who provide opportunities for learning from these and other groups concerned with the CoC.

Our subcommittee address these goals by working in two areas Early Childhood Mental Health (ECMH) and School Mental Health (SMH). We were also asked by the council to look into trauma-informed practices and autism and dual diagnosis. The remainder of the report is organized into these four sections, detailing the goals, accomplishments, and recommendations for that area of focus.

Early Childhood Mental Health (ECMH)

Over the past year, an early childhood work group worked on the following early childhood mental health (ECMH) Goals:

- 1. Review research, both national and from other states for:**
 - a. Evidence-based state policies that we can recommend Kansas implement, and*
 - b. The most effective ECMH models, especially those that include family involvement and peer supports, which we can adopt as recommended practices in Kansas.*
- 2. Draft and recommend a consistent definition of ECMH to guide best practices in Kansas.**
- 3. Identify recommended qualifications, competencies, best practices, and professional development for Kansas ECMH professionals.**

First, the subcommittee must acknowledge that it was known, from the start of the year, given the volunteer nature of the subcommittee and the important work that each member does for each representative agency, this was an ambitious undertaking. Therefore, the subcommittee's work focused on Goal 1. Although the subcommittee made progress to inform Goals 2 and 3, the work was not sufficient to produce a final recommendation for this year's report. The recommendations below focus on evidence-based state policy and effective ECMH models:

State Policy Recommendations

Systemic Approach

It is clear, after spending a year completing research reviews, that, in order to thrive, children and adults need nurturing, supportive relationships, experiences and settings that foster development and learning, decent living conditions that provide economic stability, and protection from harm and toxic stress.

This is certainly a high aim, but a worthy and important one. Therefore, the subcommittee recommends that the state adopt and support a systemic approach in planning, which many refer to as a tiered system.^{37, 38, 39, 40} When such an approach is adopted and supported, there is not a give and take in supporting prevention efforts to the detriment of intensive services or crisis services. Rather, there is an understanding of different approaches based on the population and the needs of the population in each "tier." The three tiers include:

- ✓ Preventative and Universal Supports and Interventions for everyone
- ✓ Targeted and Preventative Supports and Intervention for community, providers, staff, children and their families with identified needs and risks
- ✓ Intensive Supports and Intervention for children and their families who are in crisis or at risk

Support Coordinated State Data Systems

The State and programs for children and families need reliable and qualitative data to help inform decision making, program design, and program improvement. There are two policy recommendations that would help Kansas make progress towards a more coordinated state data system that would involve and inform ECMH programs over time:

- ✓ Support the provision of a unique statewide child identifier
- ✓ Link child-level early childhood data with K-12 and other data systems.⁴¹

For example, providing the funding and process to support early childhood programs in getting a Kansas Individual Data on Student system unique identifier for the children they serve would allow early childhood program data and K-12 data to be combined to identify the impact of services on a child or group of students over time.

Recommendations to Capitalize on Upcoming Opportunities

The subcommittee does not know all the changes that Kansas will experience as a result of federal policy changes over the next year. However, the subcommittee does know that there are changes on the horizon for Kansas, including a Request for Proposal (RFP) for new Managed Care Organization (MCO) contracts for KanCare (aka KanCare 2.0). The subcommittee also knows that, due to implementation of new regulations and other changes in the Child Care and Development Block Grant, there are opportunities for systemic changes and coordination at the national and state levels, especially around implementation and support of a Kansas Quality Rating and Improvement System (QRIS).

The following policy recommendations are organized according to these two known opportunities:

MCO RFP

- ✓ Maximize and provide flexible funding to:
 - Develop and fund robust infrastructure to support a statewide screening, referral and care coordination model.⁴²
 - Increase access to ECMH services and financing: Advocate for language in state Medicaid and behavioral health plans to cover ECMH screening, assessment, and treatment.⁴³
 - Support payment for two-generational services, parent support services, and dyadic therapies.^{44, 45}
 - Recognize Diagnostic Classification for Ages 0-5 (DC:0-5) for reimbursing ECMH services, including in-home services. (Wisconsin)⁴⁶

Quality Rating and Improvement System (QRIS)

- ✓ Ensure early childhood programs are supported, including funding, through QRIS to:⁴⁷
 - Use a relationship-based approach,

- Ensure children and caregivers are screened and assessed at regular intervals,
 - Provide support and education to caregivers, not just the child,
 - Work on transition planning from day one, and
 - Maintain appropriate staffing ratios.
- ✓ Ensure coordination with various other programs (maternal child health, child welfare, home visiting, and Individuals with Disabilities Education Act Part C early intervention initiatives) to promote the cross-cutting nature of ECMH: Create a state strategic plan to infuse ECMH into behavioral health.⁴⁸

Effective ECMH Model Recommendations

Pilot a Pay-for-Success or Social Impact Bond Project

Consider supporting evidence-based early childhood pilot projects. An example is Utah's Early Childhood Programing, a collective impact partnership and one of America's first pay-for-success (PFS) contracts, otherwise known as a social impact bond (SIB). The plan called for United Way of Salt Lake to work with area partners, including Strive Together, to expand high quality preschool opportunities in high-need communities, and for Goldman Sachs and J.B. Pritzker to provide \$7 million in up-front funding to pay for the program. If the children who had been identified as potentially eligible for government-funded special education (beginning in kindergarten and often lasting through high school) were able to avoid needing those services, then, ultimately, the state of Utah would pay investors their principal plus a financial return. The initiative has been a resounding success. Of the 595 low-income three and four year old children, who attended the SIB-financed preschool programs in the 2013-14 school year, 110 of the four-year-olds had been previously identified as likely to use special education in grade school. Of those 110 students, however, only one went on to use special education services in kindergarten. With fewer children requiring special education services and remedial services, school districts and government entities saved \$281,550 in a single year (based on a state resource special education add-on of \$2,607 per child).⁴⁹

If Kansas provides support for ECMH services, the research indicates that the following are best practices that should be considered:

- ✓ Focus on prevention^{50, 51, 52,53}
- ✓ Address Adverse Childhood Experiences (ACEs) and sources of toxic stress⁵⁴
- ✓ Invest in family engagement strategies that value parents as experts in their children's development⁵⁵
- ✓ Promote comprehensive screening and early detection of developmental delays and link to referral, care coordination, and intervention. ^{56, 57, 58, 59, 60, 61}

- ✓ Expand access to voluntary, effective home visiting programs and services for new and expectant parents that model relationship building, engage parents in learning, and refer for additional supports as needed. ^{62, 63, 64, 65}
- ✓ Support flexible work schedules for parents. ⁶⁶

School Mental Health (SMH)

- 1. Establish working definitions and identify research informed SMH models and practices to guide best practices in Kansas.**
- 2. Examine the necessary qualifications of both community and school-employed mental health professionals and support personnel serving children in schools.**
- 3. Enhance the capacity of behavioral and mental health staff serving children and their families along a continuum of care.**
- 4. Implement best practices for transition-age children with behavioral and mental health needs.**

Access to school mental health services cannot be sporadic or disconnected from the learning process. Traditional school mental health services have sought to tackle the complex needs of students and families by providing assistance, based on varied school and community resources. While this assistance may be strong in nature, limitations can also arise due to finite resources, high caseloads, and varying practitioner knowledge. Currently, there is no consistent structure or process in place across Kansas for community and school mental health professionals to effectively collaborate around the provision of comprehensive, multi-tiered services and supports for children, adolescents, and families.

School social workers, psychologists, and counselors are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health services are properly and effectively infused into the learning environment, supporting both instructional leaders and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning. No other professionals have this unique training background. School-employed mental health professionals may deliver similar services such as counseling, social-emotional skill instruction, and consultation with families and teachers; however, each profession has its own unique focus based upon its specializations, which result in different, albeit interrelated, services.⁶⁷ While there are variations across the background and skillsets of school counselors, psychologists, and social workers, best practice requires that they: 1) hold a master's degree, 2) have taken coursework specific to practicing in a school setting, and 3) have completed a supervised, school-based practicum.

Community-employed mental health providers vary in their level of experience and training related to schools. In general, their work focuses on a student's global mental health and how it impacts family, community, work, and school functioning. Depending on agreements between a community agency and a school, community-employed mental health providers may or may not be based in a school setting. Community mental health providers that interact most often with school professionals are those providing one of the following services:

- ✓ Targeted Case Management – Have at least a bachelor's degree or be equivalently qualified by work experience.
- ✓ Community Psychiatric Support and Treatment – Bachelor's degree or four years of equivalent education and/or experience working in the human services field.
- ✓ Psychosocial Rehabilitation – Must be at least 18 years old, and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than a client under the age of 18.
- ✓ Attendant Care – Must have a high school diploma or equivalent. Must be 18 years of age and at least 3 years older than youth. Completion of state-approved training. Pass background check.

It is imperative for all school-employed and community mental health leaders to systematically coordinate a cohesive, integrated continuum of supports to meet the needs of children, adolescents, and families in a timely and seamless manner. The children's subcommittee recommends that this be accomplished through expanded school mental health in the following ways:

- ✓ Expanded School Mental Health
Expanded School Mental Health (ESMH) builds upon a foundation of traditional school mental health services through collaboration with other professionals and entities, resulting in an enhanced scope and depth of assistance and outcomes. ESMH seeks to bridge the divide that can occur between schools and community service providers in an effort to fully support student mental health. This collaboration can benefit both systems while providing students and their families with comprehensive care and assistance. Schools may receive the benefit of added programming, resources (financial or otherwise), and collaboration with professionals from other disciplines. Community providers are, in turn, able to expand their reach and connect with students and staff in the setting where they spend a large portion of their day. (Weist, Ambrose, and Lewis, 2006.)
- ✓ Interconnected Systems Framework
The Interconnected Systems Framework (ISF) concept is based on the premise that a greater array of mental health supports for students and families can become available through school-based intervention systems involving genuine collaboration and

mutual support among school and community providers. The ISF outlines a helpful process for aligning the efforts of school and community mental health partners, within a multi-tiered teaming structure, to actively review data and coordinate the implementation, fidelity, progress and monitoring of supports at multiple levels of intensity. For more information about the ISF, see:

[http://www.pbis.org/common/cms/files/Current Topics/Final-Monograph.pdf](http://www.pbis.org/common/cms/files/Current%20Topics/Final-Monograph.pdf)

Trauma Informed Care

Continue to promote the education and implementation of trauma-informed practices across all child and family-serving sectors.

- 1. Identify specific ways to promote the *education* of trauma-informed practices to all child and family-serving sectors in Kansas.**
- 2. Identify specific ways to support the *implementation* of trauma-informed practices across all child and family-serving sectors.**

The Kansas Assessment Permanency Project (KAPP), a 5 year project, is a public-private-university partnership between the University of Kansas School of Social Welfare, the Kansas Department for Children and Families (DCF), the Kansas Department for Aging and Disability Services (KDADS) and the state's two contracted providers of foster care and intensive in-home services, KVC Kansas and St. Francis Community Services (SFCS). The project is in its 4th year, which began 10/1/16. The purpose of the project is to improve outcomes for children with trauma and mental health/behavioral health needs for the target population of children and families involved in the child welfare system. This includes children in foster care/out of home placements, as well as families receiving Family Preservation Services who are at risk of having a child placed out of the home.

KVC and SFCS have trained child welfare staff, across the state, in the use of the Trauma Systems Therapy (TST) model (Saxe, Ellis, and Brown 2016) and universal trauma screening and functional assessment, to guide case planning with the child and family. In addition, workgroups comprised of DCF staff and provider staff have revised the Child Case Plan and are currently revising the Family Case Plan, to make these plans more family friendly and promote family involvement. The case plans will be electronic and will utilize the results of the assessments completed with the child and family to develop the goals and activities of the case plan with the family. This project is being evaluated for effectiveness and efficiency by the University of Kansas team of professionals involved in the project, to inform the continued use of this model in the Kansas child welfare system.

KSDE School Mental Health (SMH) Framework: School Mental Health is a comprehensive, multi-tier system of supports, practices, and services that are integrated throughout the

school community to enhance the social, emotional, behavioral, mental health, and academic outcomes for children and youth. SMH practices address all aspects of the social, emotional, and character development of children and adolescents including mental and behavioral health, trauma and adverse childhood experiences, such as physical and sexual abuse, bullying, and substance abuse:

- ✓ universal strategies to promote the well-being and development of all students;
- ✓ selected, brief strategies to support students at risk of or with mild challenges;
- ✓ intensive, ongoing strategies to support those with significant needs.

3. Request a presentation on West Virginia’s “Handle With Care Initiative,” which is aimed at ensuring that children, who are exposed to violence in their home, school or community, receive appropriate interventions to help them achieve academically at their highest levels, despite whatever traumatic circumstances they may have endured.

Developed with guidance and technical assistance from the Massachusetts Advocates for Children: Trauma and Learning Policy Initiative, in collaboration with Harvard Law School and the Task Force on Children Affected by Domestic Violence, the goal of the West Virginia Defending Childhood Initiative, commonly referred to as “Handle With Care,” (HWC) is to prevent children’s exposure to trauma and violence, mitigate negative affects experienced by children’s exposure to trauma, and to increase knowledge and awareness of this issue and ultimately help students succeed in school. Regardless of the source of trauma, the common thread for effective intervention is the school. Research now shows that trauma can undermine a child’s ability to learn, form relationships, and function appropriately in the classroom. HWC programs support children exposed to trauma and violence, through improved communication and collaboration between law enforcement, schools and mental health providers, and connects families, schools and communities to mental health services.

✓ Law Enforcement:

"Handle with Care" provides the school with a “heads up” when a child has been identified at the scene of a traumatic event. It could be a meth lab explosion, a domestic violence situation, a shooting in the neighborhood, witnessing a malicious wounding, a drug raid at the home, etc. Police are trained to identify children at the scene, find out where they go to school and send the school a confidential email or fax that simply says . . . “Handle Johnny with care”. That’s it. No other details.

In addition to providing notice, officers also build positive relationships with students by interacting on a regular basis. They visit classrooms, stop by for lunch, and simply chat with students to help promote positive relationships and perceptions of officers.

✓ Schools:

Teachers have been trained on the impact of trauma on learning and are incorporating many interventions to mitigate the negative impact of trauma for identified students, including: sending students to the clinic to rest (when a HWC [notice] has been received and the child is having trouble staying awake or focusing); re-teaching lessons; postponing testing; small group counseling by school counselors; and referrals to counseling, social service or advocacy programs. The school has also implemented many school-wide interventions to help create a trauma-sensitive school (Greeters; pairing students with an adult mentor in the school; utilization of a therapy dog; and “thumbs up/thumbs down” to indicate if a student is having a good day or a bad day).

✓ Counseling:

When identified students exhibit continued behavioral or emotional problems in the classroom, the counselor or principal refers the parent to a counseling agency which provides trauma-focused therapy. Once the counseling agency has received a referral and parental consent, students can receive on-site counseling.

The counseling is provided to children and families at times which are least disruptive for the student. The counselors also participate in meetings deemed necessary by school personnel and as authorized by the child’s parent or guardian. Counselors provide assessments of the child’s need, psychological testing, treatment recommendations, accommodation recommendations, and status updates to key school personnel as authorized by the child’s parent or guardian.

Initially, HWC experienced hurdles. But to date, 527 notices have been provided involving 959 children. School interventions are enough to help 90% of the identified children, but for others, on-site counseling is needed. Approximately 10% or 130 children are now receiving or have received vital counseling services on-site at school. Additionally, the relationships between education and Law Enforcement have been greatly improved. The notices became an invitation for collaboration. Law Enforcement routinely call and interact with the schools. Teachers were better able to address issues in the classroom. Mental Health providers were able to see children interacting in their school environments. Child Protective Services is often given courtesy HWC notices just to keep them in the loop. Handle With Care became a magnet to assist agencies in working together, building community trust and, most importantly, helping children who are struggling with the effects of trauma.

<http://www.handlewithcarewv.org/handle-with-care.php>

Research Autism and Dual Diagnosis

- 1. Identify service providers.**
- 2. Gain a better understanding of what services for these populations looks like.**
- 3. Request presenters and information to inform recommendations.**

We invited presentations from Sarah Berens, TASN ATBS Family Services and Training Coordinator. From this presentation and other information we identified the following:

- ✓ Autism is becoming a bigger issue in service provision to children due to advances in the profession that allow us to be able to more accurately diagnose children and being able to screen for Autism Spectrum Disorder (ASD) at an earlier age. In addition, Kansas has recently opened up the Autism Waiver to include all children under the age of 18 when previously they only served younger children to age 8.
- ✓ Children with ASD have a higher rate of mental health disorders including ADHD, anxiety and depression. Over two-thirds of children diagnosed with ASD have also been diagnosed with other mental health diagnoses.
- ✓ ASD is a developmental disorder that effects communication, behavior, motor coordination and physical health. Signs and symptoms begin emerging as early as 2 to 3 years of age.
- ✓ There is a lack of screening resources in Kansas with families waiting months to get into the existing clinics.
- ✓ Interventions such as Applied Behavior Analysis and the Early Start Denver Model have been identified as effective. However, there is a lack of adequate service providers in the state. Efforts are being made to train other providers but few are trained and available to provide these service models.
- ✓ Developmental interventions in the form of speech and occupational therapy must go hand in hand with other treatment approaches.

Summary:

Our hope is that every child identified with Autism Spectrum Disorder would have timely, accessible and interdisciplinary diagnostic and treatment options. Furthermore, Kansas would have well-trained and informed service delivery teams across the state. It is also very important to provide supports to the family that are caring for these children that can sometimes present many challenges. We hope that every child identified with ASD would have access to the services and supports they need to reach their full potential.

2017-2018 GOALS:

The Children's Subcommittee has identified the following goals to pursue during the 2017-2018 year. In pursuing these goals, we need to ensure that we consider substance use services and treatment as this has been missing from our past work.

- 1. Identify a process for our subcommittee to link/communicate well with other subcommittees**
- 2. Make recommendations regarding caregiver, parent & family engagement in navigating behavioral health systems**
- 3. Explore the purpose of the Kansas Children's Continuum of Care**
- 4. Identify/describe what data elements we want in an integrated data system**

**GBHSPC
CHILDREN’S SUBCOMMITTEE
CHARTER**

GBHSPC Subcommittee Charter	
Subcommittee Name:	Childrens Subcommittee
Context:	The Children’s Subcommittee generates recommendations for the GBHSPC regarding the behavioral health system of Kansas as it relates to Kansas children and their families. The GBHSPC reviews not just this subcommittees recommendations but other existing subcommittees and presents all Behavioral Health recommendations to the Secretary of KDADS and the governor. It is acknowledged that although the priority focus of the GBHSPC are the SPMI and SED target populations (Federal law 102-321), the work of the subcommittee is to be conducted with the whole system and all Kansas citizens with behavioral health needs in mind.
Purpose:	The Children’s Subcommittee is devoted to the behavioral health needs of children and their families. The subcommittee examines and makes recommendations to improve the array of behavioral health services offered to children and their families through Kansas Community Mental Health Centers (CMHC), substance use treatment providers other children’s service systems and collaboration between systems of care such as Psychiatric Residential Treatment Facilities (PRTF), hospitals, juvenile justice services and schools. We: <ul style="list-style-type: none"> ▪ Identify strengths and needs. ▪ Make informed recommendations. ▪ Use subcommittee member networks to address identified needs and influence change.
Vision:	That all Kansas children and their families will have access to essential, high-quality behavioral health services that are strengths-based, developmentally appropriate, and culturally competent.
Mission:	To promote interconnected systems of care that provide an integrated continuum of person- and family-centered services, reflective of the Children’s Subcommittee vision and values: <ul style="list-style-type: none"> ▪ <u>Interconnected Systems</u> <i>The integration of Positive Behavioral Interventions and Supports and School Mental Health within school systems to blend resources, training, systems, data, and practices in order to improve outcomes for all children and youth.ⁱ</i>

	<ul style="list-style-type: none"> ▪ <u>Systems of Care</u> <i>A spectrum of effective, community-based services and supports that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses cultural and linguistic needs to enhance functioning at home, in school, in the community, and throughout life.ⁱⁱ</i> ▪ <u>Integrated Services</u> <i>Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.ⁱⁱⁱ</i> ▪ <u>Continuum of Care</u> <ul style="list-style-type: none"> ✓ <i>Across the Lifespan – From birth to age 22.</i> ✓ <i>Across Levels of Intensity – Preventative (Tier 1), targeted (Tier 2), intensive (Tier 3).</i> ▪ <u>Person & Family-Centered Planning</u> <i>A collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person- and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.^{iv}</i> <div style="text-align: center;"> <p>Intensive supports/intervention: for children and their families who are in crisis or at risk "Individual"</p> <p>Targeted & Preventative supports/intervention: for community, providers, staff, children and their families, etc. with identified needs, risks, etc. "Targeted Individuals & groups"</p> <p>Preventative & Universal Supports/Intervention: for everyone (state, community, agency, school, etc.) "Statewide-Communitywide-Agencywide-School Wide"</p> </div>
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GBHSPC Children’s Subcommittee Charter

Values:	The Children’s Subcommittee will use the following values to guide their purpose: <ul style="list-style-type: none">▪ Use data from multiple sources to ensure an accurate picture of the target population▪ Promote person and family-centered planning▪ Ensure all recommendations are supported by evidence▪ Maintain collaborative and inclusive networks▪ Listen and respect the voices of those we serve
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GBHSPC Approval	
Name	Signature
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Charter Effective Date: 05/08/2017

ⁱ <http://www.midwestpbis.org/materials/interconnected-systems-framework-isf>

ⁱⁱ <https://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf>

ⁱⁱⁱ <http://www.integration.samhsa.gov/about-us/what-is-integrated-care>

^{iv} <https://www.samhsa.gov/section-223/care-coordination/person-family-centered>

APPENDICES: Kansas Department of Education’s School Mental Health Framework



FOUNDATION

Integrating School Mental Health within Multi-Tier System of Supports:

1. Strong Universal Implementation
2. Integrated Leadership Teams
3. Youth-Family-School-Community Collaboration at all Levels
4. Culturally Responsive Evidence Based Practices
5. Data-Based Continuous Improvement
6. Positive School Culture & Climate
7. Staff Mental Health Attitudes, Competencies & Wellness
8. Systemic Professional Development & Implementation
9. Confidentiality & Mental Health Promotion Policies
10. Continuum of Supports

In Partnership with the Kansas State Department of Education and TASN ATBS School Mental Health Initiative

Adapted from Wisconsin Department of Public Instruction. *The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Support*. December 2015.

KANSAS SCHOOL MENTAL HEALTH FRAMEWORK

School mental health (SMH) refers to a comprehensive, multi-tier system of supports, practices, and services that are integrated throughout the school community to enhance the social, emotional, behavioral, mental health, and academic outcomes for children and youth. SMH practices address all aspects of the social, emotional, and character development of children and adolescents including mental and behavioral health, trauma and adverse childhood experiences, such as physical and sexual abuse, bullying, and substance abuse; universal strategies to promote the well-being and development of all students; selected, brief strategies to support students at risk of or with mild challenges; intensive, ongoing strategies to support those with significant needs.

Data Indicating Need

- Adverse Childhood Experiences Among Kansas Adults: 2014-2015 Kansas Behavioral Risk Factor Surveillance System
- Healthy Children, Healthy Schools, Healthy Communities: Final Report on School-Based Mental Health (Kansas Statewide Survey Data)
- Kansas Behavioral Health Profile
- Kansas Children Future Tour
- Kansas Communities That Care
- Kansas Kids Count Data
- The Governor’s Task Force on Mental Health

Aligns with Priorities, Initiatives, Structures, and Supports

- Kansans CAN
- Kansas Social Emotional and Character Development Standards
- Kansas MTSS Integrated Framework
- Kansas Learning Network
- Kansas College & Career Competency Framework
- Governor’s Behavioral Health Services Planning Council, Children’s Subcommittee
- Mandatory abuse reporting requirements, codes of ethics, and licensing requirements for school-employed professionals

Will Address Current and Pending School Legislation

- (Pending) 2017 HB 2048 (Erin’s Law)
- 2016 SB 323 (Jason Flatt Act)
- 2016 SB 367 (Juvenile Justice)
- K.S.A. 72-8256 (Bullying)
- Every Student Succeeds Act
- Positive Behavioral Intervention and Supports (IDEA)

Objectives

- Strengthen the capacity and sustainability of effective Early Childhood Mental Health Consultation (ECMHC) and School-Based Mental Health (SBMH) practices: Promote a comprehensive understanding of effective ECMHC and SBMH practices; promote the training and hiring of qualified ECMHCs & SBMH professionals; provide ongoing professional development opportunities specific to ECMHC and SMH.
- Promote the development of multi-tiered, cross-system infrastructures to comprehensively support children and youth impacted by trauma and/or who are at risk for mental illness.
- Develop a *Kansas School Mental Health Framework, Practices Protocol, and Resource Guide* to aid school communities in building and strengthening SMH systems, supports, services and practices.
- Identify and/or develop training and resources to effectively support the implementation of SMH systems, supports, practices, and services on an ongoing basis.

Resources

KSDE Social Emotional and Character Development: <http://www.ksde.org/Agency/Division-of-Learning-Services/Career-Standards-and-Assessment-Services/Content-Area-M-Z/School-Counseling/Social-Emotional-and-Character-Development>
TASN ATBS School Mental Health Initiative: <https://ksdetasn.org/smhi>

Updated 2017.06.08

END NOTES:

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Governor's Behavioral Health Services Planning Council
Subcommittee on Housing and Homelessness
2017 Annual Report
June 2017

Presented to:

Wes Cole, Chairperson, Governor's Behavioral Health Services Planning Council
Secretary Tim Keck, Kansas Department for Aging and Disability Services
Sam Brownback, Governor of Kansas

Mission

Our mission is to promote the expansion of safe, decent, affordable, and permanent housing options for all Kansans experiencing severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders. We will fulfill our mission through assertive and strategic partnerships with local communities, housing developers, lenders and Federal and State agencies.

Vision

Our vision is that all Kansans experiencing a severe and persistent mental illness, Serious emotional disturbance and/or co-occurring disorders have access to safe, decent, affordable, and permanent housing.

Introduction

The Governor’s Behavioral Health Services Planning Council (GBHSPC) formed the Subcommittee on Housing and Homelessness (SHH) in 2001 as a result of advocacy efforts of homeless service providers and consumers who experience mental illness. The Subcommittee is charged with researching and offering recommendations to the GBHSPC regarding housing and homelessness issues experienced by adults diagnosed with severe and persistent mental illness, and by children diagnosed with severe emotional disturbance and their families.

Membership

MEMBER	AGENCY/AFFILIATION	AREA REPRESENTED	POPULATION DENSITY*
Al Dorsey	Kansas Housing Resources Corporation	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Bradley Schmidt	Prairie View, Inc.	Harvey, McPherson, and Marion Counties	Urban, Semi-Urban, Densely-Settled Rural, Rural
Amber Giron	United Health Care	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Brianna Frits	Veteran Administration	Northeastern Kansas	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Christy McMurphy Vice-Chair	Kim Wilson Housing, Inc., Wyandot Inc.	Eastern and Central Kansas	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Elizabeth Worth Secretary	Johnson County Mental Health Center	Johnson County	Urban
Jennifer Wilson	Comcare of Sedgwick County	Wichita, Sedgwick County	Urban
Michael Kress Chair	Mental Health Association of South Central Kansas	Wichita, Sedgwick County	Urban
Tate Toedman	Department of Education	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Sarah Barnhart	Kansas Department of Corrections	Statewide	Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
James Costello PhD	Emporia State University	Eastern Kansas	Semi Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Korrie Snell	Kansas Department for Aging & Disability Services Behavioral Health Services Subcommittee on Housing and Homelessness, Staff Support		Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier
Misty Bosch-Hastings	Kansas Department for Aging & Disability Services Behavioral Health Services Subcommittee on Housing and Homelessness, Staff Support		Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier

***Defined by Kansas Department of Health & Environment**

List of Outstanding Accomplishments/Milestones Achieved During FY 2017

1. Four Continuum of Care (CoC) communities in Kansas brought in \$7,687,891 in 2016 and brought in as much in previous years. The communities are Johnson County, Wichita/Sedgwick County, Topeka/Shawnee County and the Balance of State (100 counties). Wyandotte/Kansas City, Kansas CoC merged with the Kansas City, Missouri CoC this year. Wyandotte County brought in \$859,633 in 2016. The Continuum of Care committees cover the entire state and are focused on increasing the number of housing and service options for our most vulnerable citizens who are homeless. Seventy percent of the members on the Subcommittee on Housing and Homelessness are involved in at least one Continuum of Care community.
2. Kansas has been declared a Super SOAR State by the national SOAR Technical Assistance Center. SOAR (SSI/SSDI Outreach, Access and Recovery), is a SAMHSA endorsed best practice that has been adopted and implemented by many CMHCs throughout Kansas. In 2016, Kansas was considered one of the "Top 10" the state had to have had at least 100 cumulative decisions. Kansas had 156 decisions in 2016 with 95 approvals. Over the last seven years, the state has had 855 decisions with 648 approvals for a 76% approval rate.
3. Kansas Interagency Council on Homelessness (KICH) was reorganized and reconvened in 2016. KICH will act as a workgroup under the Subcommittee on Housing and Homelessness. The group is charged with reviewing and updating the *State of Kansas Opening Doors Strategic Plan to Prevent and End Homelessness*. Subgroups have been formed based on the strategic plan tasks, including the need to increase safe, affordable, available housing.
4. The Cooperative Agreement to Benefit Homeless Individuals (CABHI) Kansas has begun year two of the agreement. All of the provider agencies have implemented the Housing First model and have had the baseline reviews completed. There are currently discussions on having the CABHI provider agencies provide training and technical support to other Community Mental Health Centers in their corresponding regions.

Recommendations for FY 2018

Recommendation:

Members of the GBHSPC's Subcommittee on Housing and Homelessness commend the Kansas Department for Aging and Disability Services for their previous efforts in supporting the housing needs of Kansans, which include Supported Housing Funds, Interim Housing Grant, SOAR, PATH and Rainbow Services Inc. The Homeless Subcommittee is very aware of the integral part that having safe affordable housing plays in the recovery of persons with serious mental illness and we feel that current resources are simply not sufficient for the need we see daily across the State of Kansas. We believe that the most effective housing structure offers an array of housing options from crisis facilities and group homes to independent living options. Including individualized skill building as a component of the housing not only helps to ensure timely transition to the least restrictive environment but also allows maximum use of those facilities in meeting the needs of an increased number of people. We urge the department to create an infrastructure to facilitate the expansion of an array of housing that would include a range of options from Residential Care Facilities to home ownership. These would be designed with current evidence-based practices and principles.

Rationale:

The expansion of housing will lead to decreased admissions to state psychiatric hospitals, decreased incarceration to jails and prisons and a reduced rate of individuals becoming homeless due to their disability. It will also save tax dollars and help vulnerable Kansans achieve recovery. However, if KDADS does not support an array of housing options, Kansans, possibly will be forced to reside in environments not favorable with their needs or desires.

Recommendation:

The GBHSPC's Subcommittee on Housing and Homelessness recommends that KDADS-BHS in cooperation with Kansas Housing Resources Corporation (KHRC) and other partners implement initial and ongoing training for Behavioral Health Housing Staff specifically Housing Specialists. More specifically we recommend that KDADS-BHS resumes the Housing Specialist Meetings that have stopped over the last year.

Rationale: Through the development of the Housing First approach and through HUD's program Rapid Re-housing and Homeless Prevention (RRHP), the role of the housing staff has been defined as a person who specializes in working with landlords and helping people find appropriate housing. Housing First and RRHP programs that have housing staff working in conjunction with case managers, have extremely high success rates in helping families obtain and maintain permanent housing.

Recommendation:

The GBHSPC Subcommittee on Housing and Homelessness recommends that KDADS-BHS continue to support the funding of Supported Housing Funds to assist those with Severe and Persistent Mental Illness (SPMI) and persons with Serious Mental Illness (SMI) in obtaining or maintaining housing in the community as they are integral to the work being done by the housing specialists.

Rational:

Supported Housing Fund program provides affordable housing linked to services for low-income, disabled and formerly homeless or potentially homeless people with Severe Persistent Mental Illness (SPMI) and persons with Serious Mental Illness that fit KDADS' criteria. The goal is to provide persons the help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives. The SHF program supports eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is achieved by providing temporary funds to meet the cost of their housing needs.

The GBHSPC's Subcommittee on Housing and Homelessness would like to work with KDADS-BH in reviewing the SHF program and the application process to look for improvements and process enhancements to insure that the SHF are being used for qualified persons and the funds are being used appropriately.

Recommendation:

The GBHSPC's Subcommittee on Housing and Homelessness applauds KDADS-BHS efforts to advance the provision of SOAR (SSI/SSDI Outreach, Access, and Recovery Program) statewide. SOAR is a federal program that helps states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and have a mental illness or other co-occurring disorders. In order to continue to grow the SOAR program in the state and to insure that all of those eligible for Social Security disability benefits are receiving them, the GBHSPC's Subcommittee on Housing and Homelessness recommends that KDADS:

1. Continue supporting the provision of training for SOAR case managers;
2. Collaborates with other state departments to expand the SOAR program by incorporating ongoing training to all SOAR Specialists in the state.
3. Explores funding opportunities to expand SOAR so that SOAR case managers are available for statewide access.

Rationale:

For people with behavioral health disorders, receiving SSI/SSDI can be a critical step toward recovery. SSI/SSDI benefits can provide access to housing, health insurance, treatment and other resources. Obtaining these benefits can be an important step toward ending homelessness.

Recommendation:

Knowledge is power. Specifically when working with those that are homeless and/or those with disabilities in finding affordable housing. To help service providers in this daunting task, the GBHSPC's Subcommittee on Housing and Homelessness recommends that KDADS-BS and other State entities work together to create a centralized location that is easily accessible to gather information on available housing programs.

Furthermore, the GBHSPC's Subcommittee on Housing and Homelessness recommends that a statewide homeless data collection process be adopted and implemented to ensure that homelessness data is accessible and easily attained.

Rationale:

Currently there are five Continuum of Care regions in the State of Kansas. Each uses a different method for collecting and maintaining this data. As state and community organizations work to develop housing for those with disabilities, it is imperative that the data used to make decisions is accurate and complete. With a centralized data management system, data would consistent and readily available for obtaining funding for safe, affordable housing.

Summary

The Subcommittee on Housing and Homelessness has researched best practice housing models used by other states and based on this research made recommendations tailored to the Kansas Behavioral Health System for the past several years.

There is strong evidence from other states that have invested in safe, decent, affordable housing coupled with supportive services that there is a significant reduction in the use of costly medical services like state hospitals, jails and prisons. In Kansas, the State Psychiatric Hospital system is chronically over census. Kansas needs to maintain current resources to guarantee KDADS housing programs continue to serve all Kansans with behavioral health disorders. This includes access to safe, decent, affordable and permanent housing. The continuation of this investment results in fewer hospital admissions and incarcerations. All Kansans ultimately benefit with the outcome of an improved quality of life for consumers and cost savings for taxpayers.

The Subcommittee challenges KDADS and other state and local stakeholders to work together to enhance the current infrastructure of housing experts to facilitate the expansion of housing options and resources such as SOAR and Behavioral Health Service Providers housing staff.

GOVERNOR'S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL UPDATE



JUSTICE INVOLVED YOUTH AND ADULTS – SUBCOMMITTEE REPORT

2017

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

Prepared by:

Lori Ammons, PsyD, Co- Chair

Rick Cagan, Co-Chair

Charles Bartlett, KDADS

Members of the Justice Involved Youth and Adults Subcommittee

INTRODUCTION

The interface between the mental health and criminal justice systems is substantial. The increased involvement of people with mental illness in the criminal justice system remains a difficulty for both state and local governments.

The JIYA Subcommittee convenes constituents at a policy level to carry out the vision and mission with the intent to promote actions for state level change through policy recommendations and planning.

JUSTICE INVOLVED YOUTH AND ADULTS SUBCOMMITTEE CHARTER

1. Develop a strategic plan to identify goals and objectives for state level change through policy and planning.
2. Formulate and prioritize strategies to achieve objectives of the strategic plan.
3. Implement strategies through workgroups, including timeline for completion.
5. Issue annual policy recommendations and planning to the Secretary from the Departments for Aging and Disability Services (KDADS), Children and Families (DCF), and Corrections (KDOC).

VISION AND MISSION

The vision and mission of the JIYA is as follows:

Vision

Justice involved Youth and Adults with behavioral health needs will achieve recovery.

Mission

To promote a recovery oriented system of care for individuals with behavioral health needs in or at risk for involvement in the justice system through policy recommendations and planning focused on prevention, diversion, treatment and reentry.

MEMBERSHIP

Randall Allen, *Kansas Association of Counties*

Lori Ammons, PsyD, *KU Medical Center, KDOC Behavioral Health Program Director*

Charles Bartlett, *Kansas Department of Aging and Disability Services*

Randy Bowman, *Director of Community Based Services, KDOC – Juvenile Services*

Mike Brouwer, *Douglas County Sheriff's Office*

Rick Cagan, *NAMI Kansas*

Bill Cochran, *Captain, Topeka Police Department*

Wes Cole, *GBHSPC Liaison*

Hope Cooper, *Deputy Secretary, KDOC*

Lesia Dipman, *Program Director, Larned State Security Program*

Jeffrey Easter, *Sedgwick County Sheriff's Office*

Nathan Eberline, *Kansas Association of Counties*

Letitia Ferwalt, *Johnson County DA's office*

Sally Frey, *KDOC, Southern Parole Region Director*

Jason Hess, *Executive Director, Heartland RADAC*

Sandy Horton, *Kansas Sheriff's Association*

Ted Jester, *Director, Johnson County Juvenile Detention Center*

Ed Klumpp, *Local law enforcement*

Dan Livingston, *Johnson County Mental Health*

Benet Magnuson, *Executive Director, Kansas Appleseed*

Marie McNeal, *KDOC Director Community Corrections*

Chris Mechler, *OJA*

Bill Persinger, *CEO, Valeo Behavioral Health*

Usha Reddi, *Manhattan City Commission*

Viola Riggan, *KU Medical Center, KDOC Director of Health Care*

Jennifer Roth, *Criminal Defense Attorney*

Dennis Tenpenny, *Community Support Services Director, Valeo Behavioral Health*

Jess Sholin, *Department of Children and Families*

Jennifer Truman, *Mirror, Inc.*

Susan Wallace, *Family Member*

SUBCOMMITTEE AND WORKGROUP SUMMARIES

Through FY 2016 – 2017, the Justice Involved Youth and Adults Subcommittee (JIYA) reviewed ongoing work and revised/realigned workgroups for the present year. The approach the Subcommittee used involved breaking current priority topics into two separate workgroups. Ad Hoc workgroups would be added as needed. The two overarching topic areas included Program/Best Practices and Systemic Issues.

Broad areas identified as topics to address for the Programs/Best Practice workgroup included the following:

- Crisis Intervention Training – Pre-Arrest
 - Co-Responders
 - Crisis Centers Expansion
- Training and Technical Assistance
- Mental Health Diversion – District Attorney
 - Mental Health Courts
- Assessment/Readiness for Counties
- Juvenile Services

Broad areas identified as topics to address for the Systemic Issues workgroup included the following:

- Funding/Policy
 - Formalizing Agency Relationships
- Kansas Offender Database / KEES (Ad Hoc)
- Data Sharing
- Standard of Care During Incarceration
- Competency
- Discharge Planning
 - Continuity/Care Coordination
 - Both Adults and Juveniles

The workgroups defined new goals and objectives for the year. This report will address each workgroup's recommendations as supported by the JIYA.

Best Practice Workgroup

Workgroup Goals and Objectives:

1. Identify and gather data on the prevalence of mental illness in our jails.
2. Identify what process and assessment to use to measure gaps in communities wanting to explore best practice programming for this population. Identify a pilot site.
3. Identify priorities for which we would like to have the CIT/VA Coordinator position advocate towards our goals.

4. Development of fact sheet for Drug Courts/Mental Health Courts to be placed on KDADS website.

Current Status:

1. Assessment in Jails
 - A. This is step two of the six steps recommended by the Stepping Up Initiative to reduce the number of mentally ill people in jails.
 - B. Asked Johnson County (large jail), Douglas County (medium jail) and Reno County (small jail) to participate in establishing a *Proposed Criteria for “Gold Standard” Screening and Assessment Process*:
 - i. *Jail screening for mental illness is based on a definition of serious mental illness aligned with community/state definitions of mental illness*
 - ii. *Jails use a valid screening process on all persons entering jails for mental illness, regardless of the day of the week, time of day, or reason for/pathway of admission*
 - iii. *For those individuals staying 72 hours or longer, at least 80% of persons screened positive for mental illness are assessed by a licensed mental health professional*
 - iv. *All persons assessed as having a serious mental illness are flagged or tracked in an administrative database*
 - v. *The jail is able to query this data at any time to provide a daily, weekly, or monthly census of people with mental illnesses in jail.*
 - vi. **Serious Mental Illness Definition: “Psychotic, Bipolar, and Major Depressive Disorders and any other diagnosed mental disorder (excluding substance use disorders) associated with serious behavioral impairment as evidenced by examples of acute decompensation, self-injurious behaviors, multiple major rule infractions, and mental health emergencies that require an individualized treatment plan by a qualified mental health professional.”**
 - C. Council for State Governments: Justice Center is the technical advisor for this project
 - i. They have increased the frequency of webinars and started quarterly conference calls for counties based on size; small, medium, large.
 - ii. Many counties in Kansas are doing significant work, but few have passed resolutions to join the Initiative. Goal should be to increase participating counties.
 - iii. For counties considering initiatives related to reducing the number of people with mental illness in jail, this is an untapped resource.
 - D. Intercept model – Shawnee County. Complex model.

- E. Lead agency – Would like to identify some pilot communities. Discussed identifying a community that may have buy-in often requires a precipitating event to get the community leaders activated to solving a particular problem. Short list includes:
 - a. Pittsburg – may also be a possible site
 - b. Reno – highest crime rate, but may already have gone through the process.
 - c. Manhattan – active discussion regarding the development of a crisis/stabilization center and peripherally CIT.
 - d. Hays – may have had a precipitating event. Police shooting back in August.
- 2. Justice Assistance Grant to look at an “event”/funding to do some planning activity.
- 3. Jail Study – Consider combining with Stepping Up Initiative

RECOMMENDATIONS:

- Identify next steps on exploring the possibility of the Justice Assistance Grant having money earmarked for a community planning sight to do a pilot project for the assessment process.
- Continue to follow the Stepping Up Initiative, Step 2 with pilot communities to establish best practices in Screening and Assessment in jails.

Systemic Issues Workgroup

Workgroup Goals and Objectives:

- 1. Research the process of Competency in Kansas.
 - a. Review the previous Competency Ad Hoc Workgroup’s questions regarding Competency.
 - b. Research current questions via presentation from the state hospital staff.
- 2. Establish an efficient model for Data Sharing:
 - a. Determine which agencies are interested in sharing information.
 - b. Establish how the information flows from each agency.
 - c. Determine what information is needed from each agency.
 - d. Review models from other agencies or states.
 - e. Determine what kind of information is available electronically.
 - f. Determine current obstacles for 3 agencies in sharing information. Make recommendations to solve such barriers.

Current Status:

- I. Data Sharing
 - a. Five broad areas were identified regarding data sharing, including:
 - i. Which AGENCIES share necessary data / What is the flow?
 - ii. What information is AVAILABLE among agencies
 - iii. What information is USEFUL
 - iv. What are the OBSTACLES in sharing the data/information?
 - v. What is the MECHANISM for sharing the data/information?

- b. AGENCIES:
 - i. KDOC
 - ii. Jails
 - iii. Hospitals
 - iv. Community Corrections / Parole
 - v. CMHC's
 - vi. DCF – children of incarcerated offenders
 - vii. SUD Treatment
 - viii. KDADS / MH Database
 - ix. KS Jail Inventory Data System (live data)
- c. FLOW of information / Continuity of care
 - i. Community Corrections / Parole to CMHC's
 - ii. Jail/KDOC to Probation
 - iii. Probation to the Community, etc.
 - iv. Resources where care was received previously
 - v. Prescription history – Which medications worked the best for the individual offender? Consistency in formularies.
- d. USEFUL Information:
 - i. Jails
 - 1. Need prescription history / Similar formularies
 - 2. *Known medical problems; Medical history*
 - 3. *History of Medicare/Medicaid/Disability benefits and whether benefits were suspended.*
 - ii. Parole/Community Corrections – particularly for Care Coordinators
 - 1. Those who are Seriously Mentally Ill
 - 2. Previous resources where offenders have received services – such as CMHC contacts
 - 3. History of psychiatric hospitalizations
 - iii. DCF (to KDOC)
 - 1. Primarily for female offenders
 - 2. Is it realistic or healthy to connect/visit with the offender's children?
 - 3. Who has the offender's children?
 - iv. KDOC – *From jails to KDOC; From Community BH Providers (CMHC's) to KDOC*
 - 1. Previous resources where offenders have received services – such as CMHC's/state hospitals
 - 2. Medical history
 - 3. Family contacts
 - 4. Prescription history
 - 5. History of benefits – SSI/SSDI; (*KDHE?*).
 - 6. Available resources for housing / discharge planning
 - v. State Hospitals
 - 1. Available resources for housing / discharge planning

- 2. History of medical issues
 - 3. Family contacts
 - vi. Need information from CMHC's, SUD providers, Hospital/Emergency departments, and the VA.
- e. OBSTACLES:
- i. HIPAA – Legal obstacles; Special laws regarding behavioral health and SUD information. *There is a question regarding what information can be provided to law enforcement.*
 - ii. Security of sharing the information
 - iii. Accessibility of the information – electronic vs. hard chart. How to share information and in what format?
 - iv. Political hurdles for entities to share what they own
 - v. *Releases of Information- Agreements between agencies may alleviate obstacles of sharing information.*
- f. MODELS from other agencies or states.
- i. Reviewed “The Criminal Justice Coordinating Council Network Mini-Guide Series: Three Approaches to Integrated Data Systems.” February 2013 by the Justice Management Institute.
 - ii. Reviewed the Johnson County Data System (Presentation by Robert Sullivan)
 - iii. We know it can be accomplished. All systems reviewed served specific objectives of the involved agencies.
- g. RECOMMENDATIONS
- i. **Engaging community partners.** The workgroup is moving forward with pinpointing 3 pilot communities. Involvement would initially involve KDOC, Parole, CMHC's, & Substance Use Disorders providers.
 - 1. We propose targeting three Community Mental Health Centers to begin the discussion where information sharing would be beneficial.
 - a. We will possibly model after Shawnee County/Valeo partnership where a multi-disciplinary team meets regarding high acuity patients coming up for release with KDOC and possible jailed offenders.
 - b. We also need to find ways to include those treating offenders with substance use.
 - 2. We propose targeting three of the following areas:
 - a. Wyandotte County – There are increased KDOC re-entry services (K-SHOP) and Oxford houses available in this area.
 - b. Sedgwick County (ComCare is an active re-entry partner)
 - c. Ellis County (working with High Plains Mental Health),

- d. Central Kansas Mental Health (including Saline County, Dickinson, Ellsworth, Lincoln, and Ottawa), and/or
- e. Compass Community Mental Health Centers (Dodge City/Liberal - Finney, Ford, Grant, Gray, Greeley, Hamilton, Hodgeman, Kearny, Lane, Morton, Scott, Stanton, Wichita County).

ii. Adult Continuum of Care Subcommittee (GBHSPC)

- 1. We propose making a recommendation for the GBHSPC to endorse and focus on the issue of high behavioral health acuity releases from KDOC and any other jail entity.
- 2. Primary issues include:
 - a. Integration of services from incarcerated status to community; Focus on high acuity need individuals who may be difficult to house with SPMI (ie: sexual offenders, offenders with poor impulse control); Offenders who have been screened for civil commitment/alternatives to commitment. Substance use treatment upon release.

II. Competency

- a. The workgroup reviewed the previous Competency Ad Hoc Workgroup’s questions regarding Competency. The Larned State Hospital provided a presentation to the workgroup and responded to questions regarding the process of Competency. No recommendations to the GBHSPC are ready to be presented at this time.

SUMMARY

In summary, the JIYA, through its diverse members of the subcommittee and workgroups, provides a unique avenue for members to come together to collaborate, analyze, and create recommendations for the GBHSPC. The Best Practices workgroup members will continue with their current goals of establishing a best practice in the screening and assessment of mentally ill offenders in jails, as well as review resources for funding, including grant opportunities. Additionally, the Systemic Issues workgroup members will engage communities interested in partnerships for data sharing opportunities and to establish a model to facilitate sharing of information among criminal justice entities, community mental health centers, substance use disorder providers, and any other interested agency/entity.

As a final note, Co-Chairs Rick Cagan and Lori Ammons jointly decided to solicit new Co-Chairs to lead the JIYA through the next year’s activities. Both will continue to serve on the JIYA. Bill Persinger, CEO of Valeo Behavioral Health and Ted Jester, Director of Juvenile Services Center, Johnson County, agreed to serve as the new Co-Chairs for the upcoming year.

**Governor’s Behavioral Health Services Planning Council
Kansas Citizen’s Committee on Alcohol and Other Drug Abuse (KCC)
Annual Report, 2017**

Presented to:

Wes Cole, Chairperson, Governor’s Behavioral Health Services Planning Council
Tim Keck, Secretary, Kansas Department of Aging and Disability Services
Sam Brownback, Governor

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

Vision: Kansas is a community where people are free from the adverse effects of substance use disorders, mental illness, and other behavioral health disorders.

Mission: To empower healthy change in people's lives through quality services that address the treatment, prevention and recovery from substance use disorders, problem gambling, mental illness, and other behavioral health disorders.

Current Membership:

Member	Representing
L. Kay Anderson	Domestic Violence/Sexual Assault
Kathy Allen	Citizens
Al Dorsey	Citizens
Pastor Dave Fulton, Past Chair	Citizens
Shane Hudson, Chair	Treatment
Christopher Lund	Citizens
Krista Machado, Recorder	Prevention
Det. Lane Mangels	Law Enforcement
Chris McGuire	Treatment
Bill Persinger	Mental Health
Toni Ragland	Citizens
Mollie Thompson	Prevention
Maren Turner	Aging
Kayla Waters, Chair Elect	Higher Education
Kimberly Reynolds	KDADS/Staff Liaison
Diana Marsh	KDADS/KCC Support Staff

Introduction

As an advisory council on addiction prevention and treatment in Kansas, we are basing our recommendations on three foundational premises. First, effective services save lives and promote autonomy and higher quality of life for individuals, families, and communities in Kansas. Second, prevention and treatment of addictions is financially responsible. For example, data from the collaboration between Central Kansas Foundation and Stormont Vail Healthcare shows that of 658 patients placed in SUD treatment services from 4/1/15-3/31/17 there was a 58% decrease in ED visits and/or admissions following their treatment placements. Third, effective addiction prevention and treatment services are essential to public safety for the citizens of Kansas, reducing rates of assault, accidents, abuse, crime, and suicide (Boles & Miotto, 2003; Drug Abuse Warning Network, 2011).

Specific Recommendations and Action Steps

The state officials reading this report are in the best position to recognize opportunities to support addiction prevention and treatment. We ask that you adopt as your own this vision of a safe and healthy Kansas, supported through effective, integrative, cost-saving addiction prevention and treatment services. In addition, we offer the following information and recommendations.

Funding

The first step to supporting any of the recommendations in this report is to promote adequate funding for the field of addiction counseling. Approximately 70% of addiction services are currently funded by the SUD Block Grant. Unless additional streams of funding are secured, implementing the recommendations below will pull resources from other valuable programs. We make the following recommendations for improving resources in the field of addiction counseling:

- Ensure that the Problem Gambling Alliance Fund is used in accordance with bylaws and statutes.
- Reinstate the 4% Medicaid cuts that were enacted in July 2016. These cuts have negatively affected providers who continue to do their best to provide increasing levels of quality services with less money to do so. Ultimately, providers must turn to options such as reducing programs and/or staff in an environment where cost of service delivery is rising annually and rates have not increased since 2011 for Block Grant or Medicaid.
- Support Medicaid expansion to insure Kansans for substance use disorder and mental health services, who would otherwise utilize block grant funding and often face wait lists for services
- Support a global payment model that would allow providers to define the appropriate care for each patient while managing per member per month funds and tracking quality outcomes. Fee-for-service models negatively affect providing individualized care plans to consumers due to restrictions on covered services. Meanwhile, providers have staff and resources that could greatly benefit the consumer if there were more flexibility created by global payments.
- Ensure that behavioral health services (substance use disorder and mental health services) are covered by existing and future health plans. If patients are not able to access the necessary

service to treat their substance use disorder or mental illness, unnecessary cost and strain will be put on other health systems that cannot appropriately treat the illness. Create a new state-level grant-writing position. Agencies are currently too under-resourced to devote efforts toward pursuing various grants that are available only at the agency-specific level. A dedicated SUD Grant Writer could work with agencies to do as much of the grant identification, writing, monitoring, and wrap-up as possible, leaving agency directors and staff to focus on their strengths in service provision.

Intervention

Treatment works. Addictions services promote quality living for Kansans and responsible use of precious resources. But treatment agencies in Kansas currently face several serious challenges that are undermining effective services.

- The **workforce** crisis means that some agencies are forced to terminate effective, cost-saving programs because they aren't enough qualified professionals to staff them. Current professionals in the field are stretched too thin, creating a risk for poorer quality services and attrition. In some cases, agencies must resort to hiring staff who are technically eligible to perform the work, but have very little specific training in addiction counseling, which is a highly demanding field with specialized treatments and challenges. Under-prepared staff create substantial training demands and attrition problems.
- Integration of Services is necessary to improve outcomes and reduce waste. Services must be integrated across the continuum of care (referral/screening, diagnosis, treatment, and recovery) and across domains of care (primary care, mental health, and addictions). Within the domain of addiction services, integration includes coordinated services for alcohol/drugs, problem gambling, food, pornography, etc. Integration also requires family and community-based approaches. Gaps in services are created when agencies aren't allowed to seek reimbursement for services provided.
- **Immediate and affordable access to care will ultimately reduce both human and financial costs of addictions.** Early intervention is most effective and prevents tertiary losses.

We offer the following specific recommendations for improving the outcomes and cost-effectiveness of addiction treatment services:

- Support workforce development by adequately funding agencies (specific recommendations provided in the previous section of this report).
- Support initiatives that reduce the costs of entering the field (e.g. tuition reimbursement similar to that available in similar fields).
- Support reimbursement for the flexible, responsible, supervised use of the **full contingent of addiction service providers**, including peer mentors, recovery coaches, and person centered case managers. Global payment would be an option that creates the

flexibility needed to deliver the right service at the right time, thus reducing gaps in service delivery.

- Support initiatives that allow professionals with specialty training in addiction counseling to provide more integrative services to clients with co-occurring conditions.

Prevention

Prevention is an effective and financially-responsible approach to addiction in Kansas. Kansas was once a national leader in prevention, but with the dissolution of the Regional Prevention Centers, much ground has been lost. This means that under-resourced agencies are facing increased caseloads of people who would have been protected against developing addiction disorders in the past. With the recent decision to require parent consent on the Kansas Communities that Care (KCTC) Student Survey, prevention specialists are operating with less complete data. Much ground has been lost. But Kansas Prevention leaders are making innovative use of technological advances to re-expand services. For example, the Kansas Prevention Collaborative has developed a website that makes effective prevention programs accessible to Kansans (discussed below).

We offer the following recommendation for supporting prevention programs in Kansas:

- Work to reverse the Active Consent policy that currently requires active parental consent on the KCTC student survey. (Return the use of passive parental consent.)
- Support funding for general prevention in Kansas, particularly relating to adverse childhood experiences (ACES).

Community Engagement

Kansas is full of concerned people who want to help but aren't sure how. Here we simply repeat the request we already made earlier in this report: Please use your status and visibility to spread this empowering message across Kansas:

- There are serious problems with substance abuse in our state.
- And, there is reason to believe that we will face growing challenges in the very near future.
- *But*, Kansans are not powerless. Faith-based groups, parents, schools, community leaders, etc. can access and implement effective prevention programs to protect their families and communities. Specific tools are available at www.kansaspreventioncollaborative.org. In addition, state-wide assistance and training as well as data collection and evaluation support are available through the Kansas Prevention Collaborative.

Conclusion

We appreciate your commitment to Kansas. We would be delighted to provide any additional assistance or discussion that might be helpful.

References

- Boles, S. M., & Miotto, K. (2003). Substance abuse and violence: A review of the literature. *Aggression and Violent Behavior, 8*, 155-174.
- U.S. Department of Health and Human Services, Drug Abuse Warning Network (2011). *National estimates of drug-related emergency department visits* (HHS Publication No. (SMA) 13-4760). Retrieved from <https://www.samhsa.gov/data/sites/default/files/DAWN2k11ED/DAWN2k11ED/DAWN2k11ED.pdf>

Governor's Behavioral Health Services Planning Council Prevention Sub-Committee 2017

VISION

To ensure that key representatives and stakeholders are involved in the provision of reflection, feedback, and guidance relating to initiatives within Kansas Behavioral Health Prevention Initiatives to ensure enhanced collaboration, effectiveness, and impact on State and local level prevention and behavioral health outcomes.

MISSION

To provide feedback, guidance, advocacy, and engagement at the State level for related behavioral health prevention outcomes and identification of systems changes to address challenges, barriers, issues, and needs at the State, regional, or community level.

MEMBERSHIP

The Prevention Sub-Committee was established to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes and increase the effectiveness of state and local efforts to address prevention issues.

NAME	ORGANIZATION
Marcia Bartelston	Sumner County Community Drug Action Team
Mende Barnett	Kansas Department for Aging and Disability Services
Bailey Blair, LMSW	American Foundation for Suicide Prevention – Kansas Chapter Board Member
Teresa Briggs	GBHSPC Prevention Liaison
Andy Brown	Headquarters Counseling Center
Chad Childs	WSU Community Engagement Institute
Steve Christenberry	Family Service and Guidance Center
Diane Garvey	Live Well Finney County
Chrissy Mayer, Chair	DCCCA
Pamela McCartney	Iowa Tribe of Kansas and Nebraska
Marissa Woodmansee	20 th Judicial District Juvenile Services

BACKGROUND

Kansas has a strong history of innovative approaches to prevention work. In 2015, the scope of prevention work in the state shifted to respond to the changing needs of Kansas communities. This shift allowed communities to be more comprehensive in their approach to prevention and focus on shared risk and protective factors in behavioral health.

The prevention sub-committee was established in the Fall of 2016. Initial committee members focused on recruiting a diverse cross-section of individuals engaged in behavioral health prevention work in Kansas. The committee began meeting regularly in November 2016. One area of focus for the committee was preliminary development of a statewide plan to address behavioral health prevention. Strategic plan development will allow sustainable use of prevention resources in challenging times.

GOALS

As a newly established committee, the primary focus for the past several months centered on developing a strong membership and leadership structure. The committee also focused on establishing a comprehensive charter. The committee began an initial assessment process to identify prevention efforts as highlighted in our data collection and research goals.

Data Collection and Research

- 1) By June 30, 2017, the prevention sub-committee will identify and catalog behavioral health prevention efforts that are occurring across the state.
- 2) By June 30, 2017, the prevention sub-committee will identify the top five behavioral health prevention data priority areas as indicated by available state data resources.

Update the prevention sub-committee charter

- 1) By April 21, 2017, the prevention sub-committee will finalize the prevention sub-committee charter and submit it to the GBHSPC for review and approval.

PROGRESS

At the inaugural meeting of the prevention sub-committee, we provided an overview of the committee purpose and the importance of focusing on a comprehensive approach to behavioral health prevention. We learned about the work of the Suicide Prevention Sub-Committee and began to discuss appropriate integration of the two committees. This process laid the framework for ensuring that all aspects of prevention were represented on the prevention sub-committee including substance abuse prevention, mental health promotion, suicide prevention and problem gambling prevention.

Early meetings of the committee also focused on data sharing. Committee members expressed a desire to learn more about available data points related to behavioral health prevention and to identify potential data gaps. The committee continues to review available prevention data and note trends within the data to make informed recommendations and data-driven decisions.

The committee has gathered information on behavioral health prevention efforts in the state, both funded initiatives and grassroots efforts. It was important to conduct an initial assessment of current efforts to determine potential gaps in services and to identify efforts that are occurring that some committee members may not be aware of. Having a clear picture of prevention initiatives allowed the committee to begin laying the framework for a statewide plan to address behavioral health prevention.

The bulk of the committee work the past several months focused on developing a template for the statewide prevention plan. We reviewed plans from several other states to determine areas that were essential for the Kansas plan. We also identified areas that were emerging and those that were expendable. To date, the committee has completed work on guiding principles and values. We also have conducted initial work to determine prevention efforts across state agencies.

The framework for the statewide plan currently includes the following topic areas –

SECTION 1: Executive summary

SECTION 2: Information about the process to develop a plan

SECTION 3: Mission, vision and values statement

SECTION 4: Guiding principles

SECTION 5: Goals and priorities

SECTION 6: Current behavioral health systems

SECTION 7: Assessment of system strengths and gaps

SECTION 8: Funding breakdown specific to prevention

SECTION 9: Populations served

SECTION 10: Agencies and councils engaged in prevention work

SECTION 11: Potential strategies based on gaps in services

SECTION 12: Call to action (community level and state level)

SECTION 13: Accountability

SECTION 14: Sustainability

SECTION 15: Cultural Competence

APPENDICES

APPENDIX 1: List of acronyms and/or a glossary of terms

APPENDIX 2: Inclusion of other plans developed (i.e. suicide prevention)

The prevention sub-committee also prepared for the Center for Substance Abuse Prevention site visit for the Partnerships For Success (PFS) initiative in March. This was a federal site visit for grantees to ensure compliance and progress on the project. The PFS currently funds four community coalitions to address underage drinking and four pilot sites to address prescription drug abuse. Prevention sub-committee members attended the first day of the site visit to be available to the federal project officer. The results of the site visit were positive indicating that prevention work in Kansas is moving in an appropriate direction.

COORDINATION

The prevention sub-committee recognizes the value in collaborating and coordinating efforts with other sub-committees. It is important to have a basic awareness of the role of other committees to avoid duplication of services and identify areas that can be strengthened in partnership. Prevention can be infused in multiple areas and our committee has a desire to understand work that other committees are coordinating and having conversations about how prevention can be engaged.

Recently, the prevention sub-committee shared information about our efforts with the Kansas Citizens Committee. These two committees share an interest in prevention, so coordination of efforts is important to avoid duplication of services and recommendations. During the upcoming fiscal year, the prevention sub-committee will contact other committees who may have a shared interest in behavioral health prevention to identify potential opportunities for collaboration.

NEXT STEPS

The prevention sub-committee will continue on course for the next year. A primary priority will be finalizing content for the framework of the statewide prevention plan. We also will continue to recruit committee members as terms of current members expire ensuring sustainable work on this process. We have identified three goal areas for FY18. Those include continuing our data collection and research goals, statewide plan development, and developing a list of priorities and/or recommendations for the council –

- 1) Data Collection and Research
 - a. By June 30, 2018, the prevention sub-committee will continue to identify and catalog behavioral health prevention efforts (funded and unfunded) that are occurring across the state.
 - b. By June 30, 2018, the prevention sub-committee will identify the top five behavioral health prevention data priority areas as indicated by available state data resources.

- 2) Develop framework for statewide prevention plan
 - a. By June 30, 2018, the prevention sub-committee will develop content for all identified sections of the statewide plan template.

- 3) Develop a list of priorities/recommendations to present to the GBHSPC
 - a. By May 30, 2018, the prevention sub-committee will identify the top five prevention efforts that the committee would like to see continued or enhanced.
 - b. By May 30, 2018, the prevention sub-committee will identify the top five behavioral health prevention needs as indicated by data and identify strategies for addressing the needs.

Rural & Frontier Subcommittee

2017 Annual Report

August 16, 2017
Governor's Behavioral Health Services Planning Council
Topeka, KS

1

Who we are:

- Renee Geyer, MMC – Lead Chair
 - Grant Coordinator, Compass Behavioral Health
 - Garden City, KS
- Nichole Tice, PsyD – Co-Chair
 - Program Director of Larned State Hospital Psychiatric Services Program, Larned State Hospital
 - Larned, KS

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Annual Report Overview

- Vision, Mission & brief Subcommittee history
- What we know about behavioral health issues and needs in rural & frontier areas
- FY2017 Objectives, and Progress to date
- Recommendations and Advocacy Appreciation

3

Because we know that...

“The vast majority of all Americans living in underserved, rural, and remote rural areas also experience disparities in mental health services... Rural issues are often misunderstood, minimized and not considered in forming national mental health policy.”¹

¹New England Commission on Mental Health, *Addressing the Problem: Improving Mental Health Care in America Final Report*, 0105 P.A. No. 8M-1333(1), Baltimore, MD, 1993, p. 9

4

Our Vision

“Behavioral Health Equity for All Kansans.

All residents of rural and frontier communities of Kansas will have access to essential, high quality behavioral health services.

March 14, 2016 Rural & Frontier Charter

5

We have learned that...

“Epidemiologic evidence suggests that the prevalence and incidence of adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) are similar between rural and urban populations (Kessler et al., 1994).

However, access to mental health care, practitioners, and delivery systems to provide care, and attitudes and cultural issues influencing whether people seek and receive care differ profoundly between rural and urban areas.”

6

Our Mission

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

7

History of the Rural & Frontier Subcommittee

- Originated as a committee subgroup focused on the mental health needs of children in the child welfare system.
- In July 2008, the subgroup moved under the umbrella of the GMHSPC to become the Frontier and Rural Subcommittee.
- The GMHSPC functions as the Kansas planning and advisory council that is required to receive federal Behavioral Health Block Grant funding.
- This affiliation (which is now inclusive of substance abuse disorders and renamed the GBHSPC) provides us with a formal process for making recommendations to the system and acknowledges the uniqueness of frontier and rural issues.

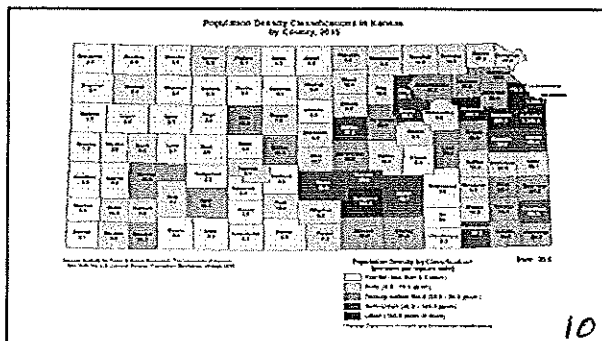
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Why do we advocate for the use of KDHE's definition of the frontier through urban continuum?

“Defining rural does make a difference in ensuring limited resources intended to address critical rural needs actually are transmitted to locations that have those needs.”

U.S. Department of Health and Human Services, Health Resources and Services Administration, Rural Health Policy (2007). *Mental Health and Rural America: 1994-2009: An Overview and Assessment of Geography*. Available at <http://www.hrsa.gov/health/rural/mentalhealth/>

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Unique Rural/Frontier Behavioral Health Needs

- Lack of Urban/Semi-Urban Resources in 8 out of 10 counties in Kansas (89 of 105 counties)
- Rural legacy of depopulation has continued over the past decade; a disproportionate share of the elderly population remains
- Higher percentage per capita of Hispanic residents in Rural/Frontier counties, especially in the southwest corner
- Behavioral Health provider shortage and barriers to service provision

11

Lack of Urban/Semi-urban Resources

Implications:

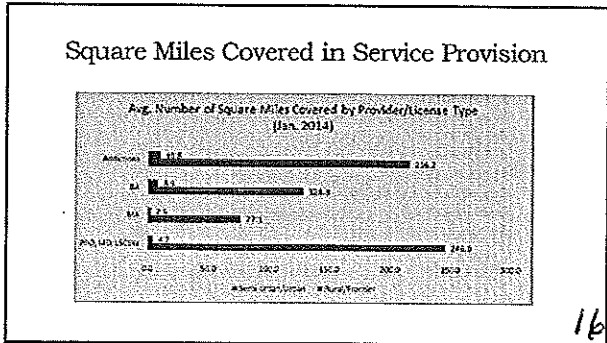
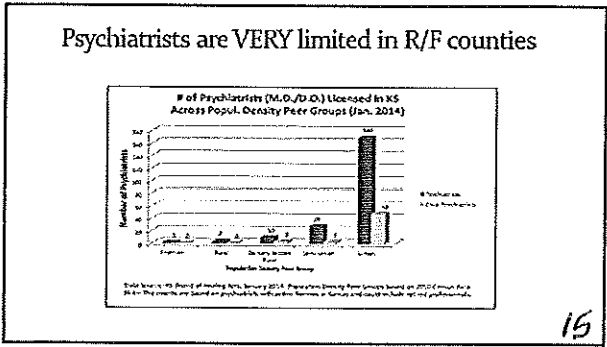
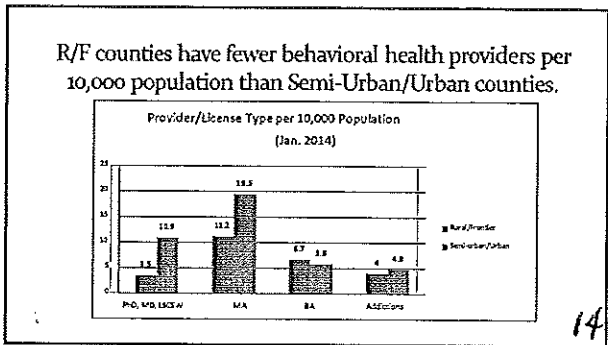
- Fewer services are available
- People must travel farther and bear the related travel costs
- Kansas policies or services that are financed or supported on a per-capita basis, result in underfunded programs and service shortages in more than 80% of the state
- Rural/frontier counties have smaller economies of scale and must provide services in more creative ways... or not at all

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Behavioral Health Provider Shortage

An overall shortage in health care services in rural/frontier areas is compounded by an even greater shortage of behavioral health providers and services.

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Rural Legacy—Depopulation

Implications:

- Over the last decade, decreasing populations in rural/frontier counties have resulted in erosion of the economic base and a decline in vitality for many communities.
- As the economic base declines, health services become more difficult to support locally.
- Therefore, the focus is on illness rather than on adequate early intervention and prevention.

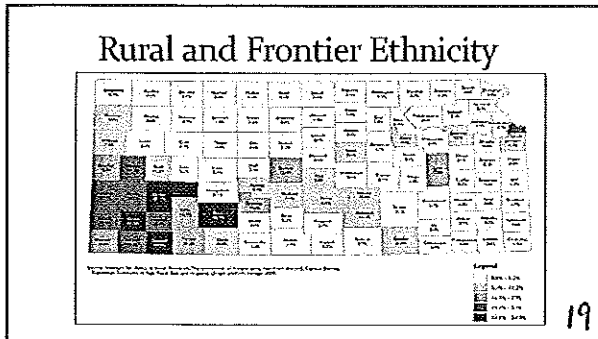
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Rural and Frontier Ethnicity

The ethnic landscape is also considerably different in Kansas' rural and frontier counties.

- Although the Hispanic or Latino population comprises approximately 10% of Kansas' total population, there are 21 counties with Hispanic or Latino populations greater than 10% — 18 of which are rural or frontier.
- Ten counties concentrated in the southwest corner of the state all have more than twice the state average for this population segment, with the top 4 considerably higher—Seward (54%), Ford (49%), Finney (45%), and Grant (42%).

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Ethnic & Cultural Diversity

Implications:
 In rural and frontier areas, there is an increased need for providers who understand rural culture, have bilingual and bicultural skill sets, and are responsive to a diverse range of ethnic cultures from an already limited workforce .

- All materials and services must be provided in at least two languages = increased costs

20

Addressing Barriers through Innovation

Rural and frontier agencies and residents recognize that...

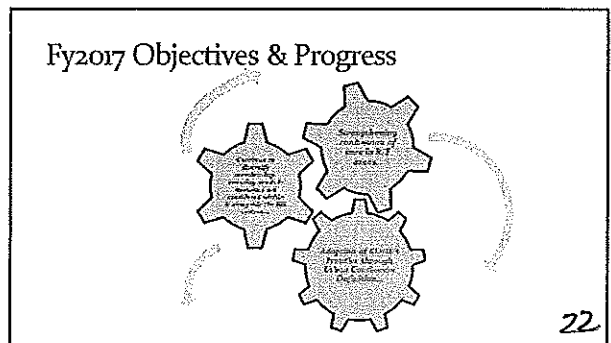
1. collaboration is necessary to address behavioral health barriers
2. necessary partners must be brought to the table

To affect meaningful change across the agency, county, or state...

1. entities must work together creatively
2. a diverse group of stakeholders can implement tangible change
3. needs and resources must be considered from within and alongside the behavioral health system

The Rural and Frontier Subcommittee is a partner in this effort.

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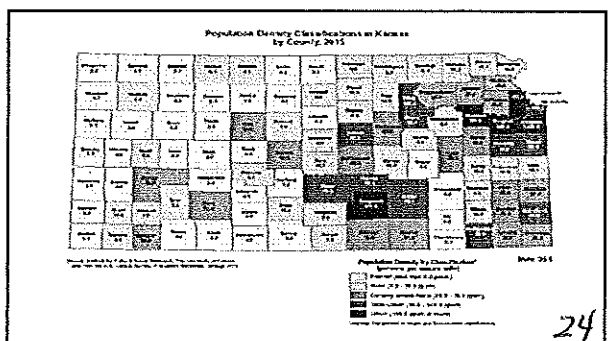


1st Fy2017 Objective

Adoption of KDHE's Frontier through Urban Continuum Definition

PROGRESS:
 Rural and Frontier Subcommittee members continue to share the message and it's importance at every opportunity, with various agencies and in multiple venues. Defining rural is the fundamental cornerstone necessary to build Behavioral Health Equity for all Kansans.

23



2nd Fy2017 Objective

Strengthening the Continuum of Care in R/F areas

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A. Through championing use of televideo technology, and sharing established protocol and resources to support those who need assistance implementing televideo technology and practice.

PROGRESS:
**Established partnership with KU Center for Telemedicine and Telehealth & Heartland Telehealth Resource Center. 12.1.16*
**Plans for Telehealth Survey to explore telehealth as tool for delivering an alternative service. 1.26.17*
**Letter to BSRB re: use of telesupervision for qualified mental health professionals seeking behavioral health independent licensing. 2.27.17*
 "... technology itself is no longer the barrier to use. Perceptions of technology and related local and state legislation and organizational policy are now the more significant barrier." (R/F Subcommittee FY2016 Annual Report pg. 5, 2c)

26

Strengthening the Continuum of Care in R/F areas

B. Through further defining specific transportation challenges for both routine and emergency mental health and Substance Use Diagnosis needs based on current trends and observations.

PROGRESS:
**United Healthcare review of service delivery with member of the community (R/F members Ric Dalke & Geovanni Gone' attended) 1.26.17*

27

C. Through increased funding for crisis beds for the non-insured &/or underinsured to fill the gap in rural and frontier areas of the state.

PROGRESS:
**When opportunity arises, advocate for next crisis center in Western Kansas. Must think about crisis resources beyond crisis beds. More community outreach is always needed. 1.26.17*
**Medicare Provider Panel expansion info to Wes for Aging Subcommittee. i.e. (telehealth services reimbursement issues; higher cost of delivery in rural areas due to lower patient volume; MCO licensing restrictions on providers; increased provider costs due to complex & fragmented funding systems). 3.23.17*
**R/F Member Marilyn Roberts volunteered to join Aging Subcommittee. 3.23.17*

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D. By advocating for adequate resources to meet behavioral health needs of consumers and providers.

PROGRESS:
**Efforts to conduct a R/F Telehealth Use Survey began & are ongoing. 1.26.17*
**Letter to BSRB (with GBHSPC approval) re: telesupervision use with array of barriers agencies and individuals within membership have encountered. 2.27.17*
**Partnered in Children's Mental Health Awareness Day in Ashland. (R/F members Ric Dalke, Vicki Broz, Tabitha Murski, and Renee Geyer attended). 5.4.17*

29


D. By advocating for adequate resources to meet behavioral health needs of consumers and providers continued...

PROGRESS:
**Article "Mental health: the next farm crisis in rural America" regarding Ashland with quotes from R/F members Ric Dalke & Tabitha Murski. 5.9.17*
**SAMHSA "Addressing Rural Homelessness & Behavioral Health Needs" webinar highlighting GBHSPC & R/F function/work 4.24.17 and*
**SAMHSA "Addressing Rural Homelessness & Behavioral Health Needs" community of practice with expanded focus on GBHSPC & R/F history & function 5.4.17 by R/F member Renee Geyer*

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3rd FY2017 Objective

Continue to diversify membership ensuring needs and resources are considered within and alongside the behavioral health system.



PROGRESS: Added stakeholders to Subcommittee... Family Services, Inc.; Kearny County Hospital; KU Center for Telemedicine & Telehealth; Wright Psychological Services; Heartland Resource Center; Behavioral Sciences Regulatory Board

*Telehealth Use Survey & BSRB letter regarding use of telesupervision
*Provided GBHSPC - links & documentation supporting efficacy of electronic supervision for BSRB review; Darkness to Light Training availability through KCSI; Clover House residential home for sex trafficking through SFCS

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Fy2017 Goals & Recommendations

1) *Statewide adoption of KDHE's Frontier Through Urban Continuum Definition by Executive Order.*

We recommend and will continue to work towards collaboration with other Subcommittees to accomplish.

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Fy2017 Goals & Recommendations

2) *Strengthening continuum of care in R/F areas*

Recommendations include...

- Continue to champion use of televideo technology
- BSRB adoption of telesupervision option for licensing
- Address various telehealth reimbursement barriers
- Expand Medicare Provider Panel's use of telehealth

(Above items address shortage of BH provider workforce.)
Advocate for next crisis center in Western Kansas

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Fy2017 Goals & Recommendations

3) *Continue to diversify membership in the subcommittee to ensure that needs and resources are considered within and alongside the behavioral health system.*

Recommend continued collaboration with GBHSPC and organizations across the state; in order to identify and address barriers to Behavioral Equity for all Kansans.

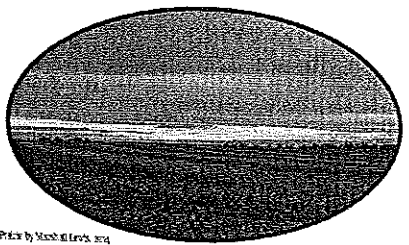
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Rural & Frontier Advocacy

- Because the Governor's Behavioral Health Services Planning Council functions as the Kansas planning and advisory council for the State - it provides this **window of advocacy.**
- Members appreciate and recognize the value of advocacy through the Subcommittee; providing a formal process for making recommendations regarding **behavioral health equity for all Kansans** to the system and acknowledging the uniqueness of frontier and rural issues.

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Thank You!



Source: via the Flickr by NASH 811678, 2014

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Questions?

For more information about the Rural/Frontier
Subcommittee contact...

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rgeyer@compassbh.org

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KANSAS SUICIDE PREVENTION SUBCOMMITTEE
2017 ANNUAL REPORT
Governor's Behavioral Health Services Planning Council

Introduction

This is the final report of the Suicide Prevention Subcommittee, the subcommittee stopped meeting after the formation of the Prevention Subcommittee, and formerly active members of the Suicide Prevention Subcommittee are now members of the Prevention Subcommittee.

In the State of Kansas suicide remains a public behavioral health issue. The number of state suicide incidence is higher than the national goal of 10.2 per 100,000 population.

The Suicide Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council which is comprised of representatives of behavioral health organizations, state agencies, military/veterans organizations, educational institutions, and the community at large, who are dedicated to reducing the frequency of suicide attempts and deaths, and the pain for those affected by suicide deaths, through research projects, educational programs, intervention services, and bereavement services. Over the years, the SPS has met to prioritize goals and activities around transforming policy, programs and services, and funding.

Encouraging state and local activities such as:

- Recognizing suicide as a significant public health problem in Kansas and declare suicide prevention a statewide priority.
- Supporting the development of accessible behavioral health services for all 105 counties of our state, implementing evidence-based and best practice strategies on suicide prevention.
- Acknowledging that no single suicide prevention effort will be sufficient or appropriate for all populations or communities; and
- Encouraging initiatives based on the goals and activities contained in the National Strategy for Suicide Prevention and Zero Suicide of the National Action Alliance for Suicide Prevention.
- Outreach, education and awareness through conferences and workshops to schools and organizations.
- Support implementation of the Kansas Suicide Prevention State Plan.
- Signing of annual Suicide Prevention Proclamations with the Kansas Governor, state and local legislators, and in many city commissions/councils and county commissions across the state.

Mission

To bring Kansans of diverse backgrounds, government and private agencies, health care providers and funders together to share information about suicide risk, attempts, and deaths in Kansas, about evidence-based and promising practices that are employed in the state or nationally, and to stimulate and support the adoption of new initiatives where needed to recognize and reduce suicide risk.

Vision

To create a suicide-free Kansas where quality mental health services are available, trusted, and used when needed, without stigma.

Membership

This subcommittee has been disbanded and no longer has any members.

FY 2017 Highlights, Activities and Goals of Suicide Prevention Subcommittee:

- SPS members have provided training on suicide prevention in state-wide conferences, as well as local communities.
- Several SPS members are active in the American Association of Suicidology and the Zero Suicide Learning Collaborative, to bring the most current understanding of effective suicide prevention to Kansas.
- Recognition of annual National Suicide Prevention Week, with a state proclamation meeting and signing by Governor Brownback.
- Encouraged and increased availability and usage of suicide data from KDHE Vital Statistics.
- Increased awareness on linkage between problem gambling, SUD, and suicide shared risk and protective factors.

The following chart highlights the FY 2017 Goals, Objectives, and Progress of the SPS:

GOAL	ACCOMPLISHMENT
1. Promote Suicide Prevention State Plan.	The state plan developed in 2015 has been published and shared through KDADS, the Suicide Prevention Resource Center, the Kansas Suicide Prevention Resource Center, and made available to prevention coalitions around the state.
2. Provide Suicide Prevention Awareness Presentations at Statewide Conferences and/or Annual Meetings.	Suicide prevention awareness messages have been added to the It Matters campaign materials and suicide prevention has been integrated into the Kansas Prevention Collaborative and PreventionWorKS and PreventionTalks.
3. Create Kansas Suicide over the Lifespan Prevention Resource Center	Headquarters, Inc. is operating a Suicide Prevention Resource Center and it is partially funded through a KDADS Kansas Prevention Collaborative grant.
4. Inform public policy for suicide prevention in Kansas	SPS members participated in Suicide Prevention Week including the SPW Proclamation-Signing with Governor Brownback. Jason Flatt Act went into effect in January, requiring school employees to complete suicide prevention training.

Final Goals and Recommendations

Goal for 2020: Reduce the number of state suicide incidence equal to or below the national goal of 10.2 per 100,000 population, as listed in the Healthy People 2020 Leading Health Indicators.

The SPS recommends the following activities in support this goal:

- Working to promote funding opportunities for suicide prevention.
- Encourage National Suicide Prevention Week activities in communities across Kansas
- Write, distribute and promote op-eds, and disseminate information about safe messaging covering suicide, and urge the development of effective materials, including through local media outlets.
- Encourage the development of new local coalitions and enrichment of collaborating existing local coalitions each bringing unique perspectives and resources for effective suicide prevention initiatives.
- Support and increase availability of support groups for survivors of suicide loss.
- Assist local suicide prevention efforts and promote local support groups in fund-raising efforts, building capacity, and increasing availability for survivors of suicide loss.
- Identify and develop relationships with other high-risk populations as well as rural and frontier geographical areas in Kansas to bring evidence-based and best practices around the state that would benefit from targeted resources being applied to promote suicide prevention and measure for reduction in suicide/suicide attempts at specified intervals.
- Increase number of trainings and workshops, to promote and support application of best practices and evidence-based approaches in the field of suicidology among BSRB licensed behavioral health practitioners and community gatekeepers when working to prevent suicides.
- Increase collaboration with KDADS and KDHE to promote use of evidence-based and best practices where applicable, and work with KDHE and KDADS to disseminate data and act upon measured outcomes from this effort.
- Promote and increase utilization of the National Suicide Prevention Lifeline (NSPL), including the Veterans Crisis Line, across the state, especially in rural areas, in attempt to establish consumer involvement in suicide prevention in those areas.
- Develop a sustainability plan for a cross-lifespans suicide prevention resource center in Kansas.

Summary

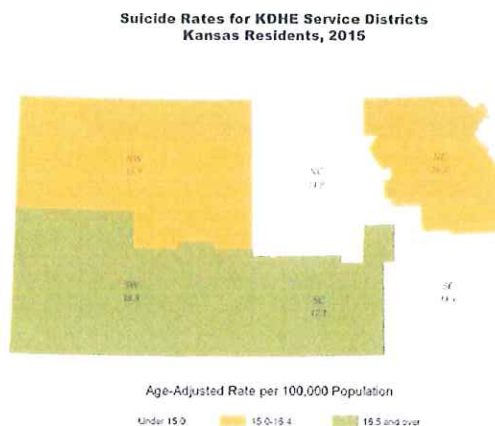
Too many Kansans are lost to suicide each year. The 2015 age-adjusted rate of suicide are above the national target rate of incidence by suicide. A key ingredient critical to the success in reducing suicide in Kansas is collaborative partnerships among key stakeholders to form local planning teams or coalitions of public and private agencies, organizations, and individuals, each bringing unique perspectives and resources at the community level to shape community values and norms for successful suicide prevention initiatives. Everyone has a role in suicide prevention.

Suicide in Kansas, 2015

Final U.S. data for 2014 (the most recent year available) showed suicide was the 10th leading cause of death, responsible for 42,773 deaths [1]. Suicide was also the 10th leading cause of death in Kansas in 2015, responsible for 477 deaths [2]. The Kansas age-adjusted suicide death rate was 16.3 per 100,000 population, which was higher than the goal set by the Healthy People 2020 project, 10.2 suicide deaths per 100,000 population [3].

Kansas Highlights

- There were 477 Kansas resident suicides in 2015, up 6.6 percent from 454 in 2014.
- The age-adjusted suicide death rate for Kansas residents in 2015 was 16.3 deaths per 100,000 population, up 3.8 percent from 15.7 deaths per 100,000 population in 2014.
- In 2015, Southwest Kansas had the highest age-adjusted suicide rate (18.8 deaths per 100,000 population) and Southeast Kansas had the lowest age-adjusted suicide rate (13.4 deaths per 100,000 population). This difference was not statistically significant due to the small number of events.*
- Men are much more likely to die by suicide than women. In 2015 there were 374 Kansas resident male suicide deaths, compared to 103 female suicide deaths. The age-adjusted suicide death rates were 25.9 deaths per 100,000 for Kansas resident males and 7.1 deaths per 100,000 Kansas resident females.
- White non-Hispanics had more suicides (397) than any other Kansas population group in 2015, with an age-adjusted suicide death rate of 17.3 deaths per 100,000 group population. Native American non-Hispanics had the highest age-adjusted suicide rate (25.6 suicide deaths per 100,000 population), but this was not statistically different from the rate for White non-Hispanics, due to the small number of Native American non-Hispanic suicide deaths (6).
- Age-group 25-34 had more suicides than any other age-group (97) in 2015, closely followed by the 45-54 age-group (91). These two age-groups also had the highest age-specific suicide rates (25.0 and 25.2 deaths per 100,000 age-group population, respectively).



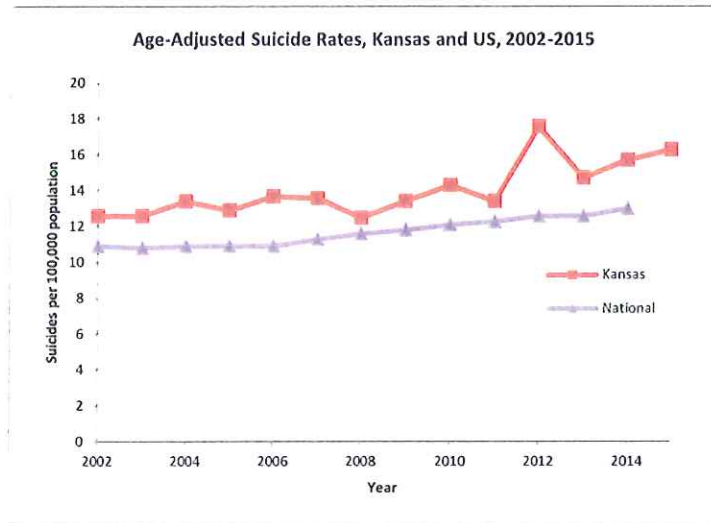
More Kansas Health Statistics and Publications

- For a list of all publications issued by KDHE go to http://www.kdheks.gov/data_reports_stats.htm.
- Visit Kansas Information for Communities (KIC) the department's online data query tool at <http://kic.kdheks.gov>.
- Community Health Needs Assessment information at <http://www.kansashealthmatters.org/>.

- Firearms accounted for a plurality (47.0%) of Kansas resident suicide deaths in 2015, a decline from 52.2 percent of all suicide deaths in 2014. Suffocation, the second most common method of suicide, accounted for 30.8 percent of all suicide deaths in 2015, an increase from 27.1 percent in 2014.

State and National Comparisons

The Kansas suicide rate has been higher than the national rate since 2002. In 2015, the Kansas suicide rate (15.7 suicides per 100,000 population) was 20.8% higher than the national rate (13.0 suicides per 100,000 population). (National data from 2014, the most recent available year.)



Want to know more about suicide?

For information about Kansas suicide prevention programs, visit the webpage of the Injury and Disability Program (part of KDHE's Bureau of Health Promotion), http://www.kdheks.gov/idp/core_injury.html.

For information about suicide prevention counseling services, visit the webpage of Headquarters, Inc., a Law-rence-based suicide prevention counseling center, <http://www.headquarterscounselingcenter.org/>.

Authors: David Oakley, Greg Crawford

* Differences in age-adjusted rates may be assumed to be statistically significant unless it is explicitly stated that they are not.

Acknowledgements: Cathryn Savage

Related References:

[1] Kochanek KD, Murphy SL, Xu J, and Tejada-Vera, B. Deaths: Final Data for 2014. National Vital Statistics Reports; vol 65 no 4. Hyattsville, MD: National Center for Health Statistics. June 30, 2016. Available at <http://www.cdc.gov/nchs/products/nvsr.htm>. Accessed 16 Sept 2016.

[2] Oakley D, Crawford G, Savage C. 2015 Kansas Annual Summary of Vital Statistics. Topeka, KS: Kansas Department of Health and Environment, 2016.

[3] Healthy People 2020 suicide targets available at <http://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives>. Accessed January 9, 2015.

Governor's Behavioral Health Services Planning Council Vocational Subcommittee

2017 Report

Accomplishments

A major strategic goal of the Vocational Sub-Committee (VS) has been to encourage implementation of the Individual Placement and Support (IPS) model of supported employment. Developed and researched through The IPS Employment Center at Rockville institute Westat, this evidence-based model provides successful strategies to empower persons with mental health disabilities to achieve competitive, integrated employment. The Committee is pleased to report the following important initiatives pertaining to this goal that are underway throughout the mental health system:

- Currently there are 12 IPS sites. KDADS is looking into ways to provide ongoing technical assistance and monitoring of fidelity measures to ensure that the quality of these programs supports achievement of the desired outcomes.
- The Kansas Department of Aging and Disability Services (KDADS) received a \$4 million, five-year grant from the US Substance Abuse Mental Health Services Administration (SAMHSA) to expand access and use of the IPS employment services model to individuals with severe mental illness, including those with a co-occurring substance disorder and by employing peers (persons with lived experience) in their IPS teams. With the award of this grant, IPS Supported Employment Services was implemented at two Community Mental Health Centers; Compass Behavioral Health and Comcare of Sedgwick County. Both implementation sites augmented the IPS Supported Employment model by expanding the target population to include uninsured adults with a severe mental illness and those with a co-occurring mental illness and substance use disorder and by employing peers (persons with lived experience) in their IPS teams. Both implementation sites will convene local supported employment steering committees to address barriers for employment services in their communities and to develop resources or collaborations to enhance their services. The Governor's Behavioral Health Services Planning Council Vocational Subcommittee (GMHPSC) also serves as the Supported Employment Coordinating Committee (SECC) for the SAMHSA Grant. This committee coordinates activities across state departments and consults the grantee or statewide infrastructure measures that will promote and sustain supported employment.
- Kansas Rehabilitation Services, the state's vocational rehabilitation program in the Department for Children and Families (DCF), demonstrated support for the priority to implement IPS through its End-Dependence Kansas (EDK) initiative. IPS was included as one of the evidence-based models and promising practices to be implemented through EDK. As of July 2016 community service providers have been awarded contracts to deliver IPS to Vocational Rehabilitation consumers. The goals of End-Dependence Kansas include:
 1. Increased competitive, integrated employment options and outcomes for Kansans with disabilities.
 2. Further development and sustainability of evidence-based employment practices.

3. Collection of the data necessary to establish a sustainable cost structure for VR-funded services that allows services to be maintained after EDK ends and allows provider partners to succeed in the delivery of services.

In addition to DCF, four other state agencies are supporting the implementation of EDK. They are Health and Environment, Commerce, Corrections, and Aging and Disability Services.

- Previously, the Vocational Subcommittee (VS) undertook the task of educating itself on the new Ticket to Work (TTW) Program. We wanted to find the means and methods to make the program more available to community mental health centers and providers serving other disability populations; thereby, potentially adding another funding source.
- The VS was able to educate CMHCs and other service providers about the availability of the Benefits Planning Academies. These Academies are designed to train interested individuals in the various Social Security Administrations work incentives.
- The VS provided information regarding on-line training from Dartmouth as a low-cost option for training vocational and supported employment staff across the state.

2017 and 2018 Goals

Goal #1: Recommend that the State use their KanCare 2.0 renewal application to implement a 1915(i)-“like” waiver to provide employment supports and other services for individuals with behavioral health issues. An 1115 Demonstration Waiver, the federal authority under which KanCare operates, provides states with an opportunity to test whether a program works before making a long term commitment. Including a 1915(i)-“like” pilot as part of KanCare 2.0 would allow the State to test, over a five-year period, whether the supports provided through a 1915(i) result in an increased number of individuals becoming employed and living as independently as possible. If post program evaluation indicates that this pilot was not successful, the State would not have to continue it beyond the five-year demonstration period.

Goal #2: Mental health centers will use available resources to support getting consumers to work.

Recommendation #1: Encourage integration of Peers into employment services at the CMHC’s

Recommendation #2: Statewide educational campaign to dispel the myth of working and losing benefits and decrease the barrier for consumers wanting to work.

Goal #3: The IPS Supported Employment model is the model of choice for the Kansas mental health system and should be made available at every Community Mental Health Center.

Recommendation #1: All CMHC's will use the IPS Principles whether they are an IPS site or not. Any new employment initiative will apply the IPS Principles as listed:

1. Eligibility is based on client choice.
2. IPS supported employment services are closely integrated with mental health treatment services.
3. Competitive jobs are the goal.
4. Employment contact begins rapidly after clients enter the program.
5. Employment specialists build relationships with employers based upon client job interests
6. Job Supports are continuous.
7. Consumer preferences are honored.
8. Benefits planning (work incentives planning) is offered to all clients who receive entitlements.

Recommendation #2: Provide outcome information about CMHCs that implement Supported Employment IPS model. Incentivize the system for better employment outcomes.

- More than 50% of the CMHC's do not offer IPS
- Currently, 40% of the individuals with SPMI do not have access to IPS services.
- 60% of this target population have a desire to work
- 85% of individuals with serious mental illness are unemployed

Recommendation #3: Require CMHC's that do not meet their employment outcome standard implement IPS-SE as part of their performance improvement plan.

Recommendation #4: Require that CMHC's survey consumers a minimum of twice per year to evaluate interest in achieving competitive employment using the Need for Change Scale. Have field staff work with individual Centers.

Recommendation #5: Actively seek out and provide grants to the CMHC's from the State General Funds to offset costs to initiating and implementing IPS services in rural and frontier counties.

Goal #4: Training and collaboration opportunities will be available across the state, to address areas of consistency of services and proper mental health and vocational rehabilitation training for all providers of supported employment services.

Recommendation #1: In SFY 2017, KRS in collaboration with KDADS will seek the participation of one or more community mental health centers to develop and pilot improved referral procedures and documentation, cross-training, and collaborative meetings.

Recommendation #2: Explore mechanisms to improve systems integration of MH & VR that will improve the state's overall goal of implementing IPS statewide.

- Faster referral process
- Increased and timely communication

Goal #5: Increase engagement of stakeholders, consumers, families and employers.

Recommendation #1: KDHE or KDADS require agencies implementing IPS to create opportunities for assertive outreach and engagement for consumers and families.

Recommendation #2 MCO's do more to engage stakeholders with the implementation and sustainability of IPS.

Updated 6/16/2017 MA

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404



www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Gary Parker, Vice Chairperson

Sam Brownback, Governor

August 28, 2017

Tim Keck, Secretary
Kansas Department for Aging and Disability Services
503 S Kansas Avenue
Topeka, KS 66603

Dear Secretary Keck;

In submitting the FFY 2018-19 State of Kansas Combined Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Assessment and Plan, it is required that a letter from the Governor's Behavioral Health Service Planning Council (GBHSPC) be enclosed, including inclusion of comments on the Block Grant application. The GBHSPC did not only review the grant request but was also actively involved in its development.

During the past year, the GBHSPC has continued to focus on ensuring that behavioral health services are integrated and meet the need of children, adults, and their families who are experiencing a mental health, substance use, and co-occurring disorders. GBHSPC members continue to participate in sub-committees and task forces. Currently, the GBHSPC has eight active sub-committees. The sub-committees are: Housing and Homeless, Justice Involved Youth and Adults, Supportive Employment and Vocational Rehabilitation, Prevention, Children's, Rural and Frontier, Veterans, and the Kansas Citizen's Committee on Alcohol and Drugs (KCC). The KCC is a unique Subcommittee in that it is established under its own Kansas statute with the purpose to review the substance use disorders service system in Kansas and advise the Secretary on issues and needs for services. The KCC also reviews the SAPT Block grant and reports recommendations to the Kansas Department for Aging and Disability Services (KDADS).

The GBHSPC membership currently is 62% consumers and family members. The sub-committees represent many consumers, family members, providers, and stakeholders from across the state. The GBHSPC and its subcommittees report recommendations not only to the Secretary of KDADS, but also to other State Agency Secretaries who share populations receiving services. These subcommittee report findings and recommendations continue to have an important role in the evaluating and implementation of behavioral health services for Kansas.

The GBHSPC currently has two active Task Forces in progress, the Adult Continuum of Care, and the Children's Continuum of Care. Their task is to identify the continuum of services and resources for consumers, and identify any gaps/unmet needs. Recommendations will be provided to the Secretary of KDADS, who will also report the recommendations and findings to the Governor and the Kansas Legislature.

The GBHSPC is appreciative of the support provided by your office in the advancement of behavioral health services in Kansas. The caring and professional expertise of KDADS (who provides logistical support for the GBHSPC) continues to be superb and most supportive. The GBHSPC pledges its continued efforts to ensure that Kansas ranks the higher amongst those states that demonstrates effective planning and implementation of community based services for those individuals who experience a behavioral health disorder.

Sincerely,



Sherman Wes Cole

Chair, Governor's Behavioral Health Services Planning Council

cc: Susan Fout, Commissioner, KDADS BHS
Michelle Sweeney, Director, KDADS BHS

GBHSPC Executive meeting, KDADS; New England Building, Topeka, KS January 12, 2016

Start at 10:12 am; End at 11:30 am

Attendance: Wes Cole, Charles Bartlett, Monica Kieffer, Gary Parker, Jane Adams

KDADS Update

- Will schedule orientation for Secretary Tim Keck.
- Will send all meeting dates for the year out to the council

Block Grant update

- There will be increased to the block grant.
- State is preparing for ways for expense those dollars and how people can request them.

Subcommittee/Task Force Updates

- Veterans
 - Sheli Sweeney has added Harold Casey as a co-chair.
 - The Veterans resource website is up. Sheli will continue to work with them on this project. It is searchable and breaks down by county. It is maintained by KDADS.
- NFMH
 - Kathy Keck putting together good information. Will have her come to the next full council meeting and present.
- Continuum of Care
 - Originally met because of Osawatomie overpopulation and diversion.
 - The group was very productive and produced lots of good recommendations
 - Recommending to leadership that they be a part of the council as a task force.

Planning Session

- Want to find ways to share information across the council and subcommittees.
- Want to review materials and reports from the past that may be useful in the current work of the council.
- Fine ways to maintain intellectual history during times of transition.

Agenda

- Kathy Keck will present.
- KDADS Budget update from Bill Rein
- Osawatomie State Hospital update
- Randy Bowman present on the Justice Involved Youth and Adults subcommittee efforts
- Mark Dodd present to Tribal issues.
- Stacy Chamberlain present on the block grant and ways to engage the council.
- Work on the mission and vision.

Respectfully submitted,
Monica Kieffer

GBHSPC meeting: Kansas Housing Resources Corporation January 28, 2016

Start at 9:00 am; End at 3:10 pm

Attendance: Wes Cole, Roxanne Bollin, Mark Dodd, Margie Manning, Sandra Dixon, Al Dorsey, Victor Fitz, Molly Brace, Guy Steier, Fran Seymour-Hunter, Randy Bowman, Rodney Shepherd, Stacy Chamberlain, Alison Allen, Robbin Cole, Jane Adams, Gary Parker, Charles Bartlett, Jim Costello, Kathy Keck, Bill Rein, Viola Riggins, Tim Keck

Phone: Rick Dalke, Nick Reinecker

Welcome: Wes Cole welcomed everyone and introductions were of all those present.

NMFH Workgroup Presentation: Kathy Keck

- The workgroup reviewed how do we approve current process and how do we look at gaps. They looked at the system and how determined way to make it better. The group identified other process crisis services and made specific recommendations. They also started identifying service needs for those who do not need nursing homes. They also looked at co-occurring issues. Lastly, the group increased collaboration between NMFH and the system as a whole and brought them back into the system.
- There are 10 NMFHs currently. Four in Shawnee County. They are licensed and regulated as a nursing facility and have extra licensure for mental health. They are held to the Homestead Act and have a continued stay process.
- Wes Cole stated that he would like this work to continue under the guidance of the council.

Announcements and Council Work Planning: Wes Cole

- Cole said there is a new Interim Secretary Tim Keck
- Randy Bowman presented a letter that was from the Juvenile Justice Workgroup presented to the legislature. The Executive Committee had approved to support the letter.
- Ted Jester, Pam McDiffett and Shelli Sweeney have all resigned their positions.
- The Executive Committee voted to continue the Continuum of Care Workgroup as a task force under the council. Amy Campbell and Randy Dick will co-chair that group.
- Gary Parker said that he had submitted a new SAMHSA application for a consumer network grant for a 3 year project that would be a virtual resource center for young adults. He said he is partnering with Keys for Networking on transitional youth and young adults and Georgia to get technical assistance on developing the resource center.
- There will be an upcoming meeting where subcommittee chairs and liaisons will come together and work with the Executive Committee. A motion was made and passed to break up the reports of the subcommittees to have the Executive Committee and the full council review them. All previous subcommittee reports are available on KDADS website.
- The Executive Committee will be more active in subcommittee reports and pulling the recommendations together into one presentation to the Secretary and other attendees.

Tribal Presentation: Mark Dodd

- Mark Dodd gave a Power Point presentation on the fundamentals of Tribal Sovereignty. He provided information on the sovereignty of the tribes in Kansas.
- He also provided information on programs and initiatives being managed by the tribes.
- He also stated that there may be ways the council and tribes can work together on behavioral health issues in the future.

KDADS Update: Bill Rein

- Bill Rein said that there is nothing to report yet on the budget. The team at KDADS is still working on it.
- He addressed issues at Osawatomie. The state had hoped to be recertified and that did not happen yet. The state has hired a highly qualified specialist to handle the recertification process solely. The state will continue to work on getting recertified. One positive is that there has been increased communication between all areas.
- Tim Keck came in and introduced himself.

Block Grant 101: Stacy Chamberlain

- Stacy Chamberlain provided a Block Grant 101 Power Point Presentation to the council. She has been the Block Grant Coordinator for 12 years.
- With integration of services, the state has started to submit a combined behavioral health application.
- The narratives are based on the strategic initiatives for things that are requested.
- KDADS Administrative Overhead is less than the 5% that is allowed.
- The application was submitted for 9/1 and it should be approved soon.

Approval of the Previous Meeting's Minutes: The minutes were reviewed and a vote was completed to approve the minutes.

Future Meeting Dates for 2016: The full council meeting dates for the 2016 year were set. The executive meeting dates will be approximately one month before the next meeting date. The meeting dates are:

- Thursday, May 12
- Thursday, July 14
- Thursday, September 8
- Thursday, November 10

Next Meeting Dates: March 10, Valeo Behavioral Health Care

Respectfully submitted,
Monica Kieffer

GBHSPC Executive meeting, KDADS; New England Building, Topeka, KS February 10, 2016

Start at 1:00 pm; End at 3:00 pm

Attendance: Sandra Dixon, Al Dorsey, Ric Dalke, Gary Parker, Wes Cole, Monica Kieffer

Discussion of 1/28 Meeting

- Meeting went well.
- Will work to get Megan Bollinger on Children's subcommittee
- Will also work to improve attendance.

Block Grant Process

- The council submitted a letter of support.
- Council would like more regular process and involvement from the subcommittees.
- Liaisons can work to bring more information to the council and the council can provide feedback.
- Hope to ensure that all current programming funded by the block grant is referenced.
- Need to review subcommittee reports and come to consensus on what items to include.
- Investigate where the 5% administrative support is going.
- Need to include more related to youth and children's issues.

To Do

- Review KDADS and BHS budget
- Consider developing a State of the State on Mental Health and Substance Use Disorders
- Ensure that subcommittee reports continue to be posted on the website.

Review of Council Assessment

- Jane and Gary will work on the mission and vision.
- Develop one page guide for subcommittee chairs.
- Will include assessment information as a future meeting topic.

Agenda

- Next meeting is March 10
- Discuss plans for a future meeting of liaisons, chairs and council for some strategic planning and sharing of recommendations.
- Will provide bylaws, statutes, and other information for the council to review as they begin planning work.

Respectfully submitted,
Monica Kieffer

Start at 9:04 am; End at 3:05 pm

Attendance: Wes Cole, Roxanne Bollin, Margie Manning, Al Dorsey, Victor Fitz, Molly Brace, Guy Steier, Fran Seymour-Hunter, Rodney Shepherd, Robbin Cole, Jane Adams, Charles Bartlett, Jim Costello, Teresa Briggs, Nikki Gilliland, Megan Bollinger, Kirk Schottler

Phone: Rick Dalke, Stacey Chamberlain

Welcome/Announcements: Wes Cole

- Bill Rein is Acting Superintendent at Larned State Hospital. Nikki Gilliland is assuming some of Bill's responsibilities. Pam McDiffett has resigned.
- Director of Mental Health position was posted and getting applicants. Some positions will stay vacant until a new director is hired.
- There will be a combined subcommittee chair and liaisons meeting in June.

Council Orientation: Charles Bartlett

- Bartlett presented the orientation. The council has been integrated this council for about 3 years. The orientation contains information on the purpose and work of the council. It also includes membership of the council.

Review of Bylaws & Expectations: Wes Cole

- Cole led group work session on modifications, changes, and updates to the bylaws and expectations.
- Jane Adams will facilitate changes to expectations.
- Cole would like to still review the assessment and the mission and vision.

Community Mental Health Center: Kyle Kessler

- Kyle Kessler, director of the Community Mental Health Center Association, gave the council an update on the work of Community Mental Health Centers and the legislative session related to Mental Health.

Update on Substance Use Data and Block Grants: Stacy Chamberlain

- Stacy Chamberlain said that updates were approved and the report for Substance Use was approved. The report on Mental Health has yet to be approved. They will be posted on the website. The subcommittees will be involved in helping with pieces of the block grant.
- The council has no role in determining how dollars are allocated from the block grant.

Keys for Networking: Jane Adams

- Adams presented on the work that Keys for Networking does. They help families find services and navigate resources. They rely on word of mouth and referrals to support families.

- She walked the group through what families go through when they are trying to get help and access resources.

KDADS Update: Nikki Gilliland

- Gilliland provided the KDADS update. KDADS has not been asked to identify resources for budget cuts. Plan is to continue with current funding and begin planning for FY17.
- Gilliland gave an update on state hospitals. There was additional money added to support higher salaries at the state hospitals. Consultants have been brought in to help with the recertification of Osawatomie.

Approval of the Previous Meeting's Minutes: The minutes were reviewed and a vote was completed to approve the minutes.

Future Meeting Dates for 2016: The full council meeting dates for the 2016 year were set. The executive meeting dates will be approximately one month before the next meeting date. The meeting dates are:

- Thursday, July 14 - Salina
- Thursday, September 8
- Thursday, November 10

Next Meeting Dates: May 12, Valeo Behavioral Health Care

Respectfully submitted,
Monica Kieffer

GBHSPC Executive meeting, KDADS; New England Building, Topeka, KS April 20, 2016

Start at 1:00 pm; End at 3:00 pm

Attendance: Wes Cole, Charles Bartlett, Gary Parker, Al Dorsey, Monica Kieffer, Jane Adams, Rick Dalke

Discussion of the March GBHSPC Meeting

- Will include review of bylaws at a future meeting. Discussion was productive and lots of good suggestions were made.
- Will include new standing agenda item of messages to leadership about issues and concerns. The council will put together a list of items and present those to KDADS leadership in attendance at the meetings. This will be a way to share examples like Robbin Cole's waitlist situation with KDADS.
- Will continue to address vacancies and attendance at each meeting. Will look to reach out to members who have not been attending and include attendance requirements on all meeting invitations.
- KCC has its own statute in regards to membership and organization. This includes a vetting process of membership and nominations. It has been recommended and the executive committee agrees to allow them to keep their current systems.
- Executive committee make-up was assessed and will move forward with the addition of Robbin Cole from Pawnee.

Review of Subcommittee Report Process

- All subcommittees will finalize their reports by 5/20/16.
- Will make their presentations to the council and present their prioritized goals.
- Will ask questions and suggest modifications and ways to reprioritize.

Announcements/To Do

- Invite the Secretary or Commissioner to an upcoming executive meeting.
- Continue to develop position description for liaisons.
- Interviewing for Director position
- Bill Rein is still working at Larned.
- Recommendation will be made for a 50%/50% position for CIT and Veterans work at the state.

Agenda:

- Review the assessment of the council.
- Children's Issues – presented by Jane and consumers. May is Children's Mental Health Month.
- New Juvenile Justice law changes – presented by Randy Bowman
- Want to continue work on mission and vision.

Next Meeting is May 12 at Valeo. June is a special meeting for the subcommittee presentations at Kansas Housing Resources Corporation. July will be in Salina at Central Kansas Foundation. September will be in Dodge City at Compass Behavioral Health. November's meeting is the day before Veterans Day.

Respectfully submitted,
Monica Kieffer

GBHSPC Executive meeting, KDADS; New England Building, Topeka, KS June 16, 2016

Start at 1:00 pm; End at 3:00 pm

Attendance: Wes Cole, Charles Bartlett, Al Dorsey, Monica Kieffer, Jane Adams, Rick Dalke, Robbin Cole, Jane Adams, Sandra Dixon (phone)

Budget Update

- No update because of education funding issues.
- There is a 4% cut to Medicaid. This will have a substantial impact on providers and their budgets. Some will see reductions of \$250,000 – 300,000. This will mean loss of staff and elimination of services.
- There was also the elimination of health homes and reduction in screening dollars. For some providers, all three cuts total \$1 million in lost funding.
- The impact of cuts will be included in the messages to KDADS leadership.

Announcements

- Adult Continuum of Care meeting will be taking place later in the afternoon to finalize the charter and review the initial invitation list. The executive committee reviewed both of these documents. They will be continuing their previous work and will start with reviewing their recommendations going into the next legislative session. The co-chairs will be Amy Campbell and Randy Callstrom.
- There was an expressed need to establish a Children's Continuum of Care group as well in the future.
- Interviews have been completed for the Mental Health Director position but no announcements have been made.

Block Grant

- Stacy Chamberlain came in to speak about the Block Grant. SAMHSA will be holding a block grant meeting in August in DC. Stacy, Wes, and several other KDADS staff will be attendance.
- A process for more formalized involvement will be created for the executive committee to review. This will ensure that all subcommittees have an opportunity to review the appropriate portions and provide feedback in advance.

Data

- Any requests for data from KDADS will be reviewed and handled through legal once the request has been made.

Agenda

- Travel to Salina for a presentation by Central Kansas Foundation
- Afternoon will be at Central Kansas Mental Health Center
- Updates from KDADS
- Present messages to KDADS
- Public Participation

Respectfully submitted,
Monica Kieffer

Start at 9:03 am; End at 2:22 pm

Present: Wes Cole, Charles Bartlett, Mark Dodd, Al Dorsey, Guy Steier, Patrick Hall, Deann Mitchell, Robbin Cole, Peg Spencer, Rodney Shepherd, Victor Fitz, Molly Brace, Jim Costello, Ric Dalke, Margie Manning, Teresa Briggs, Randy Bowman, Allison Allen, Jane Adams, Sandra Dixon, Denise Baynham, Cherie Bledsoe, Gary Parker, Fran Seymour-Hunter

Guests: Tammy Broadbent, Linda Blasi, Cherie Reynolds, Taylor Miller, Bill Rein

Call in: Nick Reinecker

Welcome: Wes Cole welcomed everyone to the meeting. Introductions were made as there were new members present.

Presentation on Children's Issues: Jane Adams

- Adams brought in two presentations related to Children's Issues and the work of Keys for Networking. Cherie Reynolds told the council about her son Jacob and the types of services and supports Keys was able to direct her towards. Adams read the testimony provided Taylor Miller about her experience related to children's services and her siblings.

SB 367: Randy Bowman

- Randy Bowman gave the council an overview of the Juvenile Justice Policy Changes in SB 367.
- The bill included the following steps:
 - Establishing Juvenile Justice Oversight Committee (JJOC)
 - Creates the Juvenile Justice Improvement Fund and modifies other statutes which direct funding to Boards of County Commissions
 - Provides Direction for Office of Judicial Administration, Kansas Department of Corrections, Attorney General, and State Board of Education to develop training for stakeholders
 - Repurposes State investment in local detention operations to alternatives to detention
 - Expands local juvenile corrections advisory boards (add Defense) and amends purpose to include support of juvenile code goals, coordination with JJOC, and to inventory services in community
 - Amends waivers to adult and how youth are assigned for supervision to then be supervised by assess risk level

Announcements/Officer Elections: Wes Cole

- Cole provided updates and announcements. The Continuum of Care group will continue as a subcommittee of the council. There will be a Continuum of Care group for children's issues as well.
- Subcommittee reports to the council will be on June 21st. The meeting will be strictly to review the reports and give feedback. It will also be to prioritize their goals and find ways the subcommittees can work together.

- The meeting that would include liaisons and chairs of the subcommittees will be delayed until all subcommittees have liaisons and chair positions filled.
- Dr. Michael Leeson with the VA has resigned his position with the council.
- Gary Parker said that the Recovery Conference was taking place 6/14 and 6/15. Registration information was available at cac.org.
- Guy Steier nominated and Mark Dodd seconded the nomination of Gary Parker to continue as Vice-Chair. Parker accepted and no other nominations were made. Parker will retain the position.
- Cole stated that the council would be working on the document of information, questions, concerns, and updates that will be sent to KDADS. Robbin Cole provided information on one particular instance of someone on the waitlist for services and the efforts to ensure they received services. These included holding the individual at the county hospital, onsite Pawnee psychological staff, and constant law enforcement monitoring for a week before they were admitted to Osawatomie State Hospital. Wes Cole stated this is the type of information to include in the information sent to KDADS leadership.

KDADS Update: Bill Rein

- No additional information related to the budget as it is pending legislative work related to education funding.
- Staffing at the state hospitals remains an issue and top priority. Work continues to be done to attract staff and mental health professionals to the vacant positions.
- Dr. Mike Dixon is now administrative head and clinical director of the sexual predator program at Larned. Currently there are 258 individuals in the program.
- The wait list and moratorium means that all individuals needing admission and every mental health center are treated the same. The state is working through the waitlist the best they can.
- Doug Wallace has left his position with the state.
- The mental health director is still vacant and Rein hopes to fill the position soon.
- It is the time of year when grants and contracts are due and preparations are underway to get those out.

Approval of the Previous Meeting's Minutes/Bylaws: The minutes were reviewed and a vote was completed to approve the minutes. The revised bylaws were reviewed and a vote was completed to approve the revised bylaws.

Future Meeting Dates for 2016: The full council meeting dates for the 2016 year were set. The executive meeting dates will be approximately one month before the next meeting date. The meeting dates are:

- Thursday, July 14 – Salina – Central Kansas Foundation
- Thursday, September 8 – Dodge City
- Thursday, November 10 - TBD

Next Meeting Dates: July 14 – Salina – Central Kansas Foundation

Respectfully submitted,
Monica Kieffer



Sherman "Wes" Cole, Chairperson
Gary Parker, Vice Chairperson

Sam Brownback, Governor

Governors Behavioral Health Service Planning Council Minutes for meeting on February 15, 2017

In Attendance: Charles Bartlett, Mark Dodd, Randy Bowman, Diana Marsh, Victor Fitz, Jim Costello, Al Dorsey, Ric Dalke, Teresa Briggs, Cathy Ramshaw, Margie Manning, Peg Spencer, Gary Parker, Wes Cole, Deann Mitchell, Fran Seymour-Hunter, Jane Adams, Robbin Cole

On the Phone: Molly Brace

Guests: Kimberly Reynolds (KDADS BHS), Linda Blasi (KDADS), Reyne Kenton (Kansa Board of Pharmacy), Alexandra Blasi (Kansas Board of Pharmacy), Nick Reinecker (Citizen), Brad Ridley (KDADS), Susan Fout (KDADS), Chris Bush (KDADS), Randy Callstrom (Wyandot BHC), Amy Campbell (MH Coalition)

Meeting called to order at 9am

- Prescription drug tracking (KTRACS) presentation (Alexandra Blasi, Executive Secretary, Kansas Board of Pharmacy)
 - State of Kansas' prescription drug monitoring program
 - Kansas one of the first states to utilize a programs like this (2008)
 - Started collecting data in 2010
 - Monitors schedule 2-4 controlled substances and drugs of concern dispensed to Kansans
 - Web-based, available 24/7
 - Goals
 - Education/info, public health initiatives, drug abuse prevention, early intervention
 - Why is there an epidemic?
 - 10 mil Americans aged 12-49 over 5 yrs initiated non-medical use
 - 3.6% of these transfer to heroin
 - 80% of heroin users started with prescription opioids
 - has an advisory council that meet quarterly
 - Membership: Law Enforcement, schools of pharmacy, dentist, APRN, KBI, licensed physicians, education, Kansas Hospital Association
 - Authorized to review and utilize data, notify law enforcement, notify prescribers or dispensers who prescribed/dispensed, utilize volunteer peer review committees to create standards
 - Shall work with agencies with oversight, KBA, KBI
 - What is suspicious behavior? (MD) – patterns of prescription/dispensing, will make recommendations to disciplinary panel (BOHA)
 - 49 states have a program like this (not Missouri, thinks it's an abridgement of privacy rights; Missouri counties are trying to implement county-by-county approach)
 - 30 states require registration

- 36 require prescribers to access the PDMP in certain circumstances (varies state by state; we don't mandate)
- Interconnect lets us connect to 25 other states. Workings to connect with other states. 3 states are not in interconnect.
- Steady increase in number of providers actually using program.
- Pharmacists have a higher willingness to use. About 58% of those registered pharmacists are using, 36% of prescribers.
- Who reports?
 - Outpatient dispensers/pharmacists – person who delivers to an end user.
 - Hospital pharmacies, vets, medical care facilities, exempt prescribers are not required.
- Dispenser
 - Report daily, electronically
- Mark – since tribe facilities aren't technically in the state, do they participate?
 - Yes, they are required by CARA to register, many have already signed up for KTRAC. Do not have state-level MOU but may have federal.
- Peg - are patients notified?
 - No. If pharmacy uses KTRACS to query, they are required to post a sign indicating this. Most pharmacies have at least one pharmacist who is interacting with KTRACS daily
- Mark – how does this jive with 4th amendment?
 - Still confidential, protected, and private. Just another electronic record system interconnected throughout the state.
 - When you get into non-medical, then you run into needing court orders, subpoenas, search warrants, or valid investigation. And they have to show us an active case number. Data not available to those involved in civil proceedings. Patient can choose to disclose by signing a form (Notarized)
 - What is the process?
 - Have to supply their information, their employers, their credentials
- What constitutes a drug of concern is based on statute
 - Regs outline what is a drug of concern
 - Any product containing ephedrine, pseudoephedrine, and promethazine with codeine
 - Stakeholders will be notified by board if drug is to be added
 - Kansas doesn't track schedule 5
- Data is confidential and de-identified data may be provided for reports
- Exceptions
 - KDHE for Medicaid fraud
 - Boards of
 - Healing arts
 - Nursing
 - Optometry
 - Law enforcement
 - Patients
 - KTRACS personnel
 - Exempted from FOIA requests
- Budget – mainly software; also salaries/benefits, travel, printing/postage
 - Ran out of grant funding
 - Entered into cooperative agreement to share cost through 18/19 to provide time to look into a long-term funding solution.
 - Other states level fees. By law Kansas is not allowed. 22 states have an additional licensing fee
 - No SGF
- Has a CDC grant through KDHE
 - Reducing barriers to registration
 - Increase numbers of prescribers
 - Increase frequency and availability of unsolicited reports

- Ensure KTRACS data is available and useful
 - Develop integration projects.
- 5/5/90 rule – 5 prescribers at 5 different pharmacies in a 90 day period (172 people met this threshold in 4q16)
 - these individuals can be referred to a local law enforcement, KBI, or DEA.
- Looking for ways to provide more helpful analytical tools
- Neonatal abstinence syndrome – a new concern. Learning how to better inform practitioners.
 - Pediatricians maybe not thinking they need to participate because they don't see clients who can abuse these medications.
 - Should be checking even if you aren't prescribing the patient these meds at the time.
- Teresa – how do you fight over prescription (prescribing more of a medication than are needed)?
 - Some states are trying to regulate number of pills, that the initial prescription is smaller then they have to come back.
 - Mark – do we really want to have a board providing cookie cutter responses for doctor/patient interaction? Shouldn't it be more case-by-case?
 - CDC has just provided new guidelines.
 - Having insurance companies cap provider incentives?
 - Only helps if the patient uses insurance
 - Should big pharma play a bigger role? Claim they're helping, but also producing more opioids now than at any other time in history.
 - Reyne recommends Dreamland: The True Tale of America's Opiate Epidemic by Sam Quinones – how the opioid/heroin epidemic came to be.
 - Professional “shoppers” shop every 3 days: hit the insurance company for a 30 day supply, then pay cash.
- Sending threshold letters to prescribers, can result in a patient being dismissed from practice.
- Females 25-44 were more often the higher “utilizers”
 - More depression/anxiety
 - Send females because they're less likely told 'no'
 - 3/4ths of the mpe prescriptions are opioids (also some benzos and amphetamines)
 - More likely to have benzo/opioid overlap
- No current plan to integrate with the Kansas Health Information Network (KHIN), due to cost/difficulty with compatibility.
- TBI presentation (Kim Reynolds, SUD/Block Grant Coordinator, KDADS Behavioral Health Services)
 - Definitions vary
 - Kansas definition of TBI for waiver – injury to the brain caused by external physical force. Care about the cause, not the effects
 - Different than an Acquired brain injury – stroke, tumor, etc. – which is not covered under the Kansas TBI waiver
 - TBI in Kansas
 - 585 TBI related deaths – suicide-related, unintentional falls, motor vehicle, homicide, other
 - 2634 hospitalized – unintentional falls #1
 - 16800 ER treatments
 - Demographics
 - highest number 65 yrs plus
 - ER-related visits most common among 14 and younger
 - Fire arms associated with 40% of deaths, 1.2% of hospitalizations
 - Higher among men
 - TBI and Behavioral Health
 - Danish study of 1.4 million people with lifetime TBI (1977-2000)
 - 65% < likely than the general population to be diagnosed after with schizophrenia
 - 59 < likely to be diagnosed with depression
 - 28% more likely to be diagnosed bpd
 - Greatest risk within first year, risk still significant after 15 yrs

- These individuals did not have signs of MH before TBI
 - Canadian study of 7th-12th graders
 - Kids who reported a TBI are significantly higher:
 - Suicide attempts/ideation
 - Crisis counseling
 - Sold marijuana
 - In a study of 27 SUD treatment facilities in New York City:
 - TBI have younger first use
 - Have a MH diagnosis
 - And be hospitalized for it.
 - Almost half are legally intoxicated at time of TBI
 - 10-20% with TBI develop SUD after injury
- TBI waiver
 - Kansas is one of only a few states with one.
 - 723 potential participants
 - 460 on any given month with open slots
 - Be a KS resident over 65 or under 16 and be accessed at ADRC.
 - Be Medicaid eligible
 - Be in need of rehab services
 - Have medical documentation
 - Have a capacity to make progress
 - It is time limited (4 yrs)
 - The goal is to be transitioned off this waiver
 - Services provided
 - Therapies – speech, occupational, physical, behavior, cognitive, transitional living skills (must receive at least one)
 - Personal care and enhanced care services
 - Home-delivered meals
 - Medication reminders
 - PERS – personal emergency response system
 - Assistive services
 - One of the challenges is finding providers willing to work with this individuals/are available in the area (esp. bad in rural areas)
 - Research shows there is a window where people can fully/mostly reacquire their
- TBIRF – TBI Rehab Facility
 - Inpatient level supports
 - 6mos-1, 1.5 yrs
 - Medicaid eligible who community really can't help (tech needs)
 - 1 in the state (Meadowbrook)
 - Must be approved by TBI manager
 - Less than 50 people at any given time
- Why she wanted to talk to us
 - Had a client in Larned who was receiving MH services but may have been on TBI waiver before.
 - When Kim looked him up, discovered he qualified for TBI and IDD.
 - Started to wonder how we can get people identified and hooked up with these supports before they leave the hospital
 - Redone intake to make sure they can identify individuals with TBI early on so that we can start having the conversations as early as possible.
 - Inform MCO, reinstate Medicaid, find providers, get SSI/SSDI reinstated.
 - Have been discovering that there are more individuals with TBI/IDD in the state hospitals.
 - Mark – would love some more information about what is being asked, who is being talked to, to get some more feedback.
 - Want this to be more of a part of a standardized discharge/intake

- TBI waiver does not have a time limit for when the TBI occurred versus when they apply.
 - Is there education to the MH centers to identify potential TBI in foster kids/kids who suffered trauma so they can get hooked up with these services?
 - Working on getting the systems to talk more so that we can figure out what needs to be done to serve these people better, regardless of “silos”.
 - Why do we have different waivers?
 - Medicaid/Medicare/CMS/federal rules.
 - How do we (@the state level) coordinate better within the rules the feds give us?
 - Does the rewrite of the 1915(c) address this? (Waiver reapplication process still ongoing)
 - Shouldn't we care about a correct diagnosis? Why are we only focusing on the psychological trauma without potentially looking for the potential for other issues (IDD, TBI)?
 - Groups currently discussing the concept of early intervention/diagnosis – DCF high risk users, KDHE
 - Can we get someone from these groups to come and talk to us?
 - Schools no longer working to help kids get identified/diagnosed?
 - We're forming task forces and groups but we're not listening to the families/consumers who are dealing with this every single day.
 - We need adequate screening processes.
 - Gary – we don't listen to the consumer/families. We determine that they're broken and don't build on the strengths. Stop identify what is wrong with us. We have needs but we're not broken.
 - How you're “broken” is how they determine who pays for your services.
 - Struggling with adults who had issues as children that were never identified and not documented.
 - Disparity between health diagnosing and MH/behavior diagnosing and how people react to those diagnoses.
 - If we don't have money, we need to figure out how to reallocate the money so we CAN.
 - Charley – shift of licensing to a different commission should free us up to get more into these systemic/programmatic issues.
- Council Business
 - Announcements and meeting dates
 - 3rd Wednesday of the month every other month – February, April, June, August, October, December
 - Moved and seconded and carried.
 - Discussion on integration strategies
 - Exec committee concerned of integration of SUD
 - Brought by the ACC report's majority focus on MH, not SUD
 - Have experts on the council who could be involved
 - Propose that second charge of ACC TF be SUD, but also likely the adolescent populations (16 and up) and then report to the Secretaries.
 - Placing the task force under the council gives us the opportunity to task them with additional tasks.
 - Also moving forward with a children's continuum.
 - Considered having it under the children's subcommittee, but they are already focused on other projects.
 - Released a school MH manual
 - SOC grant and the council's involvement

- Federal grants (SAMHSA) frequently ask for an oversight committee’s involvement
 - 4 CMHCs, KDADS, WSU collaborating on children’s SOC grant.
- Wanting to provide a permanent infrastructure for these grant committees in the future.
 - Same structure could work for block grant oversight/monitoring
 - The subcommittee that represents the topic area will be selected to assign participants and/or consultants. KDADS subcommittee liaison will work with the subcommittee, the chair, and the staff liaison, the identified member of the GBHSPC advisory board, the grant coordinator, and the designated rep from the subcommittee to develop the members of the workgroup and provide logistical support.
 - Ric says the other CMHCs involved are onboard. Has KDADS and SAMHSA buy-in.
 - Will provide communication with the Council and from the council with the oversight group.
 - Motioned and seconded.
 - Motion carried unanimously
 - Will need to make sure all the subcommittees have Council membership/liaisons.
- Aging subcommittee
 - Contacted by Secretary Keck
 - Rolled the former Aging subcommittee into the statewide group
 - The big movers on the group have left the coalition and it’s gone dormant.
 - Also received a request from the KanCare Subcommittee regarding their aging group (objective #3)
 - Supposed to report to the council/subcommittee
 - No family/consumer involvement on current group
 - Sent them copies of former subcommittee reports
 - Executive committee recommends relaunching the subcommittee
 - Steve Denny is willing to help
 - KDADS Commissioner on aging has offered to be the liaison to the subcommittee
 - Motioned and seconded
 - Motion carried unanimously
- United MCO brainstorming session (rural/frontier focus)
 - Ric, Wes, and Stephanie Salisbury attended
 - Didn’t raise any new issues – all things that have been discussed before
 - Felt like a Topeka-focused discussion about rural Kansas.
 - Majority of counties here are rural/frontier by definition.
- Subcommittee Liaison Changes

Subcommittee	KDADS Liaison	Council Representative
Kansas Citizen’s Committee	Kimberly Reynolds	Victor Fitz
Rural & Frontier	Chris Bush	Ric Dalke
Veterans	Ron Jeanneret	Jim Costello
Children’s	Linda Blasi	Jane Adams
Vocational Rehabilitation	Missy Bogart-Starkey	Peg Spencer
Housing & Homelessness	Korrie Snell	Al Dorsey
Justice-Involved Youth & Adults	Charley Bartlett	Randy Bowman
Prevention	Sarah Fischer	Teresa Briggs
○ Suicide Task Force	Kimi Gardner	Deann Mitchell
Aging Subcommittee	Craig Kaberline	

- Will do an orientation within a week or so.
- Put together a new scope of work for liaisons and support
- Kansas suicide prevention check off
 - Andy brown (prevention group)
 - The act will provide a checkoff on the taxes to give \$5 to suicide helpline
 - Fundraised half of the money they needed to stay funded, KDADS provided other half

- Strike Out Stigma/CAC Bowling Charity event to fundraise for CAC
 - April 8th, in Wichita (The Alley Indoor entertainment Center)
- Recovery conference
 - Recovery conference will be held June 13th and 14th, 2017, in Park City.
 - Cost of attendance has been raised from \$45 to \$100 for consumers, due to no state funding for the conference.
- KDADS update and budget report
 - Budget (Brad Ridley, KDADS Director of Operations/FISC Commissioner)
 - KDADS FY17-FY18 budget will see a big difference. It is not a decrease, just KDADS Medicaid money moving to KDHE to align Medicaid moneys into one account.
 - Enhancements – \$4 mil for diversion in FY18 and FY19
 - KDADS Administrative Decrease – increasing shrinkage rate (\$270,000)
 - Enhancement of \$9 mil to OSH related to decertification and backfilling loss of federal money
 - \$6.5 mil for LSH for settlement for disproportionate share funds with CMS and lower revenue from Medicare/Medicaid
 - Otherwise, pretty flat for the agency.
 - 4% Medicaid reduction
 - Brad doesn't have specifics (in KDHE) but governor's budget has plan to restore. Will be hearings on this.
 - Is hospital budget the same as last year, or new?
 - Enhancements for current fiscal year. Budget assumes we will be recertified, then we would have the Medicare/Medicaid revenue coming back in (brad can get the exact figure of how much revenue was lost exactly to Wes. It impacted somewhere around \$1 mil a month fiscally)
 - Is RSI funded in the budget? How about ComCare's Crisis Stabilization Unit?
 - RSI – budgeted 3.14 mil through June '18, continuation, not new money, can double-check info to get exact date
 - *This question was also asked to Randy Callstrom during his ACC Report presentation and he supplied the following information:*
 - *According to Randy, funding is \$3.5 million (equal to the operating costs the last year of Rainbow Mental Health Facility was operational), originally ended June '17 but has been extended through extend to June '18*
 - *Margie – Will RSI be looking for new space/funds for new location? Doesn't KU own the building?*
 - *Started in old rainbow building, which was sold to KU in December of the first year.*
 - *KU had to let them use the building through June '17.*
 - *Working with them to extend lease, commitment in writing*
 - ComCare totaled 1.4 mil since July '14, ending June '17. ComCare was special funding and is not in base budget
 - Legislature has not recommended any additional cuts
 - Senate ways and means – HCBS funding (not SED) previously enhanced funding from consensus caseload, but some viewed it as an increase when it was really a reallocation
 - There is no indication that there is any financial impact currently related to the CAP from CMS
 - Commissioner Update (Susan Fout, Behavioral Health Services Commissioner)
 - Staffing changes in the commission
 - CIT/VA Coordinator – Ron Jeanneret
 - Block Grant Manager/SUD Director – Kimberly Reynolds
 - SOC Grant Coordinator – Kelsee Torrez
 - Housing and homeless coordinator – an offer has been made to a candidate
 - Adult consumer affairs – have a candidate
 - Director – will start in March?

- Received the okay to add another position that is a children's position, posted by next week, changing the PD some from when Pam McDiffett was here.
- Working on continued collaboration between HCBS/BH, meeting jointly on a monthly basis.
- SMHH
 - Waiting on certification at OSH; still recruiting to fill staff
- Legislation
 - HB2240, 72 hour hold/Crisis Intervention Act (CIA)
 - being heard today in the judiciary committee
 - Likely will be opposition, although bill has lots of protections built in.
 - No appropriation/funding attached (possible source of opposition)
 - Discusses licensing/regulation (by KDADS) which would take time/staff.
 - SB195, Bill to suspend Medicaid eligibility – instead of losing eligibility when you go into a hospital, allow it to be suspended instead. As soon as KDHE is notified of discharge, would reinstate eligibility.
 - Council supports suspension
 - Opposition would be financially-based
 - Concern about time limits because of SSI/SSDI
- Visited with SMHH and CROs to start discussion of how to get CROs working with patients and the CMHC liaison at the hospitals to ensure the patient knows what is available and that there are supports in the community.
 - Issues between CROs/CMHCs, working with a different CRO.
 - Looking into a similar relationship with NFMHs
 - We know looking at MDS data that there are potentially people in NFMHs that could be served elsewhere.
- SOC grant – Kelsee is getting up to date and hit the ground running
- Opioid grant due Friday
 - SAMHSA grant – awarding 38 or so
 - Targeted to areas with biggest problems (we're not #1 but we're gaining)
 - Focused on what state thinks is their need
 - Focusing ours regionally:
 - Medication Assisted Treatment
 - Targeted populations
 - Would then go out in RFPs to the regions, write RFP and work with partners/systems in region to find the model that works best, focused on sustainability.
 - They are pretty open with what they are allowing people to do with the grant funding.
 - Get creative, we'll work with you.
 - By working regionally, it allows the region to decide best what works for them/what their need is.
 - Has prevention and education portions as well.
- Visited half of CMHCs, finishing the rest in March.
- Spoken to CMHCs that deal a lot with children to see what would be the most helpful ways the new children's position could be used.
- Crisis centers
 - Would like to see some community buy-in for those services. It's a benefit and shouldn't be lost.
 - Has law enforcement and hospital impact
- Licensing transition
 - Codi Thurness Commissioner
 - NFs, NFMHs, Adult Care Homes, DD licensing and Waiver Quality Assurance, BH Licensing
 - Heard rumor about going to every two years; not true.

- Will not be in the facility every month; go in annually
 - Less micro-managing
 - Be the regulatory arm, keep program issues to program staff.
 - Focus on regs
 - Process is still being worked out
 - Ric would still like a single license for MH/SUD
 - Codi's goal is for all BH staff to be able to do all the BH licensing.
- Secure Beds
 - For people picked up by law enforcement or at hospital so they could be treated in the community and diverted from SMHH
 - Looked at sites in Shawnee, talked to other counties
 - Similar to rainbow, but longer-term, licensed like a hospital
 - Secure place to keep involuntarily committed people while waiting for a bed, might be diverted (go voluntary, be diverted back into community.)
 - RSI/Crisis Center is voluntary
 - Not tied into the 72-hour hold legislation, but those locations are likely where someone going under a 72-hour hold might go.
 - Would have to be 24/7 staffed
 - Funding discussion still ongoing. Communities having those discussions too. Looking at the options and requirements.
 - Nothing in stone at this point, but a lot of discussion going on.
 - Ric – if we could replicate RSI statewide, we'd be in pretty good shape
- Adult Continuum of Care Task Force report
 - Addendum to 2015 report; doesn't replace it, is an edition to it.
 - The council requested this continuation
 - Met twice a month from July-November
 - Diverse group of members
 - Priority recommendations:
 - Restore capacity at OSH (Immediately if possible)
 - Enhance Continuum of Care and provide State Hospital alternatives
 - Improve quality of care of consumers
 - Restore peer support training
 - No opportunity taken in the year between the two reports to enhance the system with the recommendations (especially the OSH beds)
 - 70% of those accessing SMHH have no Medicaid or private insurance
 - Cost from those in ER and law enforcement involvement
 - Moratorium means people in crisis must wait for treatment
 - Law enforcement impact due to number of people waiting in jails
 - Secretary shared all the efforts being done to recertify OSH
 - Challenges remain – upgrade facilities and meet staffing goals.
 - Must implement regulations and funding to incentivize options to enhance the system and availability of care
 - TF did not review or provide input into privatization RFP and does not support it.
 - Role of the state hospitals
 - Other states (Arizona) have county beds as well as state beds – and the state beds are fewer.
 - Committee feels the role should provide public safety; that hospitalization should be used for intensive treatment only and should not be limited to involuntary or by pay source.
 - Should be for crisis stabilization or longer-term stabilization
 - Recommendations
 - Maintain current funding (this was made before the 4% reduction was announced)
 - Reinstate funding for crisis stabilization units
 - House Bill 2240 – the crisis intervention act

- Had a great presentation on how Missouri funds supported housing/residential programs/intensive outpatient services.
 - Tiered approach to level of care, per diem reimbursement rate to provide Supported Housing at a round-the-clock basis. (Kansas has a 1-1 fee for service approach)
 - Valeo transition bed project taking hard to place individuals and doing intensive wraparound
- Social detox
- Access to medication management
- Recommendations from the NFMH workgroup are supported by the ACC TF
- Report lists several concerns the committee has about the potential for privatization, based on information available at the time.
 - Wes – committee’s main concern with privatization is who will oversee it. Where is the oversight?
- Interested in continuing their work and working with the administration to implement some of the recommendations.
- Jane – will you please consider taking on grandparents/parents raising children who need as much help as the children do in any future discussion of service gaps? Need to approach things at a family level, not just an individual level.
- Amy – report being used to support other initiatives at the capitol.
 - Agency budget suggestions included enhancements based on the report. Governor did not fund it with his budget. Amy and other advocates are pushing the idea that these things should be funded.
 - Ensuring this serves as something that reminds legislators about what is important.
 - Focus seems to currently be on bolstering community services, restoring the 4% reduction, the CIA (72-hour hold), state hospital beds.
 - Hopes we can start targeting our reports (task forces, subcommittees) to ensure they are effective.
 - Rural and frontier subcommittee does this to a degree with their Legislative Day Out
 - (Amy – then follow up the next day with “now how do we move forward?”)
 - Coalition’s role is to turn consensus into policy.
 - Ric is seeing more comprehension among the legislators of BH issues (even if the next statement is “but we don’t have the money to do anything about it.”)
 - Amy – association has done its job to groom/train allies.
 - More community-focused legislators
 - Have people who are physicians, people in the social service field, direct care experience seated in the chambers now.
 - More open feel to the interactions between the legislators.
- Robbin – we do need to honor the work of those who put in the work on these reports, and I hear you say there are some changes in mindset in the legislature, but wondering if, going back to when the initial report was released, if there are any recommendations out of that original report that we’ve seen actual change on? Or are we still working on seeing any real change?
 - Amy – most tangible change came from agency leadership and the understanding of/interest in the continuum. We had legislators interested but they were so locked down by their inability to do anything that we were unable to see any real momentum. Members of the tf that were in the original group were really disappointed in the lack of progress, and that we had actually lost things. Was all of it KDADS fault? No. But there were somethings that were the agency’s decisions. Think there were some gains made, even if we didn’t get any new resources added to the system.
 - Randy – agency has attempted to make improvements – ComCare CSU, the Valeo crisis unit, conversations of expanding the model. What is missing is the additional funding resources to develop/maintain.
 - Robbin – it’s really been a short period of time, so it may be too soon to be too disappointed.

- Randy – I think with this group’s support and the support of the secretaries, we can get some traction.
- Public participation
 - None
- Next meeting on April 19th, KHRC, 9-3.
- Move to adjourn, seconded

Adjourned at 2:43.

**Governors Behavioral Health Service Planning Council
Agenda for April 19, 2017**

Kansas Housing, 611 S. Kansas Avenue | Suite 300 | Topeka, KS 66603

Conference Call line: (866) 620-7326

Conference Code: 2451197599

Present: Jane Adams, Teresa Briggs, Deann Mitchell, Al Dorsey, Denise Baynham, Margie Manning, Rodney Shepherd, Jim Costello, Robbin Cole, Victor Fitz, Sandra Dixon, Ric Dalke, Kirk Schottler, Guy Steier, Patrick Hall, Mark Dodd, Cathy Ramshaw, Charles Bartlett, Gary Parker,

Guests: Ron Jeanneret, Carrie Billbe, Penny Hodgekiss. Charlotte Morrison, Kelsea Torrez, Chris Brown, Cissy McKinzie,

On the Phone: Peg Spencer, Randy Bowman,

Block Grant Public Comment Guests: Audrey Gieske (Crosswinds), Heather Elliot (Association of Community Mental Health Centers), Stacy Kratz (Crawford County MHC), Larry Montgomery (KDADS), Leslie Sewester (A Connecting Pointe), Fran Avery (Beacon), Kris Carnahan (Heartland RADAC), Stuart Little (Kansas Association of Addiction Professionals), Rev. Charles Davis, Jimmie Phox, Randy George, Toyaun Withers (TVI)

- Introductions/Announcements
 - Wes is in the hospital. Taken to Olathe medical center yesterday, put in a temp pacemaker. Today he is in ICU. Charley will update as he knows more.
 - Gary's Resignation
 - Will be retiring as of June 30th, moving to Denver
 - Also retiring as executive director of the Kansas Consumer Advisory Council.
 - Will hopefully do something special for him at the June meeting.
 - Recovery Conference
 - Recovery conference will be held June 13th and 14th, 2017, in Park City.
 - Cost of attendance has been raised from \$45 to \$100 for consumers, due to no state funding for the conference.
 - Will send out brochure with minutes to Council.
- Human Trafficking Presentations, *Allison Farres and Kalynn Cheney, Wichita State University Center for Combating Human Trafficking; Mel Miller-Garrett who is our Clover House Director of Saint Francis Community Services; Deb Kluttz Executive Director of The Homestead*
 - Center for Combating Human Trafficking
 - Human trafficking is a sensitive topic connected to delicate issues, if you become uncomfortable feel free to step outside.

- The presenters took a moment to find out a little about the group, including who has received human trafficking training before, who works in rural areas, what agencies/populations are represented, what experience people may have with human trafficking, and what they hope to learn from this presentation.
- Who is CCHT?
 - Survivor-founded, led, and operated, more than 100 yrs of direct service.
 - Dr. Karen Countryman-Roswurm: survivor and treatment provider
 - Vision: all communities empowered and equipped to effectively prevent and or intervene
 - Mission
 - Direct service facilitation: prevention for prosperity, pathway to prosperity, victim to vitality, victim-centered/survivor-led staffings, referrals, brokering of community resources, advocacy and support services
 - Pathway to Prosperity
 - 2 paid survivor internships a year, receive a scholarship to WSU as part of program.
 - Survivor sisters group – goals, recognizing healthy relationships, getting out of survival mode
 - Education, awareness and training, consultation and technical assistance, research, policy development.
- Media portrayals are presented in a way to be attention-grabbing and do not accurately represent all the survivors.
- Word association exercise: what do you think of when someone says:
 - Prostitute – street walker, pay-for-play, drug abuse, Las Vegas, Pretty Woman, no morals, survival, STDs
 - Human trafficking – children, victim, slavery, someone’s profiting off someone else, entrapment, prisoner, dehumanizing
- Educated sensitivity=effective response
 - Misbeliefs and stereotypes glamorize and sensationalize and empower a context that supports the perpetuation of HT
- What is human trafficking?
 - Form of abuse and exploitation
 - Been a federal crime since 2000
 - Modern day slavery
 - Can be international and domestic
 - Labor trafficking or sex trafficking (sex trafficking focus primarily on youth, not adult)
 - Categories
 - Minors involved (no proof of fraud or force required)
 - 18 or over forced into sexual labor
 - Forced labor not involving sex, does require force, fraud, or coercion
 - Force, fraud, coercion must be proved by testifying in court.
 - Components
 - Action – recruits, harbors, transports, provides to someone

- Means – force, fraud, coercion *not required for minors
 - Undocumented individuals promised one job then forced into another, forced to work off a debt to get their money/id, threats to family or of deportment
- Purpose – labor or services, commercial sex acts
- Some minors detained until 18, then charged, esp. if unwilling to participate in the investigation
- The issue of choice
 - Lack of viable options means that the options available to the victim would be deemed unsafe or harmful
 - Lack of accessible alternatives
- Different terms that mean the same thing
 - Human trafficking
 - Domestic Minor Sex Trafficking (DMST)
 - Commercial sexual exploitation of children (CSEC)
- DMST refers to commercial, sexual exploitation of an American or lawful resident under 18, defined as giving or receiving of anything of value in exchange for sex, includes survival sex/rape
 - Is a type of violence, person treated as a commodity, stressor causing trauma and thus psycho/neurobiological damage
 - Teen or child prostitute is never an acceptable term. It denies any kind of social responsibility
 - Robbin - Does the Kansas age of consent impact 16-17 year olds and how they're treated? It shouldn't, since the law specifies 18.
 - Mark – don't know why they would hold someone and wait to charge them since the charge is based on the age of act, and they can always charge someone at 14 and up as an adult.
 - The way we've seen it play out in Wichita: victim isn't displaying classic "signs of victimization." The trauma has made them angry or confrontational and they come across that way, seen as less of a victim.
- The Scope
 - Exact statistics are often unavailable and even contradictory due to lack of funding, inconsistency with terms
 - Is a 32 billion dollar per year industry
 - Tied with illegal arms trade as second-fastest growing criminal enterprise behind drugs
 - Less risk, recyclable product, lucrative
 - Pimps sell minors in america for an average of \$400/an hour between \$4,000-50,000 per person
 - Estimated 27 million men, women, and kids worldwide
 - 800,000 internationally
 - 50% are children
 - 80% are women and girls

- LGBT men/boys are at higher risk
- 200,000-300,000 children each year, girls between 12-14, boy and transgender 11-13.
- Kansas – 44 calls last year
 - Operation cross country, 2015 – 4 minors and 8 traffickers in kansas
 - Operation cross country 2016 – 12 traffickers and 14 buyers, 5 victims 15-17 (4 of 5 from wichita), 5 adult victims. 44 women arrested for selling sexual relations.
 - Sandra – the number seems low compared to what I see in our services
 - this information comes from the attorney general’s office and may be limited because of how the information is gathered.
 - Can also get info from the national hotline. We don’t catch that data because we’re focusing directly on the individuals in need/service.
 - Mark – has to be a way to get more conclusive numbers.
 - Guy – these are criminal statistics
 - DCF is now reporting to the hotline if they learn someone in their service has been human trafficked. It is important to know how many total are out there, but our focus
 - Victor – that 27 million in respect to the 44 in kansas is a tremendous variance in people not being identified. Where does that gap come from?
 - These are estimates. That 27 million is worldwide. We estimate 200-300 youth in the wichita area have been sexually exploited. Getting these numbers (the sw/ww numbers) from DOJ and federal sources)
 - Chris – social media: is there any correlation?
 - Yes, and we do talk to the kids about responsible social media and the access they’re allowing the world.
 - Social media is used extensively in the investigation.
 - Robbin – there needs to be some centralized leadership in Kansas so we can get more accurate numbers (KDADS?). Some sort of procedure where licensed organizations are required to provide this information? Education on what human trafficking is is needed in the system and the public. We need an initiative to gather real information/numbers in Kansas.
 - The board could be looking into that. Representatives from each of the agencies participate in the board. We see our role as that educational piece.
- Possible in all communities
- Risks higher in rural communities because of geographic isolation, fewer employment options, close-knit and interconnected, truck stops, discrete, demand for low skill labor, fewer services/access to services.
- According to garden city public schools
 - 72 % economically disadvantaged
 - 11% migrant/undocumented
 - Kids would enroll and then disappear

- only 1-2% of victims are ever identified
- Even one is too many
- This is just the tip of the iceberg.
- What can you do?
 - Support SB 179 – now in the House judiciary, prevent survivors from being charged as recruiters. Provides an affirmative defense option. Two active cases they're working on this law would impact.
- Questions and Answers
 - Guy – how funded?
 - Operate under university structure, but funded through grants, contracts, and donations. Website: combatinghumantrafficking.org. Also have a fb, getting ready to start a social media campaign.
 - Charles – what kind of reaction do the kids have?
 - Kids know more than we think they do. A lot of the schools we go into are lower income, minority. Kids do know about places in the community where this happens. Engage them instead of lecture them. NORMALIZATION IS A RISK FACTOR
 - Ric – can you say more about pathway to prosperity?
 - Funded through a donor in wichita. Internship that provides a job/job skill training, space to grow and be in a regular work area, plus a scholarship for partial costs for a student (at least 6 hours per student). Survivor sisters is a support group and educational space where they focus on holistic healing and education.
 - Mel Miller-Garnett, Cloverhouse, Saint Francis
 - Been working with kids for 20+ years in outpatient mental health, YRCs, state hospitals, and worked with survivors of Human trafficking in all those places.
 - Saint Francis Mission: Saint Francis, providing healing and hope to children and families.
 - Vision: Saint Francis will be recognized nationally and internationally for transforming lives and systems in ways others believe impossible.
 - (Founded by an episcopal priest; current ceo is one as well)
 - In five states, has Kansas contract for foster care and adoption, operates a PRTF and a YRC-like facility.
 - Why is the mission/vision important to Human trafficking program?
 - Foster kids more likely to run away
 - Foster youth and runaways are among highest risk for human trafficking
 - Traffickers target youth in foster care because of increased vulnerability – unmet needs for family and emotional relationships. Promise to meet those needs, using manipulation to woo them and recruit them and then violence or physical control to hold onto them and exploit them.
 - Traffickers and exploiters often come from a similar background
 - Focusing on the purchasers/johns for prevention is more likely to help the problem, since they are more vulnerable to consequences than the pimps and they are the larger group.

- Seems so large it's almost impossible to address.
- SFCS Continuum of Response
 - Staff training, rapid response team, voca funded Human trafficking therapies, community and professional education, immigrant children/family services, clover house, research
 - Cross system alignment/coordination
- RRT assessment identification and referral
 - What to do when someone is identified as a survivor of human trafficking
 - Team of trained individuals covering the western 3/4ths of the state
 - Responds 24/7
 - Coordinates with LEO
 - Identifies next steps
 - Provide trauma-informed advocacy
 - Taken to staffed residential center for assessment
 - Based on assessment, they will be directed to a placement based on individual need – home, with out of state family, drug treatment, MH services, etc.
- VOCA-Funded human trafficking Response therapists. Consistent Clinical Services to a Transient population
 - Likely pre-existing trauma before the trauma of human trafficking.
 - These youth, when identified, don't act like grateful victims or openly identify as survivors. Tend to move a lot.
 - Program currently in 2nd cycle of grant funding
 - Two half-time therapists committed to meeting youth where they are at.
 - Solves problems of gaps in MH services
 - Consistent advocacy and resources, despite frequent absences and moves
 - Trauma-informed response to a highly traumatized population
 - Promote continuity of services across services.
 - Always face-to-face.
 - Therapists carry small caseloads – 4-5 clients per (high risk of secondary trauma)
- Clover House Trading Vulnerabilities for Resiliency Factors
 - Created to fill a gap, that takes youth into a place of healing and provides the services they need.
 - Treating youth survivors is more difficult, esp. residentially, because they do not have autonomy.
 - Replace abusive, exploitative, and neglectful relationships with those that reflect value and dignity.
 - Replace educational deficits with individualized, supportive educational resources.
 - Replace low self-esteem with sense of inner beauty, strength, and worth.
 - Replace a dangerous and indifferent community with one that teaches, supports, and nurtures.
 - Replace instability with predictability
 - Replace scarcity with abundance

- Replace future of exploitation with a vision of self-sufficiency, capacity, and hope.
- Community is one of the most healing places for youth
- Clover House: Tenets of Healing
 - Complex trauma necessitates complex healing (holistic)
 - We are all on our own healing journeys
 - Because trauma has happened in relationship, healing must happen in relationship – less strict boundaries to prepare them better for complex decisions and choices in adulthood.
 - Because trauma impacts mind, bodies, spirits, and relationships, services must address these same areas
 - Grace is a guiding principle
 - We, as staff, must live into and treat one another with the same grace we extend to our youth.
- Clover House is a house, a home, not an institute.
 - Exclusionary factors – MH or SUD services required beyond what CH can provide
 - Inclusionary factors – Human trafficking survivor, must be ready and willing; have to opt-in.
- Q&A
 - Sandra – how many kids?
 - Can house 4 currently, get their own rooms but not their own bathrooms, would like to expand to 8 but keep them in groups of 4. LOS is 12-18 months. Where they go from here is dependent on their personal journey. Only allowed to serve foster care due to licensing currently but would love to expand. Licensed as a YRC2. Is some talk about a separate licensing structure for restorative residential.
 - Jane – would you consider a phone discussion for parents about what they can look for/do to prevent/assist?
 - Mel says she'll talk to anybody.
- Homestead
 - Serves 8 adult women
 - Rescue and reintegration; transitional, teaches the women about financial sustainability.
 - July 2012 – opened
 - Have served 40 women nationwide. Currently have 5 women from wichita. Referrals are coming from agencies in Kansas.
 - 7 participants lived off site because they had a child in their custody, recruits family into network of support (Homestead Plus)
 - Can house 6.
 - 2 in line to graduate in the next few months
 - Go into strip clubs in their area to reach out to ladies currently being trafficked from them.
 - Two main qualifiers – is she ready? Is she able?
 - Addiction/MH issues under control, where is she at in her recovery?
 - Screen team of 5 who look over applications

- Granted 501-c3 status in November.
- Birthed from a Salina church, but separated now to be their own nonprofit
- Provide wraparound services much like Clover House.
 - MH/SUD (partner with Pawnee MHS)
 - Weekly support group
 - Meet with trauma service coordinator
 - Self-care coordinator
 - Mentors
 - Monthly life skills training
 - Medical screening/Care (Via Christi)
 - Dental care (Kanza Clinic) local clinic that helps with pain management
 - Weekly church services
- First 30 days are probationary
- Career training
 - Paid apprenticeships
 - Dental Assistant
 - Assistant Real Estate Broker & Property Management
 - Funeral Home Director & Embalmer
 - Optician
 - Dog Groomer
 - Florist
 - Building & Grounds
 - Painting
 - Housing & Dining
- Length Of Stay depends on job training. Some will go to school (on their own dime). Career training/apprenticeships are free.
- Once graduated, continue wraparound as much as they want/need
- Develop individual growth plan at the start.
- Develop after-care plan after graduation.
- Faith-based, but don't require the women have a religious tendency.
- Everything provided free to women except medical bills, prescriptions, cigarettes
- Funded through donations only. Partnerships are voluntarily provided.
- Partnering with World Hope International for domestic missionaries. Three ladies currently raising funds through this to work with Homestead.
- Lauren – clinical challenges experienced at homestead
 - Complexity of trauma cannot be overstated.
 - Began in childhood; comparatively, the human trafficking is just a small pebble in a huge pond.
 - While best practices exist, none exist for ht-related trauma specifically.
 - Working on it at KSU, piecing it together based on previous trauma work.
 - Biggest barrier – comorbid addiction. (They saw it at home, they use it for numbing, the pimps forced it on them). Ask them to shed maladaptive behaviors.
 - Most who fail in the program do so because of preexisting addictions.

- Severity of trauma presents as complex PTSD with psychotic features. These types are more than their facility is setup to support; inpatient programs aren't setup to treat them either, so where do they go? Huge gap in service provision
- Those who maintain contact with pimps or johns have a problem completing. 30-day noncontact phase, but after those 30 days, it can become difficult to fully cut the ties.
- Community and policy barriers – many show up with multiple felony charges and large criminal records.
- Questions?
 - Guy – current age range?
 - Typically, 25-45 is the most successful range. (First girl was 15 and lied to the referral agency and Homestead about her age). Take women 18 and up. Trauma can pause your development so that a 45-year-old woman might only function at about 13.
 - Charles – are there any programs in the US that serve male victims?
 - Program in Alabama that works with men and transgender individuals.
 - Sandra: Where do the referrals come from?
 - Ministries, rehabs, addiction recovery programs (inpatient). Because of the complexity of the trauma, you need a plan or “system” that allows for dealing with trauma and getting out of bed, going to work, etc. without the crutch and a 28-day program isn't enough.
 - Charles – reintegration with children?
 - We focus on the women
 - Victor – have you worked any with the oxford houses?
 - Yes. Will send women that aren't ready to oxford houses, or when they relapse.
 - Kirk – for those in recovery there, are they allowed to attend their meetings, see their sponsors?
 - Yes. Have started a NA meeting at the church.
- Block Grant Update and Public Discussion, *Kimberly Reynolds, KDADS*
 - *See attached transcript*
- Children's Mental Health Awareness Day May 4th, *Jane Adams, Keys for Networking*
 - Hosting children's MH awareness day may 4th in Ashland, KS
 - Town where the fire came right to the edges and stopped. (60-80% of the county burned but it remained untouched.)
 - Start at 8:00 with a High School presentation, talk to kids and parents and teachers about what trauma is, that help is available and traumatic things don't have to ruin their lives.
 - 11:30 – meet with parents listening group.
 - 1-6 at the community library, will have experts available to chat with individuals in a more private setting.
 - Sponsored by Iroquois and Compass, WSU, DCCA, GBHSPC Rural & Frontier subcommittee, KDADS, SAMHSA.
 - May 4th is also the 10th anniversary of the Greensburg tornado.
- GBHSPC Grant Advisory and Review Boards
 - Being tested with the SOC grant.

- Kelsee Torrez
 - Establishing local advisory councils that should be 51% youth and family voice to lead efforts on a local level, then have a statewide board that the locals filter info up into.
 - Charles – info would then funnel up through the subcommittee into the council.
 - The board will be able to look at all the parts of our system in order to see gaps in the grant and address them.
 - Advisory Council goal to also be majority consumer/family voice
 - Planning a listening tour of the communities to share what is and isn't working.
 - First one will be May 1st.
 - Outreach being done at CMHC level, sending it out in newspaper ads, social media, church bulletins, center mailing lists, CMHC partners. WSU doing a lot of the community organizational pieces.
 - Ric – our group is really excited about what we can do to reach populations we may not usually reach. End result has to be a to find those ways the state can do things in new ways.
- Subcommittees Reporting Procedure for 2017
 - Subcommittees have reports prepared by June 1
 - Reports not done previously to secretaries added into the reports
 - In the June meeting (June 21st), subcommittees report to council, then schedule a report to the secretaries in mid-July.
 - Try to get several committees to report each day instead of one at a time over numerous days.
- Public Participation
 - Mark – effort to take funds from lottery to CMHCs in legislature. Hasn't come to fruition completely because of how it was done. Senators concerned about taking money from one program to another. Discussion of tying it to Problem Gambling funds that already exist, which is complicated. Think they're going to try to reach out to CMHC providers. People are trying to find ways to increase the funding. We need to pay attention to what's going on and find ways to provide feedback. Were looking at \$20 million over a three-year period.
 - We've already seen this fund get treated like low-hanging fruit, used to cover medicaid short falls.
 - Adjourn at 2:39



Governors Behavioral Health Service Planning Council Minutes for June 21, 2017

Present: Wes Cole, Sandra Dixon, Rodney Shepherd, Fran Seymour-Hunter, Charles Bartlett, Jane Adams, Steve Woolf, Ric Dalke, Mark Dodd, Deann Mitchell, Robbin Cole, Patrick Hall, Victor Fitz, Peg Spencer, Gary Parker

On the Phone: Roxanne Bollin, Al Dorsey, Guy Steier, James Costello

Guests: Kimberly Reynolds, Ron Jeanneret, Linda Blasi, Missy Bogart-Starkey, Matthew Angel, Andy Martin, Sky Westerlund, Misty Bosch-Hastings, Andy Brown, Korrie Snell, Mende Barnett, Cherie Blanchat, Erick Vaughn, Nancy Crago, Michael Kress, Christy McMurphy, Shane Hudson, Chrissy Mayer,

- Wes called the meeting to order at 9:02am
- Welcome and Introductions
 - Wes introduced new member Steve Woolf, superintendent for USD 101.
- Children's Subcommittee Report – *Cherie Blanchat, Nancy Crago, Erick Vaughn*
 - BG Overview
 - CDC statistics
 - Adverse Childhood Experiences (ACEs, early trauma)
 - Societal and community factors
 - Barriers in Consistency of Services
 - 2016-2017 Goals
 - Identify specific, effective practices
 - Look for opportunities to champion and inform a Continuum of Care/birth-to-school age
 - Areas of Focus for Goals
 - Early childhood – Erick
 - Goals for 2016-2017
 - Review research, both national and from other states
 - Evidence-based state policies
 - The most effective models
 - Draft consistent definition of Early Childhood MH for state of Kansas
 - Identify recommended qualifications, competencies, best practices, and professional development for Kansas ECMH professionals.
 - Policy Recommendations:
 - Systemic approach
 - Preventative services and universal supports

- Targeted intervention
 - Intensive supports
- Supporting coordinated state data
 - Support provision of a unique statewide child identifier
 - Link child-level early childhood data with k-12 and other data systems
- Capitalize on upcoming opportunities
 - Capitalize on upcoming MCO RFP process
 - Support statewide screening, referral, and care coordination
 - Increase early childhood MH by including language about them in contracts with MCOs
 - Support payment for two-generational services parent support services, and dyadic therapies
 - Recognize diagnostic classification of 0-5 for reimbursement
 - Capitalize on upcoming Quality Rating and Improvement System (QRIS) changes
 - Ensuring we're supporting progs that use a relationship approach
 - Ensure kids and caregivers screened/accessed at regular intervals
 - Provide support/education to caregivers
 - Work on transition planning from day one
 - Maintain appropriate staffing ratios
- Effective models
 - Pilot a pay-for-success or social impact bond project
 - Utah early childhood programing (Project Eagle) – gets funders for kids at risk of special education services. Operating for 3 yrs, improved outcomes for kids and family, looking at outcomes for the community, cost-savings for state.
 - Best Practices – if fund them, focus on:
 - Prevention
 - ACES/sources of toxic stress
 - Invest in family engagement strategies
 - Promote comprehensive screening/early detection of developmental delays
 - Expand access to voluntary home visiting programs for new/expecting parents
 - Policies and supports that would support flexible schedules for parents
- School Mental Health - Cherie

- Establish working definitions and identify research-informed models/best practices
- Examine necessary qualifications of community and school-employed MH staff
- Enhance the capacity of behavioral and mental health staff serving children
- Implement best practices for transition-age children w/BH and MH needs
- Interconnected systems of care pyramid (KansansCAN)
 - Appropriate information sharing
 - Supported navigation through the System Of Care
 - Continuous communication loop
 - Family driven & youth-guided planning
 - Wraparound support
 - Tier One - all
 - Relationship building, resiliency, and rich social-emotional learning, trauma-sensitive, universal screening
 - Tier two – Some
 - Early identification, screening, and progress monitoring
 - Tier three – few
 - Intervention & Support teams
 - Surrounded by a foundation, community & family, and community & business partnerships
- Trauma informed Practices - Cherie
 - Identify specific ways to promote education of trauma-informed practices
 - Kansas Assessment Permeancy Project (KAAP)
 - KVC and SFCS have trained child welfare staff across the state in use of trauma systems therapy model and universal trauma screening and functional assessment
 - Support implementation
 - Examine West Virginia’s handle with care initiative
 - If law enforcement encounters a child during a call that has been exposed to some kind of trauma, that child’s name and three words – handle with care – are forwarded to the school before the bell rings the next day. The school implements individual and school-wide trauma-sensitive curricula
 - Why we need trauma sensitive schools
 - All children need safe and supportive environments in order to learn.
 - Trauma-sensitive schools help ALL children to feel safe to learn.
 -
- Research Autism/dual diagnosis - Nancy
 - Goals
 - Identify service providers
 - Gain a better understanding of what services for these populations look like
 - Request presenters and information to inform recommendations.

- What we learned from presentations:
 - Technology now allows for earlier identification/diagnosis of autism spectrum
 - ASD kids have a higher rate of MH disorders than the general pop (anxiety, Oppositional Defiance Disorder, ADHD)
 - ASD Effects communication, behavior, motor coordination, and physical health, so it requires coordinated care
 - Lack of available, convenient screening resources in Kansas
 - There are EBPS and intervention techniques for ASD, but there a lack of people in Kansas trained in them, though efforts are being made
 - Will take a multi-faceted approach.
- Goals for the next year- Nancy
 - Identify a process for our subcommittee to link/communicate with other subcommittees.
 - Make recommendations regarding caregiver, parent, and family engagement in navigating BH system
 - Explore the purpose of the kansas children’s continuum of care
 - Identify/describe what data elements we want in an integrated data system
- Q&As
 - Mark - are there models out there already or are we reinventing the wheel?
 - Nancy - We do not want to reinvent the wheel. We will research existing ones.
 - Erick – every state does it differently, so it will be looking at what is out there and how it can
 - Cherie – when KIPBS was looking at a system, they were looking at the former ISIS system/tier 3 to look at those supports, don’t know where that landed
 - Steve – look at what we have already, tie them in there as soon as they’re identified.
 - Cherie – we think about that, too, but while we realize there’s a huge need for this data, how do we make sure we can protect that information?
 - Sandra – I wonder about expertise related to SUD on your subcommittee? We know there are substance use issues in schools, in families - especially of kids removed from addicted parents. We are seeing more and more kids impacted. The level of Substance Use in high schools is daunting.
 - Nancy – we are becoming more calculated about the makeup of our committee so we will definitely look at someone from the SUD side.
 - Wes – worried more about the drugs kids are being prescribed than the ones they’re picking up on the streets. There is a big law suit in Missouri because kids are being prescribed psychotropic they shouldn’t be, at very young ages. It just seems easy to just medicate an issue, whether by family/physician. Really appreciate that first recommendation about better integrating the subcommittees. Think we’re closer to that today than previous.
 - Erick – KU did a study back when KHS was the MH MCO. They put in place some protocols and procedures, so we might have some historical stuff to look at from there.

- Linda – Fran and I are part of the current psychotropic meds workgroup. Looking at what is being prescribed and the dosage for younger kids. It's a DCF workgroup. Medical centers involved from around the state.
 - Fran – MH advisory group is also looking at the issue.
 - Cherie – education side is very well aware, esp. with kids in the foster care system, of the substance problem, suicide prevention, but it's a bit like spinning wheels and putting out fires to deal with all of them, need to look at if it's a statewide issue or a community issue. Think about how we can holistically look at the issue and the prevention piece. We are not working in isolation, we're pulling our experts together and pulling our data together to better address the issue.
- Ric – really like how you've drilled down the techniques and practices that can happen anywhere. That's really neat and I really appreciate it.
 - Cherie – as we put forth recommendations, do we have a strong grasp on how to effectively collaborate and put these things in place.
- Peg – I noticed the reference to transition-aged youth. In the employment world, we consider that to be the high school-aged kids, which provides opportunity for the vocational subcommittee to work with the children's subcommittee.
 - Cherie – that was the transition we intended, even if we also meant early childhood to school-aged, as well as the transition from middle school to high school.
- Robbin – what are the barriers to ASD treatment?
 - Nancy - Training opportunity for providers.
 - State used to support through KU; still available but they have to pay for it now (\$500 per person/\$5,000?)
 - Cherie – was a budget cut that removed a liaison. Two individuals are offering an online training that a number of people have gone through it may be available to community members.
 - Erick – there is one EBP (home visit) and it's being offered through Methodist Ministries, but it costs \$6000 per person, 10-week intensive training. Often the people who get trained then leave.
- Housing and Homelessness Subcommittee Report – *Michael Kress and Christy McMurphy*
 - Accomplishments
 - Kansas brought in 7.6 billion dollars through HUD COC funds to the 4 Continuum Of Care counties in Kansas. (Johnson, Sedgwick, Shawnee, Balance of State (100 counties total). Wyandotte County merged with the KCMO COC so its \$800,000 aren't showing up in KS numbers.
 - Kansas declared a Super SOAR State. Top ten in the nation (been in effect 9 yrs)
 - Kansas Interagency Council on Homelessness (KICH) reorganized and reconvened in 2016 as a workgroup under this subcommittee. Will review/update strategic plan.
 - Working on need to increase safe, affordable housing
 - Cooperative Agreement to Benefit Homeless Individuals (CABHI) began year two of its grant. All of the provider agencies have been able to implement Housing First Model.

- Recommendations for 2018
 - Work with partners to increase safe/affordable housing
 - What options can we develop?
 - Crisis facilities
 - Group homes
 - Independent living options
 - By creating housing
 - Decreased state hospital admits
 - Decreased law enforcement interaction
 - Decreased homelessness
 - Implement initial and ongoing training for bh staff, specifically housing specialists.
 - Also, resume housing specialist meetings held by state.
 - Work on housing first model statewide
 - Use of supported housing funds – continue support of use/availability.
 - Review application process
 - Expand utilization of funds for state hospitals, corrections...open up beyond just CMHCs
 - Advance/support/expand furthering SOAR
 - Continue supporting training of SOAR workers
 - Collaborate with other agencies to expand training opportunities
 - Explore funding opportunities for expansion
 - Improve how state departments process/share/combine data sources.
 - Create a centralized location easily accessible to gather information on available housing programs
- Christy – Missouri has a more extensive housing array. We’re working on implementing/funding a wider housing array. Hopes the state will fund programs beyond what we have.
- Q&A
 - Wes – do you have a lot of data about homeless children? Really push that data when presenting to the Secretaries.
 - Mike – when you look at Wichita’s Point in Time count, our children’s numbers are so few (21 individuals below 18) but WSUs in-school data is showing a much bigger issue. That’s why we need the data to better integrate/mesh.
 - Wes – at one of the roundtables, it was the school district talking about the number of homeless kids.
 - Christy – part of the problem is education defines it differently than HUD does. KCK school district reported 1400 homeless kids last year.
 - Victor – what is the capacity of the Housing First Model? In wichita, through the triage model they’re using, it’s 4-6 months waiting list for someone defined as chronically homeless to find a home.
 - Michael – the model is that when you’re working with someone, the first thing you look at is their housing. Don’t work on getting them sober or enrolled in groups first; you’ll get them housing that they are comfortable with first. Once they’re housed, you’ll have a better chance to find them, get them to services, and get them better.
 - Victor – even with that, there is still that wait. How can we eliminate/shorten that?

- Michael – part of it is working with landlords, teaching housing specialists to talk to landlords to help them understand the person/mitigate risk. Funding is a piece, but it's also cultivating relationships with landlords. There are lots of roadblocks when you're working in housing.
 - Robbin – I spoke with an individual who is running for city office in Manhattan who has gained information on how communities are addressing these issues through his work (IT) with different municipalities. I'd like to help connect you with him.
 - Sandra – I'm going to bring this up a lot today: SUD representation.
 - Is there a Kansas specific definition of affordable housing?
 - Mike – HUD provides a federal definition: 30% of income goes to housing needs.
 - Wes – make sure to remind the Secretary that housing specialists came about because of the subcommittee, and push the data issue.
- Prevention Subcommittee Update/Suicide Prevention Report
 - Suicide Prevention Subcommittee Final Report – *Andy Brown*
 - Suicide continues to be a growing issue in Kansas. Increased call volume on national suicide prevention hotline. Don't have a solid entity statewide about suicide. Most of the suicide prevention work being done is done at the community level.
 - State plan very focused on community work and how to find funding.
 - Policy change solutions
 - More adequately promote suicide prevention material
 - Been working the last few years to integrate suicide prevention into the statewide primary prevention efforts so we're not setting up new coalitions.
 - We have 16-17 suicide coalitions around the state doing broad stroke health and wellness work. Got the Jason Flack legislation passed last year (focused on schools), zero-funded initiative.
 - Trying to get suicide prevention out across the state through other mechanisms that exist.
 - Looking forward to working with the prevention subcommittee.
 - Kansas prevention collaborative initiative providing grant to partially fund the Suicide Prevention Resource Center (SPRC)
 - Implementing national and state plans, find ways to fund it and integrate it with other prevention initiatives.
 - Most recent KDHE data shows a continued uptick in suicide rates in Kansas, esp. in the 10-24 age range category (2nd leading cause of death, part of a national trend; we're not unique in this problem. It is a large issue in rural states.)
 - Q&A
 - Ric – zero suicide initiative thoughts?
 - Andy – it's a closed systems evidence-based model. Started in hospitals for early identification and referral. Lot of fed initiative and push. Kansas deciding whether to apply for grant through SMAHSA. Have seen it used in KC, at KVC and ComCare.
 - Ric – is it showing progress?
 - Andy - For folks touched by model, it's effective. To access it, you have to get to the point of accessing the hospital system. Initial first contact is 911, might get sent to ER, seen by CMHC, and sent home if not in imminent danger. Might be

involuntarily committed otherwise. Also using it in VAs, only about 4 of the vets committing suicide a day are in hospitals/connecting to the zero-suicide system. Improves outcomes for those that use it.

- Deann – do you have county specific data?
 - We see it in on a CMHC catchment basis.
 - Robbin – county data is available in the Summary of Vital Statistics from KDHE. Might drill it down for a couple years. Annual Summary of Vital Statistics. It is online.
 - Andy - KDHE is also working on the national violent death reporting system which will help as well.
 - Ron – part of the work I did at KDHE was setting this up. It covers counties, methods, very valid. Information from police narratives not just the front-page report. It’s all anonymous with no identifiers. 2015 report will close in June, then an epi will put out a report.
- Jane – what are the best practices for preventing suicide?
 - Andy - Very small list. ASSIST – two-day training. Specific therapies. Not primary prevention models, very specific trainings people can get as a licensed therapist or community member. SPRC provides the training but there is a cost for it. No specific method. We know, based on work done, we need to work on the shared risk factors between SUD, PG, ACEs, TIC, sexual risk behaviors. Number one thing you can do is eliminate means to make an attempt. 52% in Kansas are firearms related. No program for means reduction really. There is no one thing Kansas can do to fix this problem.
- Sandra – what’s your opinion on the initiative for MH first aid?
 - Andy - It’s not on the NREP yet as proven to prevent suicide, providing training to immunize the community. The more people you train, the higher the likelihood a suicidal person will cross paths with someone trained and it may provide the opportunity to prevent.
 - Andy - Primary prevention – we know that most people that die by suicide are older white men. So, the more prevention/education we can provide to reduce risk factors over the lifespan will help. Our suicide rate won’t go down as long as our age bubble keeps going up.
 - Robbin – all roads lead to reducing stigma.
 - Andy - There are some positive things happening in that 18-24 age group where we are making more access available on college campuses, peer support/reaching out to each other, less stigma among younger generations. SAMHSA and DOD working on suicide as an issue, end suicide by 2025 initiative. We had a lot of people come out for the Jason Flack Act, I think we could do the same with other legislation.
- Prevention Subcommittee – *Chrissy Mayer and Mende Barrett*
 - Bring together key representatives and stakeholders
 - Provide reflection, feedback, guidance
 - Enhanced collaboration, effectiveness, impact

- Provide feedback, guidance, advocacy, and engagement and addressing challenges, barriers, and issues.
- Focusing on getting tribal representation, problem gambling. Have members from SUD prevention, MH promotion, corrections.
- Established in 2016, recruited members, refined charter, set goals and developed a strategic plan.
- Goals
 - Data collection/research
 - identify and catalog prevention efforts within state,
 - identify the top five data priority areas
 - update the prevention subcommittee charter, ensuring we're moving forward
- progress
 - Highlight purpose and focus
 - Integrated suicide prevention subcommittee, helped identify how we could integrate other systems/partners
 - Data sharing
 - Assessing and identifying efforts/gaps
 - Statewide plan development – what are other states doing, how can we use those as an effective model for kansas?
 - CSAP Site Visit – serve as advisory committee for the CSAP grant. Project officer had positive things to say about the kansas prevention work.
- Coordination
 - Information sharing with KCC
 - Coordination to avoid duplication of services
 - Engage other subcommittees and how can prevention interweave
 - Learn about scope of other committees
- Next steps
 - Data collection/research
 - Develop framework for statewide prevention plan
 - Develop priorities and recommendations
- Q&As
 - Sandra – how many community coalitions are out there?
 - 70 active; as of July 1, 29 will have KDADS funding. Many have other/city/county funding
 - Sandra - on average, how many engaged per coalition?
 - 10-20.
 - Andy – local coalition support is critical for getting this work done. Local problems addressed by local solutions. Need to support them on the state level (funding)
 - Wes – integration will help people understand what prevention *is*.
- Justice Involved Youth and Adults Subcommittee Report – Charles Bartlett
 - Substantial interface between BH/criminal justice system
 - Convenes constituents at a policy level to carry out mission/vision

- Divided into two workgroups – Programs/Best Practices and Systemic Issues
 - Best Practice group
 - Broad Areas of Focus
 - CIT Training - Pre-arrest for Co-Responders
 - Crisis Center Expansion
 - Training and technical assistance
 - MH diversion/MH Courts
 - Assessment/readiness for counties
 - Juvenile services
 - Goals
 - Gathering data on number of people with MH issues entering jails
 - Identify process and assessment to use to measure gaps in communities wanting to explore best practice; identify a pilot site.
 - Priorities for which we would like to have the CIT/VA Coordinator
 - Develop fact sheet for Drug Courts/MH Courts to post on the website
 - Current Status
 - Assessment in jails
 - Step two of a six steps recommended by Stepping Up initiative to reduce the number of mentally ill people in jails.
 - Asked Johnson (large jail), Douglas (medium), and Reno (small) to participate in establishing a proposed criteria for “Gold Standard” screening and assessment process
 - Council for state governments justice center is the technical advisor for the project
 - Intercept Model – Shawnee County. Complex model.
 - Lead agency – would like to participate some pilot communities
 - Pittsburg
 - Reno
 - Manhattan
 - Hays
 - Justice assistance grant to look at an event/funding to do some planning activity.
 - Jail study – consider combining with Step Up Initiative.
 - Recommendations
 - Identify next steps for pilot project using justice assistance grant monies.
 - Continue to follow Step Up Initiative, Step 2 with pilot communities to establish best practices.
 - Systemic Issues
 - Broad Areas of Focus
 - Funding/policy (formalizing agency relationships)
 - Kansas Offender Database / KEES
 - Data sharing

- Standard of care during incarceration
 - Competency
 - Discharge planning
 - Goals
 - Research competency process in Kansas
 - Establish efficient model for data sharing
 - Current status
 - Data sharing
 - 5 broad areas identified regarding data sharing:
 - Which agencies share data and what is the flow?
 - What info available among agencies
 - What info is useful
 - What are obstacles in sharing:
 - HiPPA/legal obstacles/laws
 - Security
 - Accessibility
 - Politics
 - Releases of information
 - What is the mechanism
 - Recommendations
 - Engage community partners
 - Target 3 CMHCs to begin discussion of where information sharing would be useful.
 - Would select from one of these areas:
 - Wyandot
 - ComCare
 - High Plains
 - Central Kansas
 - Compass
 - ACC
 - Recommend the Council endorse and focus on the issue of high BH Acuity releases from KDOC
 - Primary issues: integration of services, high acuity individuals who may be difficult to house, offenders screened for civil commitment.
 - Competency – no recommendations ready to be made at this time.
- Q&A
 - Jane – 4th subcommittee that talked about data sharing. I think we need a privacy subcommittee. We’re struggling to serve well the people we do have data on. More data won’t help that.
 - Robbin – how heavily skewed the information seems to be towards adult.
 - Charley - Bringing ted in as co-chair is part of a way to address that.

- Mark – we need an update from the group that talked to us last year about the changes with the justice system and see how those changes affected things.
 - Robbin – we need to be looking at this new initiative and see what the impact has been.
 - Charley – we can ask Randy Bowman to present again.
 - Sandra – I think we’re recommending a third workgroup, one on justice-involved youth specifically, and have people other than state staff involved. Providers in the community and parents are struggling.
 - Wes – this was a weakness in the ACC report, no information/focus on this issue.
 - Jane – medication is a big issue. We have kids who have been on medications for their entire lives who hit this system and (wham) they’re off them.
 - Mark – this is true in the adult world as well.
 - Jane – if parents know enough to put together an entire dossier of the kids medical history
- KCC Subcommittee Report – *Shane Hudson*
 - Based recommendations on 3 premises
 - Effective services
 - Prevention and treatment is financially responsible
 - Effective prevention and treatment essential to public safety.
 - Recommendations and Action Steps
 - Funding
 - Promote Adequate Funding
 - Ensure problem gambling alliance fund used according to bylaws and statutes
 - Reinstate 4% Medicaid cuts
 - Support Medicaid expansion
 - Support global payment model
 - Ensure BH services are covered by existing and future health plans
 - Create and hire a state-level, dedicated grant writer position.
 - Intervention
 - Treatment works
 - The workforce crisis = agencies forced to terminate effective, cost-saving programs for lack of qualified staff to run the.
 - Integration of services is necessary to improve outcomes/reduce waste.
 - Immediate and affordable access to care will ultimately reduce both human and financial costs
 - Recommendations
 - Support workforce development
 - Support initiatives to reduce cost
 - Support reimbursement for the flexible, supervised use of full contingent of addiction service providers
 - Support initiatives that allow professionals w/specialty training in addiction counseling to provide more integrated services
 - Prevention
 - Effective and financially-responsible approach to addiction in Kansas

- Former prevention framework and the Regional Prevention Centers made Kansas a national leader; much ground has been lost since change in system.
- Decision to require parental consent on the Kansas Communities That Care survey dramatically reduced data
- Prevention leaders using new technology to re-expand services.
- Recommendations
 - Reverse the active consent policy on KCTC
 - Support funding for general prevention in Kansas, esp. for ACEs
- Communit5t6 Engagement
 - Serious problems with substance use in Kansas
 - Reason to believe it will become worse
 - Kansans are not powerless. Groups in the community exist to help, and the Kansas Prevention Collaborative exists
- Q&A
 - Mark – do you have numbers on the change in the participation?
 - Sandra – we can get you the numbers
 - Mark – without showing how the data has changed, you won't have much of a chance to change people's mind.
 - Shane - It's much, much smaller.
 - *Note: numbers were sent out to the group after the meeting.*
 - Sandra – missing – the ongoing conversation in the field about lack of data. We have beliefs that there are gaps but don't have the data to support it.
 - Mark – we have to be very specific about what that data is. Who will see it, how personal is it, what is it being used for. Most of the time, they want to collect way more than what is needed.
 - Sandra – example: how many people in Liberal were assessed for needing SUD services but didn't get it because it wasn't available there. How do we identify strengths, gaps, and needs?
 - Mark – not saying there's not a need, but being able to tell them specifically what is needed will get you what you need.
 - Ric – the absence of the words opioid addictions. I have more people specifically mentioning that to me right now than anything.
 - Shane – it is growing here and it's important to talk about addiction broadly and not the substance. Talk about the brain and how to treat it.
 - Patrick – how long a person stays connected to treatment is important to mention as well.
 - Shane - Funding and length of stay has decreased. If provider were given a specific amount of money per patient we could better figure out how to serve that person (global payment)
 - Mark – is it worth addressing the Kansas lottery act funds? The legislature is asking about it constantly, taking the lottery money and using it for MH instead of addictions. Need to make a case for how to use it effectively so we keep it. If they see what it is being used for and see what it could be used for but isn't, they might not be as ready to give it to someone else. Are providers being hampered by being told that the funds are only for specific codes?

information, and we're frequently referred to medical reference copy programs that can take weeks to get the information to us.

- Victor – do you have information on DCF Goals program?
 - Peg – I can get some information and send it to everyone.
 - E-D goals are to test out and see how IPS can be implemented and the cost to establish a good funding stream for payment through the VR system.
- Mark – I just want to say, it is a fantastic program.
 - Peg – we frequently deal with the preconceived notion of what a disabled worker is. People with disabilities can do any sort of job out there.
 - And that is why employment is so important. These individuals just need a leg up.
- Mark – encourage you looking at a goal of educating employers that just because someone has a criminal record doesn't mean they won't be a good employee.
 - Peg – there is a program in western Kansas working with people in corrections and employment.
 - Other states are working on initiatives to get rid of the box on applications.
 - Mark – I wouldn't push for legislation for that, but education will go along way.
 - Missy – we're doing a whole lot with KDOC right now to be able to target the corrections population that wouldn't be as dangerous/risky as others. Implementing at ComCare and compass.
- Budget update /Block Grant update/KDADS Update
 - Budget Update
 - Ric – 4% Medicaid cuts reinstated. Have lost primary health providers who have closed because of Medicaid cuts.
 - Robbin – waiver rates enhanced by 3% starting July 1, another 1% either January 1 or July 1, 2018.
 - KDADS Update
 - Sharon Kearsse has taken opioid STR grant position. Children's position still open.
 - Opiate tracking system – funding possibly reinstated?
 - Block grant – Kimberly Reynolds
 - On track for deadline
 - Goal is to have full draft ready by July 24th, posted for public comment through August 23rd, submit to SAMHSA by August 28th. Due September 1st.
 - How can we help?
 - Have a workgroup on the SUD side who will be doing reading/provide input. Staff will be reaching out for assistance. Anyone who wants to volunteer to help would be appreciated
 - We were cited by SAMHSA for not providing opportunities for public comment. We want to ensure we get as many opportunities moving forward for people to provide their input.
 - Sandra – Kim has sent out this packet to the SUD folks to give feedback for putting together recommendations. Looking for data/evidence supported recommendations.
- Other Updates
 - GBHSPC calendar

- Wes is planning to put together a monthly GBHSPC calendar/newsletter to keep people informed of upcoming meetings of the council and subcommittees. Diana will be collating the information and putting it together.
 - Ashland initiative
 - Ric – Farm Bureau Insurance sent a letter out to members telling them services are available and where they could find them.
 - Jane – we made contact with 20 families during the event in Ashland and have maintained that contact. Several people have said their kids now feel allowed to talk.
 - They would really like another event.
 - Some people said they didn't come to the event because they thought since it was being held at the school, it was just for kids.
 - Mark – would be a good idea to coordinate future events with the statewide emergency management group.
 - Ric – the seeds we planted were really significant.
 - Aging Subcommittee
 - Wes – Secretary is going to meet with the remaining members of the MH & Aging Coalition soon to discuss reinstating the subcommittee.
 - Children's Continuum of Care
 - Charley – finally got the final approved membership list from the Secretary on the 20th.
 - Recovery Conference
 - Final total – 196 people
 - It is a testament to how important this conference is to people that the registration increase didn't stop people from attending.
 - It overall went well
 - Jane presented for the first time.
 - Gary and Jane discussed a way to implement a parent's track in the future.
- Presentation to Gary
 - Gary was presented a certificate honoring his service to the Council. This was his last meeting.
- Next Meeting
 - August 16th, possibly in Dodge City or somewhere out west, will send out location when it is finalized.
- Meeting adjourned at 2:30.

Governors Behavioral Health Service Planning Council Minutes for August 16, 2017

Present: Teresa Briggs, Rodney Shepherd, Wes Cole, Patrick Hall, Victor Fitz, Guy Steier, Robbin Cole, Ric Dalke, Al Dorsey, Charles Bartlett

On the Phone:

Guests: Renee Geyer, Walt Hill, Nichole Trice, Gina Anderson, Sharry Cole

- Wes called the meeting to order at 9:13 am
- Council Updates
 - Have started the Children's Continuum of Care group. First meeting held 8/3, next meeting 8/21, people from across the state participating
 - Will be presenting a report to the council after they're done.
 - Charter and membership will be included with the minutes when they're sent out.
 - Auspices of the council, in consultation with the subcommittee
 - Will develop recommendations and a plan to the secretary and the council, will also go to the governor
 - Review relevant rec from previous reports
 - Review current capacity and availability
 - Identify gaps and barriers for children, MH, prevention, SUD, housing, education, etc.
 - Access and make recs about how multiple systems of care can collaborate.
 - Also want them to look at sustainability.
 - SOC grant, other short term grants. How do we sustain the work after the grant funds end?
 - Block grant up for public comment.
 - Has been cut by 1 million on the MH side.
 - Keys and NAMI and MHCs were impacted.
 - Being redirected into opioid grant/issues
 - KDADS awarded 4 RFPs with the initial money received through the grant. Will include a statewide media campaign. All but 15% of grant goes to treatment.
 - May affect 10% set aside for First Episode Psychosis, we don't know yet.
 - Budget hasn't been set yet, so it hasn't been set in stone. If it doesn't go through, KDADS will amend contracts, but moving forward with them in preparation.
 - Aging subcommittee – met with secretary and Father Guy, the chair. Writing a charter and looking at the statute. Will be made up of people from all over the state. Have to make sure we don't violate anything within the statute.

- Veteran's subcommittee is meeting again. Broad membership. Focus on families and the national guard/reserve. VA does not deal with families and we think it is important not to forget them. Thought being given to reactivating National Guard and sending them to Afghanistan.
 - Bill Cochran and Steve Christenberry co-chairs, reviewing membership, first meeting should be held this month. Will work with SAMHSA Service Members, Veterans, and Families TA Center.
 - Able to increase funds to CIT to provide trainings, up to 60k this year, training at LETC, Independence, Dodge City, Junction City, 3-day Vet-specific training, and money to fund CIT programs in smaller, underserved areas.
- Next meeting – exec committee will set up a meeting with subcommittee co-chairs and liaisons for before council meets in October, figure out how we can work closer together and integrate the work between them. Late September, early October. In Topeka.
- Were planning to start the Adult Continuum of Care SUD task force, but the Secretary asked we get the Children's group off the ground first. Will get them rolling soon. Chairs will remain Amy Campbell and Randy Callstrom. Shane Hudson from CKF will join them as chair as well.
 - Once we look at the services across the lifespan, we'll figure out where we want to go next.
- Rural and frontier subcommittee report – Renee Geyer, Nichole Trice
 - Individuals in rural and frontier areas experience disparities in MH services
 - Rural issues are misunderstood
 - Rural vs urban culture is different
 - Vision: BH equity for all Kansans, regardless of where they live
 - Data shows prevalence is the same, it's the culture, the access, the availability is different.
 - Mission: collaborate through research to statistically understand and promote accessibility and availability
 - Started as a subgroup focused on MH needs of children in child welfare. Moved under the council as a subcommittee in July of 2008.
 - Why we advocate for the KDHE definition: Defining rural does make a difference. The proper definition helps ensure access to federal funds. Two grant proposals (supported employment, SOC) selected because they chose to focus on diverse areas. Our diversity is one of our strengths. Breaking the definition into a broader spectrum better tells people who we are. We're more than rural and urban. There are things in between.
 - Frontier (less than 6 persons per county per square mile)
 - Rural (6-19.9 per county per square mile)
 - Densely settled rural (20-39.9 per county per square mile)
 - These three categories make up 89 counties
 - Semi-Urban (40-109 per county per square mile)
 - Urban (150 or more per county per square mile)
 - Make up 16 counties
 - 4 unique BH needs in rural/frontier
 - Lack of urban/semi-urban resources
 - Legacy of depopulation
 - Higher per capita population of Hispanic persons
 - BH provider shortage
 - Implications
 - Fewer services available
 - Underfunded programs
 - Must be creative in how they serve their population
 - Creativity and innovation are rural counties' biggest strengths
 - Where there's a will, there's a way

- Shortage in health care services is compounded by the greater shortage in BH services and providers
 - Providers must be bicultural and bilingual
 - Must guard against burn-out while living in a community they provide services to. Your neighbors are also your consumers.
 - Takes a really special individual to fill these shoes.
- Rural and frontier counties have fewer BH providers per 10k population than semi-urban/urban (25.4 to 40-some)
- Psychiatricists very limited in rural/frontier areas
 - 197 psychiatrists in 16 urban counties
 - 14 psychiatrists in 89 rural counties
 - Not counting child psychiatrists
 - Some access to them in Wichita; those in western Kansas have better access in Denver than Wichita, KC, Topeka. 3-6 month wait.
 - 3 child psychiatrists in rural and frontier
 - 51 in semi-urban/urban
 - Square miles covered by an individual psychiatrist
 - 4.7 in semi-urban/urban
 - 246 in rural and frontier
 - Windshield time takes away from their ability to provide services
 - Impacts recruiting and retaining
 - Ric - 10 years ago, feds changed the program used for rural recruiting, how we could recruit, redefined rural, northern New York counts as underserved rural and may seem more interesting than Moscow, Kansas.
- Legacy of depopulation
 - Our population is aging, economic base declining
- Ethnicity
 - Rural landscape very diverse
 - Hispanic pop 10% statewide; higher concentration in rural counties. Some counties up to 50%. Some school districts have 26 different first-languages in their school populations.
 - Implications
 - Increased need for bilingual and bicultural staff from an already limited workforce
 - Increased costs as well – documentation in multiple languages
- Addressing barriers through innovation
 - Collaboration is necessary (technology – telehealth, iPads used in the field, taking services to people where they are - any place, any time)
 - Entities must work together creatively
 - Diverse group of stakeholders can implement tangible change
 - Advocate for change – telehealth billing with MCOs, for example
- Objectives
 - Adopt KDHE definition
 - Share the message of the importance of the definition
 - Fundamental cornerstone
 - Only geographically-based subcommittee – only on focusing on an area, not a population
 - 84% of Kansas.
 - Not east vs west
 - Strengthen continuum of care in rural and frontier area
 - Foundation of the system

- Televideo advocacy – barrier reduction
- Established partnerships with KU Center for Telehealth and Heartland Telehealth Resource Center
- Plans for a telehealth survey
- Wrote a letter to Behavioral Sciences Regulatory Board pushing for use of telesupervision for QMHP seeking licensing
- Tech is not the barrier anymore – it’s the local and state organization and policy.
- Ric – negotiating with state to not let face-to-face exclude televideo for screening assessments.
 - Renee – would argue it is face-to-face; it’s just not in person.
 - Robbin – it’s ironic that people that are professional change-agents are the most resistant to change.
- Have an hour on the next BSRB meeting agenda to discuss telehealth supervision. They seem very excited.
 - There’s a ratio per regulation (100% in person); we’re asking to allow 50% televideo.
- Defined challenges for routine and emergency MH and SUD treatment
- Increased funding/crisis beds in rural/frontier for uninsured/underinsured. Will advocate for next crisis center to be in more-western Kansas. Medicaid Provider Panel would benefit from being expanded. Marilyn Roberts, rural and frontier member, volunteered to join the aging subcommittee
- Advocating
 - Telehealth survey – did one in the past. Didn’t get as much info. Want to focus on aging population as well.
 - Letter to BSRB
 - Partnered in children’s MH day in Ashland, 5/4/17
 - SAMHSA webinar – Renee learned that not all states’ councils operate and focus the way ours does
- Continue to diverse membership
 - Ensure needs and resources are considered
 - Added different kinds of stakeholders/providers to bring in voices from outside the CMHCs
 - Conversation changed when we added different voices to the mix
 - Brought to the council’s attention the issues with sex trafficking in SW Kansas, introduced the council to clover house
- Statewide goals and recommendations
 - Statewide adoption of KDHE definition by executive order
 - Housing subcommittee is working towards this as well.
 - Strengthen continuum of care in rural and frontier areas
 - Champion televideo
 - BSRB adoption of telesupervision
 - Telehealth barriers
 - Medicare provider panel expansion
 - Advocate for next crisis center to be a bit more western
 - Diversify membership in subcommittee to ensure that needs and resources are considered
 - Achieve BH equity
- Rural and Frontier advocacy
 - the council provides us a window of advocacy with these reports

- Members appreciate the value of advocacy and a formal process for making these recommendations.
 - Q&A
 - Wes – we need elected officials on the council; on the subcommittees. Need governor’s staff at subcommittee presentations; need to educate legislators about the work we do. Too many people don’t know what it is we do. Working on something for legislative day. Need to get the governor/his staff out here to see the work that’s being done.
 - Wes – Skye Westerlund is out here now, at sf, and working on workforce development, esp in rural areas. Has made her aware of the subcommittee.
 - Gina – state working on getting CROs into other places, willing to work with the subcommittee.
 - High Plains MHC Presentation
 - Handouts (include electronically) – annual report, 2016 served, Scwhaller Crisis Center brochure
 - High Plains has been around for 50 yrs
 - Catchment area is 200 miles by 10 miles in size, 20 counties
 - size of Massachusetts and Vermont.
 - 100,000 residents.
 - Population is reducing, but Hays is seeing some regrowth as people move back.
 - Quasi-municipality, owned by the counties, each appoint a board member
 - Not incorporated, but are a non-profit.
 - 8% of funds comes from counties
 - Service distribution – we provide services to every county in NW Kansas, SPMI and SED. As close to home as possible.
 - 50 cars, traveled 700,000 miles to deliver services.
 - 5 branch offices.
 - 1 4-bed residential adult crisis center, 3-5 day alternative to hospitalization. Non-involuntary, no detox, but otherwise similar to RSI
 - Travel to branch offices 1 day a week.
 - In Wallace, piloting a telemedicine outreach office at rural clinic.
 - 5 prescribers, 30 cm, 25 QMHP, 20-25 attendant care staff at crisis and at center/branches
 - 5,800 patients in 2016; for the first time, saw a decline in patients seen in a year. Lost 6 therapists last year (at once); when you lose a therapist, a certain portion of their caseload tends to leave as well, which likely had something to do with the decline.
 - Raised pay for staff to remain competitive with hospitals
 - No IP psych unit or social detox in those 20 counties. Larned is the closest IP beds. (Adults)
 - Telemedicine
 - 28 units in our offices (Hays, Woodhaven project, branches).
 - Placed 17 units in law enforcement offices.
 - Units in rural hospitals
 - 7.5% of service hours last year were TVC. MH screens for hospitals (350 of 700); 2nd most frequent service – entry assessment. 3rd – med mgmt follow-up.
 - Prescriber preference is to not do first appointment via TVC; prefer to do it face-to-face (Salina has a full-time TVC staffer)
 - Have never had a single complaint about TVC usage
 - SUD
 - 1000 SUD consumers seen last year
 - Most common – alcohol
 - 2nd – stimulants – cocaine and meth – meth is a major issue here
 - 3rd – opioids

- Seeing more heroin – started on pain meds, then move over to street opioids when they get cut off, then lead to heroin or a different class of drug if they can't still find the opioids.
 - Wes – being manufactured in Mexico.
 - Walt – trend of designer drugs coming from china as well. Being bought on the internet.
 - Child placement – foster home for respite care
 - MH first aid – train people to intervene when someone is in crisis. Trained 1,600 citizens. Provided to community free of charge. County clerk requested training for their staff as well. (Tax collection staff)
 - Questions
 - Wes – legislature raised taxes – this really effects the farming communities, commodities down
 - Ric – Linda Hessman has worked with ag counseling service, called yesterday about the number of farmers trying to sell out/get out. Rural economic crisis brewing.
 - Walt – little different than the 80s, people better able to keep up than then; from a psychological standpoint, though is that you have a husband who is farming, wife working in town, husband isolated, wife comes to see the center because the husband is drinking, children acting out from the stress. Suicide common.
 - Chris – see a lot of college students?
 - Walt – Fort Hays University has a counseling center; who we see are the students who are beyond their reach/capabilities. Screen a lot of college students. Consider college students here in-catchment, charge them the sliding fee
 - Gina – High Plains allows Schwaller center consumers to attend the CRO here, hire college students to work/intern there, and both things are very helpful.
 - Walt – Fort Hays is a good recruitment venue. But keeping them long-term is difficult. Now making them sign a contract to ensure a certain amount of time/service
 - Al – do you find the need to have more bilingual counselors?
 - Walt - most therapists are bilingual, 2 case managers, have some staff here on work cards, having issues with ICE renewing work cards. We also pay for interpreter services.
 - Victor – what are you seeing, being so close to Colorado?
 - Walt - we see people trafficking who are being stopped. A lot of people – excursion vans from Salina – to buy pot/have pot weekends. Issues with staff doing it.
 - Al – law enforcement involvement?
 - Walt - doing a lot of work with CIT, excellent relationship with county sheriff.
- HPII Presentation – Gina
 - CROs used to be a drop-in center, place to go when CMHCs were closed
 - Changed to CRO model in the 2000s.
 - 2012-2013 – state wants CROs to be recovery-based.
 - Because we are recovery-based, HPII started adult children of alcoholics' group/program, helps identify where behaviors come from (ones tied to experiences as the child of an alcoholic)
 - Grew up with a brother who spent 15 years in the state hospital, grew up with a different view of the MH system. First psychotic episode at 52.
 - 2015 started ACA Dual-Diagnosis because we found that a lot of people who had eating disorders, sex issues, sugar issues. Not open to public, just CRO members. Meet 6 days a week; when funding got cut we cut one day.
 - Fire in 2010 – didn't miss a day. HP provided space (and counseling for members); church gave us space, too. When we got a new place, HP had a branch office close and let the CRO have the building's furniture. Fire in August, reopened in September.
 - 35 members. Only requirement is that you have received MH services and self-acknowledge and want to work on recovery. Open Monday, Tuesday, Thursday, Friday, Saturday, and Sunday.

- Questions
 - Guy – where are you?
 - 13 & Candleberry, by the Bingo Haus (1200 Canterbury)
 - Ric – financing?
 - Get financing from KDADS through a contract. Walt has provided transportation, funding for handouts at the recovery conference, working on grant application to get the CRO a vehicle. Have community/church support for various things as well.
 - Charley – HPII determined a regional CRO, will be going into state mental health hospital to establish peer services in LSH, to work with them from intake to assure a smooth and successful discharge.
 - Robbin – you mention that your population is aging. What are your thoughts on drawing in younger consumers?
 - Putting together a brochure, doing talks at schools, have some young people, children of those young people. Have four generations of one family in the CRO. Not tech savvy and that might be one unutilized means of reaching young people.
 - Robbin – you find a lot of ways to make people feel proud of themselves and that is a wonderful thing.
- Council is reminded about the Block Grant submission deadline. A letter by the chairman is being completed. Letter stresses ongoing efforts needed to further integrate behavioral health services as well as the Council's support and participation in the development and review of the block grant.

The Council then broke for lunch. After lunch, they toured High Plains Independence before returning, touring KVC Wheatland's acute and PRTF wings, and then regrouping for final updates.

- Member Updates
 - Victor – Recovery Idol in Wichita, September 9th, Century II Convention Hall, handout included, keynote Mia Koehne.
 - Will bring clips to share at next meeting.
 - Wes – will spend next meeting talking about the Adult Continuum of Care, voting for the new co-chair, talking about the meeting with the liaisons, and deciding where we want to go in the next year. Will also get some more information about the block grant and the cuts.
 - We need to find a way to recognize those people that do good work.
 - Charley – maybe have the trade organizations present at the December meeting, present recognition then
 - Guy – discuss a formal annual recognition.
 - Wes – also need to discuss membership. Vacant positions, positions with question marks by them, maybe getting a legislator on board.
 - Charley – working on getting dates scheduled for subcommittee presentations to the secretaries.
- Meeting adjourned at 2:57.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dr. Jane Adams	Others (Not State employees or providers)	Keys for networking	3926 SE 6th St Topeka KS, 66607 PH: 785-233-8732	jadams@keys.org
Alison Allen	Parents of children with SED		15111 West 55th Terrace Shawnee KS, 66217 PH: 913-268-3079	alisonallen@aol.com
Charles Bartlett	State Employees	Kansas Department for Aging and Disability Services	503 S. Kansas Avenue Topeka KS, 66603-3404 PH: 785-368-6391	charles.bartlett@ks.gov
Denise Baynham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7701 Armstrong Ave Kansas City KS, 66112 PH: 913-287-3092	baynhamdenise@yahoo.com
Cheri Bledsoe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Kansas Consumer Advisory Council for Adult Mental Health, Inc.	7528 Troupe Ave Kansas City KS, 66102 PH: 913-787-3507	cheriebledsoe.cac@gmail.com
Roxanne Bollin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		109 N Hospital Drive Paola KS, 66071 PH: 913-731-1508	rbollin@headsuponline.org
Megan Bollinger	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2184 Road K Emporia KS, 66801 PH: 620-343-0982	mbollinger88@gmail.com
Randall Bowman	State Employees	Kansas Department of Corrections	4031 SE 29th St. Topeka KS, 66605 PH: 785-296-5656	Randall.Bowman@doc.ks.gov
Molly Brace	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2229 SW Jewell Topeka KS, 66611 PH: 785-233-8732	mbrace@k-state.edu
Teresa Briggs	Providers		10933 W 333rd St. Reading KS, 66868 PH: 620-481-1197	
Wes Cole	Others (Not State employees or providers)		937 Walnut Osawatomie KS, 66064 PH: 913-731-3193	scole@micoks.net
Robbin Cole	Providers	Pawnee Mental Health Services	2500 Meade Circle Manhattan KS, 66502 PH: 785-587-4300	robbin.cole@pawnee.org
Dr. James Costello	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1717 SW Stone Crest Drive Topeka KS, 66615 PH: 785-273-1495	jcstell@emporia.edu
			901 Lyle Ave Garden	

Ric Dalke	Providers	Compass CMHC	City KS, 67846 PH: 620-276-6470	rdalke@compassbh.org
Sandra Dixon	Providers	DCCCA	1808 Golden Rain Dr. Lawrence KS, 66044 PH: 785-843-5756	sdixon@dcca.org
Mark Dodd	Federally Recognized Tribe Representatives	Kansas Racing and Gaming Commission	3519 SW MacVicar Topeka KS, 66611 PH: 785-368-6203	doddmark1@gmail.com
Al Dorsey	Others (Not State employees or providers)	Kansas Housing Corporation	611 S. Kansas Ave., Suite 300 Topeka KS, 66603 PH: 785-217-2043	ADorsey@kshousingcorp.org
Victor Fritz	Providers	Substance Abuse Center of Kansas	731 North Water Avenue, Suite 2 Wichita KS, 67203	victor@sackansas.org
Susan Gile	State Employees	Kansas Department of Children and Families	555 S. Kansas Avenue Topeka KS, 66603 PH: 785-296-5254	Susan.Gile@dcf.ks.gov
Dr. Patrick Hall	Family Members of Individuals in Recovery (to include family members of adults with SMI)		807 Valley Vista Norton KS, PH: 620-815-8553	phall@valleyhope.org
Kathy McNett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2201 28th Great Bend KS, 67530	imokrightnow@yahoo.com
Deann Mitchell	Parents of children with SED		15985 South Claiborn Olathe KS, 66062 PH: 816-589-5159	deannmitchell15@aol.com
Catherine Ramshaw	Parents of children with SED		1421 SW Hodges Topeka KS, 66615	cramshaw1989@yahoo.com
Viola Riggins	State Employees	Kansas Department of Corrections	714 SW Jackson, Suite 300 Topeka KS, 66603 PH: 785-296-3317	violar@doc.ks.gov
Kirk Schottler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		17991 R Road Mayetta KS, 66509	kschott54@hotmail.com
Fran Seymour-Hunter	State Employees	Kansas Health and Environment	900 SW Jackson, Suite 900 Topeka KS, 66612 PH: 785-296-2212	fseymour-hunter@kdheks.gov
Rodney Shepartd	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Corner House, Inc	PH: 620-342-3015	rodney@cornerhouseinc.org
Peg Spencer	State Employees	Kansas Department of Children and Families	555 South Kansas Avenue Topeka KS, 66603 PH: 785-368-8214	Peg.Spencer@dcf.ks.gov
Guy Steier	Others (Not State employees or providers)	12th Judicial District	636 Grand Ave Clyda KS, 66938 PH: 785-243-8130	judges@12jd.org
Steve Woolf	State Employees	Central Plains USD 112	205 S. Main St Erie KS, 66733	swoolf@usd101.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	33	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	19	57.58%
State Employees	7	
Providers	5	
Vacancies	2	
Total State Employees & Providers	14	42.42%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	9	
Persons in recovery from or providing treatment for or advocating for substance abuse services	7	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The application was drafted utilizing annual reports developed by the Governor's Behavioral Health Services Planning Council's (GBHSPC) Subcommittees. (Please see attachments.)

In addition, on April 19, 2017, the GBHSPC was host to a Public Comment Session in which members and attendees provided feedback about a communication protocol that KDADS would follow to gather input into the Block Grant (BG). They recommended that KDADS provide education to the GBHSPC about: SAMHSA BG requirements, Kansas requirements of BG providers, Kansas Goals/Objectives/Outcomes, other funding sources that Kansas

BG-funded providers access, information about how BG funding is distributed, data about potential gaps in geographic access and other possible service barriers, data about the availability of services and any delays in accessing services, and trends in provider quality. One suggestion was to reinstate multi day, facilitated planning sessions with the entire GBHSPC to assist KDADS in preparing the BG (see footnote for transcript and public comment responses).

To assist KDADS in developing the FFY 18-19 Block Grant, a workgroup was developed that consisted of representatives from: the GBHSPC's Continuum of Care Task Force and the Kansas Citizen's Committee on Alcohol and Other Drug Abuse Subcommittee (KCC), as well as from the Kansas Association of Addiction Professionals (KAAP) and other SAT providers. Themes from their input, other public comment, and the KCC's FY 17 Annual Report were included in the Block Grant (see footnotes for individual and group comments).

On August 3, 2017, a draft of the Combined MH/SAPT Block Grant was posted on our website and placed in the State Register, soliciting public comment. An emailed request to review the document and comment was sent to: the Association of Community Mental Health Centers, the Kansas Association of Addiction Professionals, the Kansas Consumer Advisory Council, the Consumer Run Organizations, the Kansas chapter of the National Alliance for the Mentally Ill, Keys for Networking, the Kansas Mental Health Coalition, and others. Public comments have been collected, and the document has been revised accordingly. Comments received are included in the footnotes.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
 - a) Public meetings or hearings? Yes No
 - b) Posting of the plan on the web for public comment? Yes No
If yes, provide URL:
<https://www.kdads.ks.gov/commissions/behavioral-health>

It was also published in the Kansas Register.
 - c) Other (e.g. public service announcements, print media) Yes No

Footnotes:

KANSAS MENTAL HEALTH/SUBSTANCE USE DISORDER BLOCK GRANT PUBLIC COMMENT SESSION

APRIL 19TH, 2017, 1:00PM

Kimberly Reynolds, KDADS SUD Block Grant Coordinator: I'm Kim Reynolds I work in the Behavioral Health Services commission at KDADS. I spoke to some of you about the TBI program last time we met. I'm here today to talk about the block grant that combines mental health, substance abuse prevention, and treatment block programs for Fiscal Year 2017. We were supposed to have someone here to record the session because this is public comment. I'm thinking he must've gotten confused about where we are so Diana is going to take notes for us. I'm not going to stop and write down your comments but please know they're going to be captured and we're going to make them part of the overall public comments that is going to be collected over the next 30 days.

I want to talk to you about the FY17 grant, even though it's already been allocated, because I wanted to let you know information of what's in the block grant so that we can start having a conversation about how you want me to keep you informed and get your input for the next block grant period. I'm going to be asking you questions to ask not only the Governor's Behavioral Health Services Planning Council for input but also input from everyone about a protocol I'm developing to gather comments and public input on the block grant through this next fiscal year. I want to give you a handout I put together that is – what is the block grant, for folks who may not know. I'll pass that around. The federal block grant is a non-competitive formula grant mandated by the US congress. Every year we submit either a plan or a report on a two-year cycle and every two years we are given a disbursement that's non-competitive; we don't have to compete for it. Our application isn't scored higher or lower than someone else's. This is funding we're going to get that's determined by national indexes that provide SAMSHA with information about the population at risk that is used to make decisions about funding for every state and territory.

I have a little bit here about how the allocations are determined. They're a couple of indexes that are the population at risk, the cost of services, and a fiscal capacity index that's used for the substance abuse and prevention block grant. For the mental health block grant they use the same calculation except they waive the population at risk index. So, that's how it's allocated to us. The amount of funding we received for the period of fiscal year '16 and '17 in that two year increment we received \$23,799,326 for substance abuse and treatment. And \$7,543,890 for mental health services. Of that \$23,799,326, over \$5 million was set aside for prevention, which is 20 percent of the block grant, and the rest went to treatment and a small amount to administration.

The role of the Governor's Behavioral Health Services Planning Council regarding the block grant is you are the body I go to ask recommendations to review the grant to provide me with input that I will use and take back so we as a team will be putting together the block grant. At every full council planning meeting, I will be providing some sort of a report to let you know where we are with the block grant – any changes that's happening, any data that may be relevant. I'll either come in person or provide a written report. I also would like to go to all the subcommittees over the course of the next year to meet people and let them know, but I do understand every one of our subcommittees has a liaison who's from the main planning council whose part of their responsibilities is to keep the subcommittees aware of what's being talked about in the overall planning council. It will be key that I work with the liaison to make sure they have the information they need to carry that down to your subcommittee.

I wanted to talk to you about, I gave you this large number of money about what we received in terms of substance abuse prevention and treatment in mental health services – what does that pay for? For substance use, there're approximately 40 providers at 100 locations that offer assessment, services, outpatient, intensive outpatient, social detox, person centered case management, residential services and other kinds of services. The federal target population that SAMSHA has defined is pregnant women and women with dependent children, IV drug users, tuberculosis, and HIV services which we work with KDHE to provide data and collaborate with them on that. In fiscal year '18 we will be asking service providers to submit a bid to continue to provide services. This is a critical year to have the planning council and other members of the public comment to make sure the services we provide in the future are relevant and useful to the population. A task force is being formed under the adult continuum of care subcommittee of the planning council to help guide us in that work. I think Sandra (Dixon) you're going to be co-chairing that task force and Steve Denny is also going to be the co-chair.

For prevention dollars, prevention had their own similar change in bidding out their services in 2015. The funds they receive are to support the Kansas prevention collaborative which is the state's prevention system. The system includes a state-wide training and technical assistance provider, a state-wide evaluation contractor and a state-wide connection collaboration logistics coordinator, as well as two agencies that provide education, advocacy and promote mental health.

The mental health system has 26 community mental health centers that receive the block grant to serve the severe and persistent mentally ill adult population and the SED (severe emotionally disturbed) population with services like crisis response, evaluation, state hospital screening, case management, supportive housing, and employment. The reason why mental health receives less funding is because more of the target population can receive Medicaid and other funding than the substance abuse population.

What I'd like to do today is take comments from the planning council and from the public who are here today because I would like to put together this notification comment protocol for the coming year for FY18. Your comments are going to guide us not only in relation to the block grant, but also to help us at behavioral health services to come up with ideas for other funding pursuits based on needs identified by the council and community. It has implications for more than just the block grant, which is an important resource for Kansas, but it helps to guide us at the commission as well. I would like to ask questions and get feedback from you. Diana is going to be writing it down.

My first question is, what information can I provide you with and is relevant to you?

Can you talk about the requirements to follow under the block grant? There are two very specific requirements to receive treatment by the block grant on the substance use side. A person must be 200% of the poverty level, uninsured – no Medicaid, nothing. You also must prove you are a Kansas and US resident. These are two specific things that as providers we don't have as requirements. Can you also tell, if you know, the percentage of the treatment dollars that are allocated to designated women's program, which is a special piece of the block grant?

Kim: I don't know that percentage, I don't have that. I can provide that to the council in the future.

I was thinking there was a block of money that's strictly for designated women's treatment programming that has other requirements so I thought it'd be important for folks to know that as well.

Kim: I should've said this at the beginning, but I am new to this position so I am in a learning mode myself. Jump in if there's things like that we should be talking about today that'd be helpful.

Knowing those structural pieces of the block grant would be helpful while as folks are getting public comment because there are uniqueness's to that.

Kim: What other kinds of information would be helpful in providing us with input into the block grant?

I think one of the things, the existing goals and objectives that're established and where you are in terms of outcomes from those? And kinds of opportunities you see, if there's a shortcoming how you plan to address those issues?

Kim: We have metrics, goals and objectives we can provide you with. Two years ago, we had the plan then last year we had the report so I can bring information from the report to a future meeting and we can talk about that.

Related to the mental health service money, is that specific funding for facilities or can nonprofits access those funds?

Kim: Most of the money has been block granted to the community mental health centers. One program has been set aside. There is a specific interest that SAMSHA had in early episodes of psychosis so Wyandotte Center for Behavioral Health and Valeo received help.

Many years ago, all the CRO's used to be operated under the federal block grant. Then in 2006 it got shipped into the state general fund. And our CRO's started shrinking. Is there a way to start making that money shift back to the block grant to protect the CRO's so they stop shrinking? The state general fund makes them vulnerable.

Kim: I'll look into that for a future meeting as well.

Years ago, we had a planning meeting that lasted a couple days over at Topeka State Hospital and we worked through the topics and said what we cared about and the planning council was part of that. We were fed information then we were put in groups to process it and report back. I don't remember freestyling. If I had something to look at it would help me.

Kim: When you did that several days planning meeting did you have folks outside the planning council or was it just the planning council?

It was just the planning council if I remember. We had a facilitator, Melissa Ness.

I also remember that and it was just the planning council. And we did that for several years.

For those who do not know the Governor's Behavioral Health Service Planning Council sits under federal statute and one of the main issues for that is to review the block grant and provide recommendations for the secretary.

It may help, since we have service providers here that receive these program funds, they're here for comment and I think that may be more comfortable to a planning than to us. Those who deal with it on a year to year basis that need to receive money, or scale back. That would be helpful to us.

Kim: To get comment from the providers who are receiving the funding?

Yes. And those who are the planning council itself.

I wanted to ask if you had any ideas for innovative strategies that would include the urban or rural frontier areas? Also, I see we individuals who represent the faith based organizations and if there's anything that may be indicated through the latitude you have to focus on faith based initiatives and partnerships?

Kim: Ok.

I suggest we hear from providers. I think it's beyond important we hear from family members, consumers, and parents and children. You could come to Ashland with us (for the Children's Mental Health Day event, May 4th, 2017).

Kim: Ok. I'm going to ask, one of my questions is about consumers and family members. What other information can I provide that would be useful?

You mentioned there are 40 providers in 100 locations, but I think it would be helpful to find a map of the state that shows where the dollars are going and look at it from that perspective.

The mental health dollars are different than the A&D dollars. Which causes a big problem. You might come here for treatment because you couldn't find a provider there to give you what you needed. And your dollars don't follow you.

Kim: That's why it would be helpful to see where the money's going.

I was concerned with how the target areas are targeted? And which cities are on the list because they have more problems because there's no help. I'm from Wyandotte county and I deal with these issues every day. I don't see any funding coming in there to target the areas you guys are talking about?

Kim: There're mental health centers that cover the state and they all do receive some block grant funding. The substance use disorder providers not all the providers in our network receive block grant funding or were part of our network ten years ago when we began this way of providing SUD services. Which is why we're going to spend time to forward that.

I think it would be helpful, especially on that SUD side, how much money is being spent by the providers in excess of what they're being reimbursed to provide services under the block grant?

Kim: Great question. There are other funding sources as well. So, you could also look at other revenue streams to see other money sources they get money from.

In years past we've had relatively high level of success of returning to providers. Often close to 100% of what we refer to as prepaid throughout the funding. Those prepaid have also been

considered in modeling allocations. As funds have become less available it's been harder to offer that rate.

Kim: For those who may not know, Beacon is the managed care organization for which we contract for management of the SUD block grant dollars and manages the allocation process along with KAAP (Kansas Association of Addiction Professionals) and they recently redid the grant for that.

I'm assuming that is the portion of the dollars that comes out of the block grant for administration as well as your office?

Kim: Right.

Something I'd be interested in knowing more about is outcome data?

Kim: Ok, we have the current outcomes. But we could look at other outcomes as well and that would be another thing we can explore for the coming year.

As an educator, I think about this when my students ask me about it - outcome meaning successful graduation and completion of treatment be it intensive outpatient, inpatient it doesn't matter and then recidivism rates. I guess the simplest question is bang for the buck?

Kim: Right.

I'd be interested in seeing what different limitations are enforced by federal and state on both sides?

Kim: Ok. Other thoughts about things you'd like to see?

Maybe outside the block grant there might be something we're not seeing that's funding. Maybe we should put it towards here, but there's probably funds that might be covering it somewhere else that we don't know about. So, when you bring that information maybe bring with it information that says we don't put a lot of block grant money towards this because we have this fund that covers it so we don't focus on something we don't need to focus on.

Kim: That makes a lot of sense. Any thoughts?

One thing we talked about in preparation is not necessarily what the block grant funds, but what are those gaps? Whether it's geographic gaps, need based gaps or financial. I think it's important for folks to hear here's the cost of providing a variety of those services versus what's reimbursed with other funds that will help support that. I think that picture will be helpful.

Let's not forget the wait time to get inpatient treatment. I'm not going to say how many die from it, but it's surely detrimental. And I know we've got them stacked up for months. Not good. We've got less people doing inpatient treatment nowadays.

You're going to double the size of your facilities is what you're trying to say?

They're glad to get in. We refer them to outpatient, then they fail and they continue to use.

That's a gap we talked about earlier.

Yeah, it's a huge gap.

Kim: Involving the subcommittees do you have any thoughts about how we should go about doing that better so we can get information from them.

Part of what I worry about when I hear that, as the subcommittees grow and evolve in terms of number or population it seems as though that we're going to get more and more subgroups arguing for smaller and smaller pieces of the pie. That concerns me primarily because it forces specializations like we're going to do something specifically for veterans, or people with severe and persistent mental illness who have a methamphetamine addiction who are over 57 years old who use a wheelchair and cry on Easter Sunday. And we'll create an evidence-based practice around that group. The specialization begins to worry me more and more because we're learning across the nation co-occurring and multiple issues are involved in mental health and substance abuse. I don't know how effective we can be with so many specialty programs.

Kim: Are you saying to rely more on the overall planning council and less on the subcommittees?

Probably yes. I'm on the veteran's subcommittee so certainly part of my role would be to argue for, I want more emphasis towards a particular group when there are other needs as equal but may not be socially or politically as recognized.

Speaking on subcommittees, would you have any recommendations that say Kansas citizens could look at work on in regards to bring it to the table for council? Visiting those communities like that, would you have something that you would like to see?

Kim: Sure. It's a large plan. The 2016 – 2017 plan is 320 pages. It asks a lot of questions. Some of the questions they ask touch on every subcommittee specifically. So, that is a way I think would be useful to have input of the subcommittee when it's a special question about veterans.

I have a question about reentry, individuals who've been incarcerated. We're in KC and we're trying to figure out which direction to go in. Facility housing for individuals who are returning to the community who've been incarcerated who are struggling with housing, and mental health issues. We have a one stop kind of deal we're trying to find where to go and who to talk to. And does this grant even cover that?

Kim: Sure. We have some discretion in the state about what we choose to do with the funding and who we choose to fund. The purpose of this meeting is to talk about how to get useful public comment and input for planning council so we can make the best decision with the dollars in terms of going out with our next block grant. I don't know if I'm answering your question except to say that FY18 and 19 hasn't been written yet. So, we haven't said this isn't what we're going to fund or not fund. This process today is figuring out the best way to get the information out to you. To get information from you so we can make those decisions.

What group organization are you from?

The villages.

Kim: Staying involved with us is a good idea. I'm going to provide you with ways to provide additional public comment after today. I can give you my information so you can stay connected with me.

I don't know the answer to this but Jane brought up how to get those families or consumers involved to provide some feedback on what they see. We have to do that better. It's been mentioned here, I don't know what the answer is. I'm from the outside looking in so to speak. There're people that do know that. I think you need to get a group of those people together sit down and talk to them and find out how do you reach out to them and get it exposed how they go about it. We might see some of these outcomes on paper but let's talk to these individuals on their outcomes and see what they have to say and whether it fits on paper. How that happens I don't know. Some of you have better ideas. It's only been mentioned, then it goes to other areas. I want to bring that one back and I think we have to find a way of doing that and doing that well.

And a few of them are required to be represented on this program.

They are, but that is an insufficient number. We need to reach outside the group for that. The ones on the group representing those individuals is a good starting point, but let's talk with Bill and find out where else we can go to get more. Because I don't know how we make these announcements without talking to people that are receiving services.

You want me to bring them in and fill you in?

Or we could go to your place Kirk?

That's right, sure we could.

But we go to hospitals, I found it very enlightening to sit down to have someone from the hospitals sit there and talk and say this is what's happened to me. I would find it enlightening in other situations too but there has to be a good efficient way of doing that that's not just an informational piece for us it's really talking about here's the money we've been putting in has it been productive with the services you've received how do you feel about it on a personal level? I think that would be beneficial.

Kim: So why don't we open up that question to everybody to make sure we get some input about consumers and family members.

I just want to answer that question for him because I do this on daily basis. I am the liaison for the police the sheriff's department and we have clients they assign to me who have drug and alcohol problems that it's affecting the home. Your answer is not going to the hospital; it's got to be at the home.

Clapping

Because that's where it starts. It starts in the home and goes out into the community. Once it's out to the community, those people are lost. So, part of my job is a person who has a drug problem who's coming through the child support court. He can't get a job; he can't pay child support so they lock him up. So they come to me and ask me to help him. First thing we target is what is his drug or alcohol problem. Once we find that out we can send him in the direction he needs to go in. We keep track of him until they're through -we keep track of him for a full year. We progress this information back to the courts. We keep track of each individual we work with. The only problem is, we don't have much funding. We have to go out to raise money to give to other organizations and make them one body instead of separate bodies to become a

conglomerate. That means that the questions you're asking we would know and the question I'm asking you would know and it would be somebody we all know that we have somebody we can send them to make sure what their needs are along with that person the individuals, the courts, law enforcement and the families – all becomes one system so we all work together to make that person a whole person instead of part of a person.

The thirteen consumer run organizations across Kansas are a wealth of information. That's a great way to reach out to the peers to find out what's going on with people who are diagnosed with SPMI. They're the best kept secret in this state. Peer support, tremendous amount. It saves the state so much money and people aren't aware of the wealth of opportunity that exists in those programs. I encourage everyone to find out about the CRO's close to you, visit them and find out what's in them. Find out from the members in those programs. What are they doing? How are they connecting with their communities? Because you would be amazed, there's great stuff going out there. The CRO's don't get the recognition. It's quiet. It's time to talk about it.

I'd like to expand that. I think it's a great idea. Where are those places for folks who are also engaged in peer services for substance use disorders? Many of the folks working in the peer community both in the CRO's and others could be a peer for someone with mental health or substance use disorders, the substance use side doesn't have that network like the CRO's do. Engaging Oxford Houses, we have folks around this table who are engaged in peer support who train peers who do all that. I agree, I think that voice is important. The family members of folks who are still struggling who are in and out of treatment, in and out of relapse. Jay's right. Family's deal with this every day and don't understand how to navigate our world because we have all these rules we have to follow.

And bringing them in to say I found this extremely difficult because of this, this and this. Can be critical on how we provide feedback to you saying, ok this could be better if blank.

On the other side of that family coin I've treated three generations in the same family. We see a multigenerational problem that they didn't they didn't leave the family because the family was good. They ended up coming to treatment because grandma finally got clean then mom got clean before it goes the other way.

We have to address the population density issues. With communities that are rural frontier communities as well as urban densely populated rural, ways to make sure those services are available regardless of the number of people in the community. We need to hear from if we're going to bring people together we need to make sure there's representation in those groups of all parts of the state.

And within those, I always find it somewhat ironic because you have one set there's so many people you can't provide enough service and the other set there's hardly anyone so can't provide enough service. The problems different but it's still the same.

Addressing the concept of recovery and systems of care how much of the state buy-in is for that? And what we can look forward to doing with those systems that encompasses peer support and housing and other forms of recovery related services and I would like to know where the state is as far as actual buy-in or investment in regards to systems of care I know it was a SAMHSA

initiative, we try and follow that, with those dollars being spent where are we with that particular portion?

Kim: Anything else about involving consumers and family members gathering input?

I've worked with family preservation and foster care reintegration families for a lot of years and one of the things that I've discovered over the years is sometimes people go to the same providers over and over that's where the funding is. It's not where they want to go any longer. They've not been successful, so I guess I would like to know if there's any possibility of communicating where there's developing other options for families when they need to use the block grant funds to get clearance to get their kids home?

Kim: Other thoughts about consumer or family members?

I think this is bigger than just the block grant. People in the provider world you talk about safety nets, but in the other world where people live, people don't know where to get services, they don't know who provides what services and they are never quite eligible for whatever it is that is on the table. And so most of the time, we get nothing. I just have to read you this, it's very short. But I got this since we started this meeting. This is from a man who said "my son turned ten in January. Yesterday at school he was upset because his regular worker from the mental health center that picks him up on Tuesdays couldn't get him. So, he ran off the bus after school. Police were called because he was off school grounds. They finally located him with a stick in his hand. Guess where this is going. The officer said he had his pepper spray and told him if he didn't drop the stick he was going to spray him. My son dropped the stick, was tackled and placed in handcuffs. I arrived shortly after this happened and he was out of control. And so on. He's now at juvenile intake. He's been charged with a crime. I asked the officer if we could take him to a crisis place. So we did, got regulated. But he's still charged with this crime." And the man ends this by saying "what am I supposed to do? My son can't read, hates school, still wears diapers." He testified before this group two years ago, he was one of those parents who came. And he has no idea where to go to get help. Right this minute I'm not sure I know. It's as much about an information network and a way to click somewhere and hit this and things come to mind, but when you're in this there aren't, my own daughter has a serious mental illness, and I don't know where to go. When she's having a terrible crisis. And so, I know where to go where I won't get any help. Let me say that. It's sad to me that we sit in this room and we're supposed to be advising somebody and I don't know the answers to hardly any question anybody asked since you came. I'm not blaming you at all but we don't know ourselves where services are where the money is. What we have to say to get what. That is not clear information.

So, is the majority of the mental health block grant of \$7 million going to mental health centers and is that being supervised about what they're doing?

Kim: Supervised in terms of their reporting on metrics.

Right, but what are they using those funds for? As a family member and part of a families for mental health. Over the 30 years I've been involved with mental health services we had a whole lot for a while and people were getting more and more. Now 50-year-old men are sitting in their mother's houses in their bedrooms, won't come out and nobody will come see them. Nobody's

checking, nobody's doing anything. I don't know if laws need to be changed or when somebody has 95% of our long-term persistently mentally ill people are not dangerous, but there're a few that are. And when there's one that has a history of a felony attack and has been in jail when his mother calls it shouldn't take 9 visits by the police to get him some help. It took 9 times. The CIT and everything. But still, where is the help? Who's helping who? The levels of care aren't there anymore. Nobody's checking. I think KanCare. They talk about that with Medicare, and people have been dead six months and KanCare has never checked on them or something like that. Our whole system seems to be in disarray. Anyway, I'll get off my soapbox.

It would be helpful information for this group to look at how the mental health systems are spending that money and how often they're reporting on their activity, how many people are being served with it? That would be helpful to look at.

I don't disagree with you Margie, but I don't know how we could fix a whole system. I agree with something Jim said, all of us has a particular focus in a sense people always have what they want see get done out of it, so it becomes very specialized. So, you start, tying strings to every piece of money out there, to get this piece of money you have to have this, this, this and this. And if you don't have that you don't qualify and that's why everybody gets told no because there's one of those seven pieces that say you have for this piece of money that you don't have so you don't get because you don't have all seven you only have six of them. You talk to alcohol but you don't have mental health for this piece. Or you talk to mental health and you can't treat alcohol and drug addiction for this piece. And I think it's great to see what they're doing with the money. But I think the bigger question is is what can they not do with the money that they wish they could? If we get that answer, then we can provide feedback and we say we love the block grant it should go to here. But how 'bout we reach out to the feds or state or whoever's tying the string and say how 'bout loosen this string. And if we start making recommendation that these strings are too tight, maybe...

Most of them have to have a case manager before they come into the door to get a Kansas ID.

Yup, and it makes no sense.

Especially when they have to be a Kansas resident and they can't prove it.

I think what they're doing with the money is great. But if don't say what they can't do with the money sets us up to say "Why aren't you doing this?" Because that is our complaint often, "Why aren't you doing this?" They probably have this hand and an elbow tied behind their back and they're sitting there doing this instead of this.

I think there's three areas that need to be touched. One, case management and the people who are doing case management – are they doing their jobs? Because the clients they're supposed to be working if they're always going to jail, that means you're not doing something right. Also, with the facilities they're going to, who's monitoring the facilities? And are the people working in the facilities do they care? Or are they doing it for a paycheck? They know at the end of the day, they're going home. But that person who they're supposed to be taking care of or monitoring they don't know where they are. And if you ask them they'll say, "I don't know." And the third thing is, as I said before, touching the family. Talking to the family because it didn't start as an

adult. It started from the house. And whatever those kids were looking at that's what they'd seen and that's what they thought life was all about. Behind closed doors, we don't know what's going in the houses. Sometime, like the organization I've been working with NAMI, people don't want to talk about it because it's too embarrassing. But then when it gets to a crisis point that's when we come in and we've got to deal with a situation that could've been dealt with a long time ago. Only if somebodies reached out to an organization saying I've got a child or a teenager at home that's way out of control. I don't want to put him on meds, I want him to get the right help that they need, where can I go?

This discussion is good and it makes me think how important the adult continuum of care process was. We've got some of this processing out there that has to blend somewhere in our discussion about block grant funding because block grant funding can't touch what we're talking about. It's more than that, it's the whole continuum of care also, so we have to blend that discussion I think for me on this and discussed.

With the youth information that's is mentioned where're the prevention dollars is that a part of the block grant? Because we're curing or trying to cure everything on the backend, but the youth prevention dollars as few as three or four years ago the summer youth camps that they'd been housed at a college and they rented to a church or a 501-C3 where's that conversation and is this the place to have it?

Kim: Their prevention dollars is part of the block grant as well, so it's input that we'll be seeking as we're writing next year's block grant.

To what level? Sounds like we're heavy on cure over here. Nothing wrong with that. Seems to be we need to have a lot of conversation as well on prevention upfront.

Kim: 20% percent of the block grant is a federal set aside for prevention. There's other funding as well just like we're going to talk about other funding sources for our initiatives too.

The 20% we're talking about is only in the SUD grant. The mental health grant which is about \$3 million. This 10% set aside that we've been able to use for grants for the first episode of psychosis we've talked about is the first dollars that've been added to the mental health side grant that are aimed at early intervention prevention.

So, the gentleman who is a liaison for law enforcement, there's a couple things he said that have brought to mind a few other scenarios. One piece of this that's been mentioned, and I have questions about the block grant couple progress if it can, when you do get law enforcement involved it becomes something more than mental health, it has criminal aspects as well. There're some areas that have done a good job and we talked about taskforce respond to mental health issues when they get brought to the attention of those folks. I wonder how much better we can do on that? I'm an attorney and I've represented criminals a million times over and I don't do it necessarily anymore but I still get people calling me on a regular basis and I'm involved in the Hispanic community here in town. Recently I've known for a number of years; she has two sons who have serious mental health issues. He had an episode, he's been in Osawatomie a number of times in the past. He hits his grandma. They end up having to call the police over to get him out of the scenario. The police officers arrest and take him to jail and I'm not saying they're wrong in

doing that. But it's a day later before they send over a victim's person that can speak to him in Spanish. They explain to her he's been to Osawatomie in the past, he has medication he's supposed to be on medication right now. They recently changed the medication and they think this is what triggered the episode that just happened. So, they give the spiel to everybody, couple days later still nothing has happened. They end up talking to me five days in. I try to call the attorney representing him. Took three days for the attorney to call me back. Finally, after my persistence, I talked to the attorney. The law enforcement hadn't done anything; prosecutor didn't know anything about it. I finally talked to an attorney, the first attorney refused to talk to me and I had explained to the attorney why it's not improper to talk to me and I'm an attorney trying to explain this to them. After me making several comments I got the attorney to understand that there's a huge history here in mental health. Finally, the attorney went and filed something and we got him, after he was in jail for 10 days, into Osawatomie. It's crazy, it's ridiculous that it takes that to get it done. And had I not intervened, it wouldn't have happened.

It happens every day.

It does. We need to look at people who have episodes that might commit a crime how do we get involved and intervene and get them the help they need quickly and what funds can we use to put towards that because it's not happening much now. Even when money's there – the education piece. Cops don't know, they're not mean and evil, they don't know, they're not trained well on this. And the attorneys don't have a clue often what to do. If we go train better law enforcement and we let attorneys know we can stop a lot of these cases ended up criminal and these people having extended criminal histories on things that're psychotic episodes. I'm not saying they didn't commit something that is determined as a crime, but did they truly do that when you look at what it takes to commit a, a lot of times they didn't. It's not the best.

Kim: I want to be mindful of the planning council's time. I appreciate them taking part of their day. I do have another question for you. I have one for everybody, and then one more for the planning council. What other groups should we be informing when seeking input about the block grant?

I believe you should be talking to the courts, the prosecutor's office and your in-command chief of police and your sheriff's departments. Like the gentleman said, when the law enforcement shows up they don't know if this person is psychotic or has a mental problem. The first thing they do is put on their gloves and that means they're either going to take this person down or taze him. Once they get them incarcerated, this person doesn't know why he's in jail. He doesn't. And the family is not told until two days later. Because they don't call the family. They incarcerate them and just sit there until they get a court appointed attorney or they decide to give them a video court date. Where the judge will talk to them on video court instead of having that person having a representative with him because this person doesn't know what he's talking about. Sometimes I get the officials mad at me because of the comments I make, but if you were doing what you were supposed to be doing we wouldn't be having this conversation. So, it's got to start in the court system.

Hopefully it should never get to the court system, but that's a bigger problem.

Foster care integration providers and the family preservation providers they all deal with families that have substance use problems and mental health problems both. And working with families

directly in their homes and children that've been removed out of their homes they often struggle with resolving the problems when it comes to substance use. They're the hardest families to ingrate children back into and they're experiences where providers don't work together as well as maybe they should. I think they both need learning lessons on both sides. That's made a difference in communities we've worked with.

Kim: Other professional associations, groups?

I would think a valuable source would be the direct service providers. The councilors, the therapists, the addiction counselors, the peer mentors the front-line folks in both of those arenas. Who are rarely asked they're views and they see what works and what doesn't and with whom.

I would expand that just to say people who are currently receiving services from block grant funded providers would be a helpful group of people to hear from.

Absolutely. I agree

Kim: Other thoughts about that. Groups that we should be...

Consumers.

Schools.

Kim: Does anybody have any other thoughts? My final question is for the planning council. We hijacked your meeting and we appreciate it. I wanted to know if this is honestly a good use of planning council time or you feel like in the future this would be better held outside the planning council and the planning council just aware and able to go to it? I'd like your feedback?

Yes, to both.

I think there's more opportunity the more you do and are out in various communities and not just this venue, you need to go to people because they can't come here. I do hope council members are engaged in those conversations. It's important for us to be here. Not just as an individual provider this has been interesting for me today to get reinforced from things we already hear. I think it's important for us to be engaged because we have a specific role with you.

If those meetings are happening now, I have never been told about them in the past. If you're reaching out to people in the communities we've talked about. I can't promise I'll go to all of them, but I will go to some I'd like to hear. It's always been fascinating to me to get the opportunity to hear people talk about what their experiences are whether a consumer or a provider. I never got an email saying this is what we're doing at KDADS to find out if anyone at the council would like to show up.

Kim: The FY18-19 plan rfp that we'll be responding to is still in draft form, they just finished their public comment on April, 14. We don't know exactly what's going to be in it. We're not going to wait for them, we're going to start working on it now. This is the kick off for wanting to get input from all of you on the best way to get information to the planning council, to the state, to everybody who needs to be a part of this process. I want to thank the planning council for letting us take over your meeting. And for everyone who's shown up today. I do want to pass around some information about the public comment period. If you think of things after today, there are places you can go to make that comment and we will be

including all of that in the FY18-19 block grant the information we get today as well as any other info we'll be sharing with the planning council. We appreciate your time and will be using your information.

Thank you for coming.

CLAP.

Four County Mental Health Center Inc,

Feedback for SUD block grant funding

Submitted by Steve Denny, Clinical Director

Four County Mental Health Center Inc, is a community mental health center serving Chautauqua, Cowley, Elk, Montgomery, and Wilson counties located in Southeast and South Central Kansas. Four County Mental Health Center is currently licensed to provide Substance Use Disorder Treatment (SUD) in Independence, Coffeyville, Winfield, and Fredonia, KS. Four County appreciates the opportunity to provide feedback on the SUD block grant and the future of SUD treatment in Kansas.

1. What are the unmet service needs/critical gaps in the state's current system
 - **Transportation:** Many SUD clients particularly in rural areas need access to transportation to treatment activities. Most inpatient facilities are not in a reasonable driving distance, which results in undelivered care and no shows. Reimbursement mechanisms should be added to allow for clients without insurance particularly in rural areas to access transportation. This could be accomplished through partnership with general public transportation, Medicaid transportation, and perhaps some private transportation resources.
 - **Coordination of Care:** Coordination of admission, discharge, and follow up services can often take hours of a provider and/or support staff's time. There are no codes to support this type of care as there is in the mental health system. A model should be considered that allows for coordination of care through an outcome based platform.
 - **Current code structure:** The SUD block grant is currently designed around a fee for service system with a yearly capitation, which puts providers in a difficult situation. Services like case management, care coordination, and peer support could be essential in achieving positive outcomes such as employment and reduced recidivism, but the current fee structure does not allow for margin to effectively develop these programs. Either an increase in fee structure or an outcome based model could help fund the development of these services.
 - **Medical & Social Detoxification:** It has become nearly impossible to find medical detoxification services in many rural areas. This hinders the clients in moving ahead with recovery efforts and continues the addictive cycle. Social detoxification is a need especially in rural communities, but the reimbursement

rates provide not operating margin to justify opening a facility with the right amount of beds to meet the needs of a small community or region.

2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?
 - There currently exists a positive relationship between providers, state program staff, and the administering block grant managed care organization. This allows for effective decision making for the citizens of Kansas.
 - If a fee for service model continues, it is important to continue to allow the pre-paid claims system to continue. This allows providers to continue to deliver care to those in need without imposing debilitating limitations on the consumer network.
 - The development of the peer mentor certification and training is a powerful service system that should be expanded and added in as a tool to achieve outcomes.
 - Kansas embraces and promotes a Recovery Oriented System of Care approach and is committed to many other evidenced based practices.

3. What measurable changes/enhancements would we want to see over the next two years?
 - Discontinue the KCPC and allow providers to collect and submit data that interfaces with Electronic Health Records that can be submitted to the State through a repository.
 - Develop models to allow for the development of coordination of care, case management, and peer support.
 - Develop a more effective crisis management model in partnership with CMHC to allow for more effective crisis management of co-occurring populations (Programs similar to RSI that could be modified to rural areas as well)
 - Increase regulatory support and pilot co-occurring treatment models in community based environments.

4. What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?
 - Offer outcome or pay for performance models to providers to allow for the development of integrated care and more effective service delivery options including peer support, care coordination, and possible

integration of integrated care OR adjust the fee structure to give providers operating margin to develop these models

- Consider allocating dollars or value added services to fund transportation, cell phones and other incentives to help clients be engaged in treatment.

Diana Marsh [KDADS]

From: Al Dorsey
Sent: Saturday, July 08, 2017 8:38 AM
To: Sandra Dixon; sdenny@fourcounty.com
Cc: Al Dorsey
Subject: Block Grant Feedback

I would first like to acknowledge appreciation for the two of you to facilitate this effort by coordinating the many voices that have ideas related to the Block Grant. My input – after reading the well stated comments from the RADACs and KAAP are similar in point. Finally, after being on vacation for three weeks to address some health matters followed by some family events, I've found myself in a very critical "catch-up" mode at the office. Thus, my few comments arrive a day late.....

1. There seems to be the need for training resources for treating the LGBT clients as well as recognizing support systems for the LGBT population.
2. The opioid epidemic has finally surfaced as one for treatment focus. The impact of this problem seems to place a necessary focus upon rural areas. Effectively addressing the "best-practices" used through the research of evidence-based treatment of opioids is a must and should be considered for the 2018 Block Grant.
3. The Block Grant should make a point of encouraging and strengthening use of tele-med care in rural areas.
4. The Block Grant should allow for the increase of peer recovery services – especially in rural communities.
5. The development of plans that focus upon transportation in the rural areas needs to be piloted for possible solutions to that barrier (transportation).
6. I'm not sure how feasible it might be but it seems there could be a great need to consider the establishment of "Oxford Houses" in some of the more rural communities.
7. The need for adequate, affordable and safe housing – especially for those individuals participating in the Department of Correction's "Re-entry" Program is paramount. How that need can be addressed through the Block Grant could be a real challenge.

Again, Sandy and Steve- thanks for your coordination of this effort!



Alfonzo Dorsey | *Director-Housing With Supportive Services*

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To:
Sandra Dixon
Sdixon@dccca.org

From:
Brian Baker

07/07/17

Comments on State of Kansas Federal Substance Use Disorder Block Grant

In response to the four questions posed by the Kansas Department for Aging and Disability Services (KDADS) to this advisory group, please find Beacon Health Options' comments.

1) What are the unmet service needs/critical gaps in the state's current system?

Beacon Health Options feels that one of the primary service gaps in the state revolves around a lack of residential treatment options for men in both rural and urban areas. We understand that this is a difficult request, given the federal priority populations targeted by Block Grant funds; however, it does seem to be the population that is most likely to experience a wait for the recommended level of care.

Additionally, outpatient services for all populations in the rural and frontier areas of the State, while available, are often times not prevalent enough to support member success. As numbers of members are not sufficient, in many areas, to maintain an outpatient program, the supported use of technology to augment this level of care should be strongly considered.

2) What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?

Beacon feels that two of the most important components to emphasize with SAMHSA, would be our strong oversight and data collection processes, and the active paradigm of including peer support in the continuum of care. These are both factors that allow Kansas to perform better than other states, with very limited resources.

3) What measurable changes/enhancements would we want to see over the next two years?

Beacon recommends:

- 1) funding the continued support and expansion of Peer Services,
- 2) investment in technology resources that break down geographical barriers,



- 3) a web-based data collection system that reduces barriers for providers and allows more robust reporting opportunities for KDADS and finally,
- 4) renewed support of a Continuous Quality Improvement initiative to move the network forward.

Finally, Beacon Health Options would like to see further coordination with other State agencies and departments to combine resources, gather and share data and ensure support for those who utilize these, and other State and Federal resources.

4) What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?

Beacon would like to see payment structures developed which include incentives for performance, quality outcomes, fidelity to evidence-based practices and partnerships with local charities and organizations that better serve the "whole person". We know that research shows these practices improve care and reduce overall "per member" costs, allowing dollars to be stretched further, for more members.

Thank you for the opportunity to bring these suggestions forward. Beacon Health Options is dedicated to partnering with the State of Kansas, KDADS, and providers in not only continuing to care for the most vulnerable Kansans, but also in helping to move the system forward.

Sincerely,

A handwritten signature in black ink that reads "Brian J. Baker". The signature is written in a cursive style and is contained within a thin black rectangular border.

Brian Baker
Vice President – National Client Partnerships
Beacon Health Options, Inc.

Diana Marsh [KDADS]

From: Carrie Billbe [KDADS]
Sent: Friday, August 25, 2017 4:16 PM
To: Kimberly Reynolds [KDADS]
Subject: FW: Opportunity for Consumer Input!

From: Morning Star, Inc. [mailto:cromorningstar@sbcglobal.net]
Sent: Friday, August 25, 2017 4:15 PM
To: Carrie Billbe [KDADS]
Subject: RE: Opportunity for Consumer Input!

That would be fine with me. William L. Henson

From: Carrie Billbe [KDADS] [mailto:Carrie.A.Billbe@ks.gov]
Sent: Friday, August 25, 2017 4:04 PM
To: Morning Star, Inc. <cromorningstar@sbcglobal.net>
Subject: RE: Opportunity for Consumer Input!

Hi Billy,

Thank you for sharing a bit of your story and how Morning Star has made a positive difference in your life. I just want to verify that you understand that the input/comments KDADS is requesting is a comment request for public viewing. If you give us permission, your comment will be included with many other public comments (at least a dozen or more) on the Block Grant document that will be posted on the KDADS website and in a summary of public comments to be presented to the Governor's Behavioral Health Services Planning Council. Stories like yours shows that recovery is possible and the work that is done at CROs is helping people and changing lives every day. This reinforces the need for ongoing funding in many facets in the Mental Health system. Please respond to let me know if you are still okay with submitting your comment.

Many thanks!

Carrie Billbe
Adult Consumer Affairs Coordinator
Behavioral Health Services
Kansas Department for Aging & Disability Services
503 S. Kansas Avenue
Topeka, KS 66603
Phone: (785)296-3773
Fax: (785)296-0256
Carrie.A.Billbe@ks.gov



VISIT OUR WEBSITE: WWW.KDADS.KS.GOV

From: Morning Star, Inc. [<mailto:cromorningstar@sbcglobal.net>]
Sent: Friday, August 25, 2017 3:22 PM
To: Carrie Billbe [KDADS]
Subject: RE: Opportunity for Consumer Input!

My name is Billy Henson,

I started coming to the cro about a year ago when I got hired on as the driver Before I came to Morning star I was in and out of the hospital about every six months. There were weeks at a time when I wouldn't get out of bed to shower or take care of my personal hygiene. I rarely ate I went from 250 pounds to 180 pounds. Don't get me wrong, Im glad I lost weight but not that way. It is a very personal and a source of embarrassment for me. I have been in and out of county jails and spent 2.5 years in the penitentiary. Im not proud of my past but it is part of my story. Since I've been coming to morning star I take a shower every day and change my clothes daily. For most people this is not a major accomplishment but for me it is. I haven't been to the hospital or to jail I started coming to the cro.

From: Carrie Billbe [KDADS] [<mailto:Carrie.A.Billbe@ks.gov>]
Sent: Friday, August 25, 2017 2:07 PM
To: (dodgecity_peaceful_tribe_06@yahoo.com) <dodgecity_peaceful_tribe_06@yahoo.com>; (jtr127@jtr.kscoxmail.com) <jtr127@jtr.kscoxmail.com>; (pgs1969@yahoo.com) <pgs1969@yahoo.com>; (sjdewitt52@gmail.com) <sjdewitt52@gmail.com>; Caring Place, Inc. (caringplace20012002@gmail.com) <caringplace20012002@gmail.com>; High Plains Independence, Inc. (ginna713@yahoo.com) <ginna713@yahoo.com>; High Plains Independence, Inc. (hpiisoaringeagles@yahoo.com) <hpiisoaringeagles@yahoo.com>; Inc. Sunshine Connection (aujici@yahoo.com) <aujici@yahoo.com>; Morning Star, Inc. (cromorningstar@sbcglobal.net) <cromorningstar@sbcglobal.net>; Open Door (hicks8029@yahoo.com) <hicks8029@yahoo.com>; Prairie (helenstramel@hotmail.com) <helenstramel@hotmail.com>; Project Independence, Inc. (projectcro@yahoo.com) <projectcro@yahoo.com>; PS Club (jefferyhunter2011@gmail.com) <jefferyhunter2011@gmail.com>; PS Club (psclub2015@gmail.com) <psclub2015@gmail.com>; RAHN (mlp.home@gmail.com) <mlp.home@gmail.com>; RAHN (recoveryandhope.lawrence@gmail.com) <recoveryandhope.lawrence@gmail.com>; SIDE, Inc. <cheriebledsoe.cac@gmail.com>; Sunshine Connection (sunshineconnectiontopeka@gmail.com) <sunshineconnectiontopeka@gmail.com>; Wings Upon the Prairie <wings@st-tel.net>
Subject: Opportunity for Consumer Input!
Importance: High

Happy Friday to you all! I have shared a reminder below about an opportunity for you to give your input on Kansas Federal Behavioral Health Block Grant. We still need Consumer input and any comments will help!

LET YOUR VOICES BE HEARD!

IT'S NOT TOO LATE TO SUBMIT COMMENTS ON THE STATE'S FEDERAL BEHAVIORAL HEALTH BLOCK GRANT APPLICATION FOR FISCAL YEARS 2018-2019. YOUR INPUT IS EXTREMELY IMPORTANT!

If you are open to reading the first 15-20 pages of the application or do a search in the document for "CRO" and jot down your comments and please email them to: kdads.bhs@ks.gov

Any comment will help and your input is valuable.- Thank you!

"Mental Health & Substance Abuse Prevention and Treatment (SAPT) Block Grant

The Kansas Department for Aging and Disability Services is offering the public the opportunity to comment on the state's federal Behavioral Health Block Grant application for fiscal years 2018-2019.

...

Please submit written comments to kdads.bhs@ks.gov or mail comments to Kimberly Reynolds, BHS Block Grant Program Manager, KDADS, Behavioral Health Commission, 503 S. Kansas Ave., Topeka, KS 66603."

More info here, including a link to the plan, but I also have a copy (all 114 pages of it!) that I can send along:



Behavioral Health Services
Kansas Aging and Disability Services Website
kdads.ks.gov

Carrie Billbe
Adult Consumer Affairs Coordinator
Behavioral Health Services
Kansas Department for Aging & Disability Services
503 S. Kansas Avenue
Topeka, KS 66603
Phone: (785)296-3773
Fax: (785)296-0256
Carrie.A.Billbe@ks.gov



VISIT OUR WEBSITE: WWW.KDADS.KS.GOV

From: Christopher A. Lund
CEO City on a Hill Inc:
Subject: Block Grant Feedback Workgroup

Dear Stakeholder,

Thank you for agreeing to participate in this block grant feedback workgroup. We are tasked to provide feedback on the following four questions:

1. What are the unmet service needs/critical gaps in the state's current system?

A critical Gap in Kansas BG services is rural areas and the Western half of the State of Kansas. Prior to 2008 the only BG funded residential provider west of Salina and Wichita was New Chance Inc, a Men's Program located in Dodge City, Kansas. There was a program in Larned, Kansas which closed called sunrise, this was also a men's program. There was also a WRC/DCCCA program in Hoisington which also closed around this same time period which was a woman's program. (DWP). Since 2008 City on a Hill has added 32 beds to the infrastructure of state funded treatment in the Western half of the state with an 8-bed facility in Marienthal Kansas a DWP, and an additional 20 reintegration beds for women, and four reintegration beds for men in Liberal Kansas. When you look at the 32 beds that City on a Hill has, and combine them with the 32 beds that New Chance Inc Offers. The total number of beds in the Western half of the State of Kansas is 64. Since there are over 40 providers in over 100 locations. The Western half of the state is not only rural, but grossly underserved. This is not a gap, this is an enormous crater, and a very critical issue.

Commented [O1]:

2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?

I would like to know from SAMHSA how they differentiate state BG allocations between the states that have accepted or participated in Medicaid expansion, verses those states who for whatever reason have not. When we look at Medicaid Expansion, the number of people who become insured under the expansion process include a certain number of people who also fall under the 200% poverty margin. So, it would stand to reason that the states who do not have access to Medicaid Expansion would have a higher number of consumers in need of BG dollars. Is this factor even considered or is the current political uncertainty concerning healthcare make it impossible to gather enough data to allocate correctly?

3. What measurable changes/enhancements would we want to see over the next two years?

A recognition of the barriers that the rural areas face in providing SUD services, and ensuring that a client in extreme rural areas of Kansas has the same access to care that a client in Topeka and Wichita have. The introduction of a simple yet effective rate per bed, per provider across the board. The only state recognized lobbying platform is KAPP. BG allocations should have nothing to do with legislative luncheons or other political hugh fests. All providers should be treated the same regardless of their geographical location.

3. What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?

At City on a Hill Inc we have always believed that the consumer, or our clients should have the whole person treated. We try to the best of our abilities to treat all the needs of our clients. City on a Hill pays for all of our clients who enter into residential substance abuse treatment to have mental health evaluations. This is funded through grants, and private donations. If a client is deemed to have co-occurring disorders and is in need of treatment and medication we work with our mental health providers and our clinical oversight doctor to provide medication for that client which we pay for. This is also provided through grants and private donations. City on a Hill is also on the sixth year of a reading grant which provides for eye exams and glasses for any client who is in need of optometry care. City on a Hill also collaborates with the local rural hospitals to utilize outpatient care, in lieu of ER visits at a reduced rate. When working with the rural Hospitals we provide them with the data that shows the Medicaid clients whom they are reimbursed for should be considered when talking about our BG funded clients. We negotiate rates for certain services, collaborate with the hospitals and county health nurses for things like blood work, and infectious disease testing. We have successfully treated and paid for all types of medical conditions including AIDS, in which we partnered with a local county health provider, and the Ryan White Foundation and secured medication for a client who had AIDS and it cost the client 0.00 dollars. We have also begun work with Gilead Sciences and their support path for clients in need of HEP c treatment to access medications. City on a Hill also pays for any client who is in need of a GED to attend the classes and test for their GED. This is also paid for through grants and private donations. City on a Hill also places a high priority on things like driver's license, social security cards, and ID's. We have a program set up through our local churches that pays for these items when needed. City on a Hill also has begun a pilot program in which we help clients to learn how to speak to St Francis and other Guardian type programs to better their chances of reintegration with their children. This also applies to probation officers and corrections. These clients are less likely to re-offend and or relapse if they turn these relationships into assets rather than liabilities.

Now I am sure there are many programs who do a lot for their clients. But since I am speaking and addressing this issue as it relates to our specific programs. I maintain that if our BG clients are getting mental health evaluations and treatment, prescription

medications, dental work, eye exams and glasses, DL's and ID's, GED's, FASFA's, HEP C education and treatment recommendations, medical care when possible. Then these greatly increase that consumers chance of success. When considering BG allocations, I would think at some level this should matter. I Know it does to the clients we see every day.

Diana Marsh [KDADS]

From: Carrie Billbe [KDADS]
Sent: Friday, August 25, 2017 4:13 PM
To: Kimberly Reynolds [KDADS]
Subject: FW: Opportunity for Consumer Input! Dantia

From: Dantia Maur MacDonald [mailto:dantia.maur@gmail.com]
Sent: Friday, August 25, 2017 4:12 PM
To: Carrie Billbe [KDADS]
Subject: Re: Opportunity for Consumer Input!

Sure that's fine. BEST,dm

On Fri, Aug 25, 2017 at 4:10 PM, Carrie Billbe [KDADS] <Carrie.A.Billbe@ks.gov> wrote:

Thanks for taking the time to make a public comment! You are living proof that recovery is possible! I just want to confirm that you understand that with your permission, your comment will become part of the public Block Grant application document and will be on the KDADS website as part of that document and can be shared with the Governor's Behavioral Health Planning Services Planning Council. Please confirm if we have your permission.

Warm Regards,

Carrie

From: Dantia Maur MacDonald [mailto:dantia.maur@gmail.com]
Sent: Friday, August 25, 2017 3:55 PM
To: Carrie Billbe [KDADS]; KDADS BHS
Subject: Re: Opportunity for Consumer Input!

Hello, my name is Dantia MacDonald and I am a Stanford University Graduate and a Fulbright Scholar, I also have a severe mental illness, Schizo-affective Bipolar Type. I was delusional for four years, had many false beliefs that ruled my life, and was basically a noted "crazy" person around town, I was notorious. I would go into bars and restaurants and scream about the CIA and FBI, I got arrested and went to jail, I was hospitalized six times for weeks and weeks at a time. I basically lost those years of my life. After I came out of delusions I was suicidal and deeply depressed, and couldn't believe what had happened to my life. I am sure I would have killed myself if it hadn't been for the support and hope provided by Morning Star Inc., our local Consumer Run Organization. I joined Morning Star's groups and received peer-to-peer support and the center saved my life. They taught me I could have a life worth living even with my diagnosis, and today I have a job, a boyfriend and

most importantly, a great feeling of optimism for the future. I learned to have a sort of healthy pride about myself, and came to internalize that a mental illness is like any other disease and nothing to feel guilty or embarrassed about. I have not been hospitalized or incarcerated since coming to Morning Star Inc. CRO. Thank you for your support of consumer run organizations and peer-to-peer support!

On Fri, Aug 25, 2017 at 2:14 PM, Carrie Billbe [KDADS] <Carrie.A.Billbe@ks.gov> wrote:

Happy Friday to you all! I have shared a reminder below about an opportunity for you to give your input on Kansas Federal Behavioral Health Block Grant. We still need Consumer input and any comments will help!

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Any comment will help and your input is valuable.- Thank you!

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...

Please submit written comments to kdads.bhs@ks.gov or mail comments to Kimberly Reynolds, BHS Block Grant Program Manager, KDADS, Behavioral Health Commission, 503 S. Kansas Ave., Topeka, KS 66603."

More info here, including a link to the plan: <https://www.kdads.ks.gov/docs/default-source/CSP/bhs-documents/Block-Grant/mental-health---substance-abuse-sapt-block-grant-assessment-and-plan.pdf?sfvrsn=0>



Behavioral Health Services

Kansas Aging and Disability Services Website

kdads.ks.gov

Carrie Billbe

Adult Consumer Affairs Coordinator

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Kansas Department for Aging & Disability Services

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Carrie.A.Billbe@ks.gov



VISIT OUR WEBSITE: WWW.KDADS.KS.GOV

Diana Marsh [KDADS]

From: KDADS BHS
Sent: Tuesday, August 15, 2017 12:49 PM
To: Kimberly Reynolds [KDADS]
Subject: FW: KDADS Federal Block Grant

From: David Pickard [mailto:david.pickard@sackansas.org]
Sent: Tuesday, August 15, 2017 10:35 AM
To: KDADS BHS <KDADS.BHS@ks.gov>
Subject: KDADS Federal Block Grant

It would a great benefit to have a detox center in areas outside of Wichita. The community of Newton in particular could use it, as at the current time those in need of these services are referred to the ER, who doesn't want to deal with the issue.

July 7, 2017

DCCCA appreciates the opportunity to provide feedback for the federal block grant application. We understand that federal block grant funding will not increase in the coming application cycle. We believe, however, that funding quality over quantity will have a net positive impact in our state. Comprehensive, whole person approaches with reimbursement rates that are closer to covering actual costs of care are more likely to reduce recidivism in the treatment field, and reduce overall state costs in corrections, medical care, and child welfare service systems. The complex co-morbid conditions of those we serve now requires that we expand the range of interventions available and reimbursed.

What are the unmet service needs/critical gaps in the state's current system?

1. Block grant funded clients have significant co-occurring challenges that impact their ability to sustain a recovery lifestyle. As uninsured Kansans, they have limited ability to access resources that address their whole person needs. SUD treatment providers who choose to engage in integrated service models often purchase these services or create them internally in order to offer clients the best opportunity for successful treatment outcomes. This is very difficult to do within the current block grant rate structure. Increased rates or expanded billing options would support the following interventions (not an all-inclusive list):

- Mental health services, to include medication evaluation and medication management,
- Family therapy,
- Psychiatric services,
- Primary medical and dental care,
- Purchasing medications prescribed by medical providers, including those medications used in Medication Assisted Treatment

2. Communities across the state identify the lack of residential treatment options for uninsured men. While DCCCA believes that residential treatment is a needed resource in our state, we are not sure that this modality is the only option that might address this need. One barrier to creating more residential services is the very low intermediate and reintegration rates that do not come near covering the actual cost of minimal service delivery.

3. Rural and frontier communities have limited access to the full array of recovery and treatment services. Investments in technology that can reach individuals in those communities would benefit Kansas.

4. Funded peer support and care coordination throughout the treatment continuum, and as a continuing care plan following primary treatment, would benefit clients.

5. A growing number of children in the child welfare system were removed from their homes due to parental substance use as a primary or contributing factor to the substantiated abuse or neglect. These parents are, more often than not, uninsured. Expectations of the treatment system and child welfare system often conflict, delaying permanency for the child. Better coordination between the two state agencies may lead to pilot projects, new funding, and innovation that improves both treatment and permanency outcomes.

6. The adolescent treatment continuum is not as robust as what is available for adults. Family centered interventions are lacking.

What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?

1. Kansas is fortunate to have a comprehensive continuum of care that includes intensive residential services.
2. Many providers, including DCCCA, are partnering with FQHCs and other primary medical providers to offer early screening and intervention, integrated treatment, and facilitated access to ongoing medical care.
3. The managed care model makes it more likely that a consumer is getting the right treatment, in the right amount, at the right time based on assessed need.
4. The state's designated women's programs offer evidenced based, family based interventions.
5. The growth of peer support and care coordination.

What measurable changes/enhancements would we want to see over the next two years?

1. Pilot a value based and/or global payment model that allows interested providers to offer a broader range of interventions based on the unique and comprehensive needs of each clients.
2. Expanded peer support services across modalities and post-discharge from primary treatment.
3. Improved coordination among the Medicaid managed care companies and the block grant managed care company. Prior to KanCare, the same MCO managed both Medicaid and block grant substance use treatment funding. Client transitions between the payer sources was a relatively smooth process. This was especially true for female clients whose Medicaid may have been retroactive. The MCO seamlessly recouped block grant funding, then reimbursed with Medicaid funding without providers needing to do much administratively. This rarely, if ever, occurs now.
4. The KCPC is outdated and does not offer providers, decision makers or average citizens timely data from which to measure outcomes, identify trends, or improve quality. The lack of timely and available data hinders innovation. And, the administrative costs of this system for MCOs, providers and the state is burdensome. The state should deploy an interoperable, web-based system.
5. Funded early screening and intervention models like SBIRT.

What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?

Addiction is a chronic, complex health condition that must be addressed in an integrated, whole person approach. The current rate structure and facility licensing standards are not broad enough in their focus to support innovations in our field. A neighboring state has implemented a new facility credentialing level for providers whose treatment approach includes medical oversight, Medication Assisted Treatment, mental health services and other areas of integrated care. National accreditation is valued. Higher reimbursement rates are combined with specific performance outcomes. A pilot of this, or similar model may support provider innovation and improve consumer outcomes.

Diana Marsh [KDADS]

From: KDADS BHS
Sent: Monday, July 31, 2017 2:42 PM
To: Kimberly Reynolds [KDADS]
Subject: FW: Comment on the Behavioral Health Block Grant application for fiscal years 2018-2019- Tobacco Cessation

From: Duane Olberding [mailto:duane@kspts.com]
Sent: Monday, July 31, 2017 9:09 AM
To: KDADS BHS <KDADS.BHS@ks.gov>
Subject: Comment on the Behavioral Health Block Grant application for fiscal years 2018-2019- Tobacco Cessation

Thank you for the opportunity to comment on the Behavioral Health Block Grant application for fiscal years 2018-2019. I provided this information to Brian Baker of Beacon Behavioral Health also. The most important treatment aspect that should be implemented in order to receive Block Grant money is that the treatment program have Tobacco Treatment Cessation as part of their curriculum in order to be considered.

Most alcoholics, amphetamine, cocaine, opiate, sedative, gambling etc patients die of complications of tobaccoism, not the substance use disorder they present with. If programs aren't treating tobacco substance use disorders they should not be receiving grant funding. The health care cost associated with tobacco use are staggering. The primary reason many patients are not able to achieve abstinence is due to continued use of tobacco.

Duane L. Olberding
Executive Director
Professional Treatment Services, LLC
PTS-Lawrence Clinic: 3205 Clinton Parkway Court, Lawrence, Kansas 66047; w- 785-843-5483
f- 785-841-5433; Cell 785-249-8477 www.kspts.com

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Diana Marsh [KDADS]

From: Morning Star, Inc. <chromorningstar@sbcglobal.net>
Sent: Friday, August 25, 2017 4:12 PM
To: KDADS BHS
Subject: Block Grant

My name is Elizabeth Stitt and I have been a regular member of my local CRO. I led a very lonely life and isolated a lot. I have better work and social skills since my involvement. I have made several friends and enjoy groups and celebrations. I see the CRO as a regular part of my recovery and encourage others to attend.

**Block Grant Feedback Workgroup
Summary of Themes in Participant Responses
July 17, 2017**

The following themes were identified in the feedback offered by this workgroup's participants. These should not be considered the only strengths, challenges and opportunities for consideration. Further, the recommendation themes should be considered as an interconnected system, versus standalone initiatives. One participant reflected these themes are similar to those identified 15-20 years ago, and focus should be on actively creating solutions to move the field forward.

Data and Reporting System

The ongoing challenges with the KCPC system were identified as a top priority for system enhancement. Key recommendations include:

- Access to timely, relevant data.
- A system that offers better case coordination for timely treatment admissions.
- A system that reduces provider administrative burden.

System Capacity

Multiple recommendations focused on expanding specific modalities, both by geography and type. The workgroup recommends a comprehensive, data informed assessment of current evidence based capacity to guide any expansion or redesign in the SUD treatment system. Specific challenges identified include:

- Men's residential treatment beds
- Social detox
- Peer Support as a standalone modality
- The current rate structure does not cover the cost of providing treatment

Integrated Service Delivery

Several recommendations focused on increasing access to the full range of whole person interventions and reducing "silos" that exist in service design and funding.

- Establish case coordination as a standalone billable service
- Expand utilization of technology as a billable service. Technology includes tele-medicine, smart phone and web-based applications, etc.
- Incorporate primary medical and mental health care into allowable services reimbursed by the block grant.
- Offer reimbursement for prescription medications used in MAT.
- Pilot outpatient versions of RSI.

Alternative Payment Structures

Participants discussed the current fee for service structure as limiting integrated service delivery and not truly covering the cost of providing treatment. Recommendations included:

- Pilot a global payment mechanism that allows provider flexibility in the range of services offered.
- Pilot a "pay for performance" model.

- In either mechanism, the system must clearly define the provider and consumer based outcomes for measurement. A recommendation was made to look beyond the National Outcome Measures.

Rural Service Delivery

All participants identified the unique challenges of offering treatment in rural and frontier communities. Themes identified previously are relevant to this area, but it is important to document additional challenges in service provision.

- Access to treatment in rural communities is both a workforce issue and a facility issue.
- Lack of transportation to current services is an access barrier.
- If expanded access is offered via tele-health, the system needs to address gaps in connectivity in rural areas.

Heartland Regional Alcohol and Drug Assessment Center
Comment on the State of Kansas Federal Behavioral Health Block Grant

Heartland Regional Alcohol and Drug Assessment Center (HDADAC) offers the following input to Kansas Department for Aging and Disability Services (KDADS) as it plans for a future RFP for the Behavioral Health Block Grant.

Develop Funding Priorities for an Integrated Behavioral Health System Responsive to Verified Needs

Data

An integrated community behavioral health system would ideally begin with data that clearly demonstrates the need for services identified through a formalized funding priority planning process.

Service needs will vary based on:

- Geographic location in the State of Kansas (urban, suburban, rural, or frontier)
- The availability of services in those locations, and
- Rates of substance abuse, mental Health, suicide and gambling that occur in local communities.

To develop a client and community centered delivery model, reliable information and data is needed to inform resource allocation and service delivery needs. Data can be gathered from national, state and local sources including (but not limited to): Public Health Snapshots by State, State Profile of Drug Indicators, State Profiles of Underage Drinking, Hospital Emergency Room Statistics, KDADS - KCPC Database, and KDADS - AIMS database. Service utilization and organizational capacity can be estimated based on data from existing licensed providers including: numbers served, payer source, and wait-list summaries. Mapping technologies can be utilized to reflect both the need for services, and service availability throughout the state in order to target resources to match need in local communities.

Evidence Based Practices

In addition to priorities that respond to documented need, funding should be targeted to programs that can demonstrate a service delivery model that aligns with Evidence Based Practices (EBP) as recommended by national experts such as CSAT/SAMHSA Treatment Improvement Protocols (TIP), Robert Wood Johnson, and others. Being able to clearly articulate program delivery components and the factors that make it successful provides an additional layer of accountability and a means to target performance measures.

Documented Program Outcomes and Continuous Quality Improvement

Program outcomes provide the opportunity for organization and funders to reflect on the impact of services. Continuous Quality Improvement (CQI) processes create an “information loop” that allows the organization to utilize its outcome measures to identify where programs are successful and where improvement is needed. As a manager of Block Grant funds, you can require organizations to demonstrate outcome measures and CQI processes which can be regularly synthesized for transparency and accountability. The reports can be utilized and reviewed in a format that provides for dialog and conversation about what the measures mean. In doing so, trends are identified, as well as areas for improvement, systemic barriers, and ultimately how treatment services are impacting the lives of clients we serve.

Integrated Services that Focus on the “Whole Person”

CSAT/SAMHSA Treatment Improvement Protocol (TIP) 27: Comprehensive Case Management for Substance Abuse Treatment. This protocol indicates that “Substance abusers have better outcomes if their other problems are addressed concurrently”. It recognizes that alcohol and other drug use often

damages many aspects of an individual's life such as mental health, physical health, gambling, housing, employment and relationships. Individuals who receive professional attention for these additional problems see improved functioning in all life domains and a reduction of psychiatric symptoms. This Protocol highlights the Strengths Based Perspective present in Person-Centered Case Management. It provides clients with support and advocacy for accessing needed resources such as mental/physical health and recovery services. It also focuses on the strengths of the individual as a vehicle for directing changes in their lives.

Summary

KDADS/BHS should allocate funding based on funding priorities that:

- Promote services which address issues (need) substantiated through data
- Utilize an evidence-based practice of service delivery framework
- Demonstrate fidelity to the evidence-based practice
- Incorporate an integrated service delivery model that focuses on the whole person
- Document outcomes, results, and/or evaluation

HRADAC Recommendations for Funding Priorities

Expect services to address the "whole-person" through Care Coordination and/or Case Management services. This is the basic tenet of TIP Protocol 27 and Person Centered Case Management. It very closely aligns with the work HRADAC does with the Care Coordination and Case Management work which could prove beneficial for individuals seeking substance abuse treatment and other behavioral health issues.

The current KCPC* assessment tool provides a clinical recommendation of substance abuse treatment need including the appropriate level of care. Assessors make referrals to treatment providers and provide care coordination to assist clients in accessing the appropriate level of treatment. In addition to assessing clinical need for substance abuse treatment, the KCPC assessment tool covers multiple dimensions in a client's life including: mental and physical health, history of abuse, housing, veterans status, etc. to name a few. While it is not a clinical assessment tool for other co-occurring issues, it can certainly be used to identify when a more in-depth screen and follow up services are warranted. Assessment counselors make referrals to local service providers when additional needs are identified, however the amount of time allowable for this follow up is typically limited to making the referral.

Addressing the whole-person *is* client-centered. As SUD providers, we recognize that substance use takes its toll on our client's mental and physical health, employability, and legal status. It is common for co-occurring issues to exist, which compounds or impacts a person's recovery. Matching the "dose" of treatment and recovery services to the severity of addiction in a fiscally responsible manner is always the goal. Broadening the scope of services funded through block grant dollars may open the network to new and different ways of treating addiction. For example, a person assessed early on in the progression of their illness where there are not a lot of additional co-occurring issues might, in addition to a treatment recommendation, include a Recovery Coach who will help connect clients to the recovery community. Clients who have more pressing needs would have access to a Care Coordinator who not only makes recommendations for SUD treatment, but also facilitates direct referrals and appointments with mental or physical health providers, and/or other entities such as the criminal justice or child welfare systems. An individual whose substance use has progressed to a chronic level and have experienced multiple unsuccessful treatment episodes, may have a recommendation that includes an Intensive Case Manager and a Recovery Coach to facilitate a more intensive and focused case management service with the primary goal of safety and risk reduction. For others who are further

progressed in their addiction, Block Grant funds could be expanded to include Medication Assisted Treatment (MAT), which is recognized nationally as an innovative and effective approach to SUD services.

Heartland RADAC suggests that Block Grant funding be broadened to support a deeper level of Care Coordination, Case Management, and Recovery Coach Services (Peer Support) so our client's whole person, co-occurring needs, are addressed simultaneously. Heartland RADAC believes that in doing so, the addiction process may be interrupted earlier preventing further progression leading to more costly inpatient treatment needs.

**HRADAC recognizes that the KCPC tool may change in the future.*

Heartland RADAC thanks you for the opportunity to provide input. In summary, we suggest the development of funding priorities based on data; allowing for deeper care coordination following assessments (broaden the definition, adjust payment structure); and customizable treatment recommendation that include: Care Coordinators, Case Managers and Recovery Coaches.



Keys for Networking, Inc.

Kansas Parent Information and Resource Center • www.keys.org

The State Organization of the Federation of Families for Children's Mental Health

August 31, 2017

Kimberly E. Reynolds, MPA, MEd
SUD Block Grant Program Manager
Behavioral Health Services Commission
Kansas Department for Aging and Disability Services
New England Building
503 S. Kansas Avenue
Topeka, KS 66603-3404

Dear Kim:

Thank you for the opportunity to support the Kansas Department of Aging and Disability Services (KDADS) Mental Health/Substance Abuse Prevention Block Grant Application to SAMHSA. These funds and the planning for these funds are important to Kansas. I have provided detailed input to you, August 3 requesting more emphasis on integration, outreach and services for families who are non-white, non-English speaking and have diverse backgrounds and histories of difficulties from poverty, race, gender, trauma, post traumatic stress, and displacement from human and natural catastrophes. I requested then that you provide funds to support the inclusion of representatives from all groups who meet the intended target population for these monies.

I am the director of both the KDADS funded (with substance abuse and mental health block grants) statewide grant to provide information, training, peer support to Kansas families whose children have severe emotional, behavioral disabilities, and the SAMHSA funded Kansas Statewide Family Network Grant. I urge you to allocate funds for parent and youth consumer participation in planning and implementation of SA and MH services. KDADS used to provide, through these block grants, opportunities to assure parent and consumer participation. Please re-authorize funding for meaningful planning with the people who receive services. Authorize funding for the Governor's Behavioral Health Services Planning Council and its sponsored committees to include the people who use substance abuse prevention and mental health services.

In addition, authorize funding for the state organizations that provide information and training to parents and consumers whose children use mental health and substance use prevention/treatment services. Assure the funding Keys and NAMI. We are funded, in part by the Mental Health Block Grant, .25 by the Substance Abuse Prevention Block Grant, and .50 state funds. Because of potential cuts from SAMHSA this year to the Mental Health Block Grant, KDADS has cut (effective August 3) \$18,250 from the \$100,000 to our organizations. These cuts are applied disproportionately, perhaps unnecessarily, to the two programs with limited budgets that provide unfettered information, training and support to Kansas families. This loss of funding to small nonprofit organization creates significant hardships for us to continue our mission of serving information and providing support to Kansas families. With the cuts to our KDADS funding we must choose a) whether to stop representing youth and family needs at the state and community meetings, most specifically the Governor's Behavioral Health Planning Council, the Children's Subcommittee of the Council, the new Aging Subcommittee in Development, the Children's Continuum of Care Task Force, the Rural and Frontier Subcommittee (projected); or we must choose to decrease the outreach and response to the numbers of families who request our information and support each month. These are very difficult choices.

Kim, thank you for the opportunity to read the Block Grant proposal and to work with you.

Respectfully,

Jane Adams, Ph.D.
Executive Director

900 South Kansas Avenue, Suite 301 • Topeka, Kansas 66612
785-233-8732 • 800-499-8732 • FAX 785-235-6659
Www.facebook.com/keys4networking

Diana Marsh [KDADS]

From: KDADS BHS
Sent: Tuesday, August 15, 2017 12:50 PM
To: Kimberly Reynolds [KDADS]
Subject: FW: Funding

From: Julie Hendricks [mailto:julie.hendricks@sackansas.org]
Sent: Tuesday, August 15, 2017 10:48 AM
To: KDADS BHS <KDADS.BHS@ks.gov>
Subject: Funding

To Whom It May Concern,

I would like the state to consider the following for fiscal year 2018-2019:

Consider grant funds for Recovery Centers (such as SACK Crossover facilities in Wichita and Hutchinson). Presently these facilities are not funded and are supported through self-pay revenue.

Peer mentoring services be funded in the form of a grant (with increased supportive funding) rather than as it is now which is fee for service. The reimbursement for peer mentoring services is very minimal and the billing is intensive. This is the reason that few programs provide much peer mentoring...the cost of providing the service and billing is cost prohibitive.

State funding for Crisis Centers such as the Community Crisis Center here in Wichita where COMCARE and SACK provide Crisis Mental Health Services and SACK provides Sobering and Detoxification services in one facility.

Thank you,

Julie Hendricks BS LAC
Substance Abuse Center of Kansas
731 N. Water Suite 2
Wichita, KS 67203
Phone 316-267-3825 Fax 316-267-3843
Cell 316-371-3197 Office 316-283-8695 xt 118

Important: This email and any attachments may contain confidential information subject to protection under the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164). If you or your organization is a "Covered Entity" under the above mentioned regulations, you are obligated to treat such information in a manner consistent with the regulations. If this email was sent to you in error you are prohibited from utilizing or disseminating this email or any attachments. Please immediately delete it from your computer and any servers or other locations where it might be stored and email Julie.Hendricks@sackansas.org or call Julie Hendricks at 316-267-3825 advising that you have done so. We appreciate your cooperation.



Kansas Association of Addiction Professionals

Kansas Association of Addiction Professionals

**800 SW Jackson, Suite 1100
Topeka, KS 66612
785-235-2400**

Substance Abuse Prevention and Treatment Block Grant in Kansas

The Federal Substance Abuse Prevention and Treatment Block Grant (SABG) is the largest source of funding in Kansas dedicated to serving Kansas residents with Substance Use Disorder (SUD). In FY 2016, the SABG provided \$14,097,497 in funding to provide treatment for 13,777 unique Kansas residents meeting medical necessity criteria for SUD.

Eligibility for SABG funding is limited to those Kansans whose household income is at or below 200% of Federal Poverty guidelines. The SABG also stipulates that 20% of the federal funds be allocated to provide Primary SUD Prevention services.

In addition, the SABG requires prioritizing the following populations to receive funding and service:

- Pregnant women and women with dependent children
- Intravenous drug users
- Tuberculosis services
- Early intervention services for HIV/AIDS
- Primary prevention services

In FY 2016, a robust network comprised of 42 providers specializing in SUD contracted to provide treatment to SABG eligible Kansas residents. These providers are located throughout the state and ensure that geo-access requirements included in the SABG are met.

Since 1995, The SABG has operated in a managed care environment. This environment utilizes an Administrative Service Organization (ASO) which provides third party oversight of the fee for service delivery system and a high level of accountability for both clinical and fiscal activity. As the managed care system has matured, Kansas has been recognized nationally for its efforts to improve outcomes and accountability.

Key Strengths of the Kansas SABG delivery network include, but are not limited to:

- A mature managed care delivery system that includes clinical and financial oversight
- A delivery system offering a full continuum of SUD care from detoxification to peer mentoring
- Eligible Kansans can receive and transfer care to the appropriate contracted provider regardless of geographical location (reimbursement follows the client statewide)
- Specialized care for priority populations
- Consistent efforts by the provider network to improve outcomes and establish evidenced based clinical services

Key Weaknesses of the Kansas SABG delivery network include, but are not limited to:



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Kansas Association of Addiction Professionals

- Obsolete data collection software resulting in system inefficiencies and increased costs to all stakeholders
- Insufficient funding to meet demand for treatment resulting in waiting lists and delayed access to treatment
- Reimbursement rates that are well below the direct cost of providing service and are not competitive with other funding streams
- Federal barriers/block grant stipulations which inhibit innovation and expansion of evidenced based services
- Qualified workforce shortage
- Low level of investment from the state to support SUD services (i.e. State General Fund to and problem gambling and other addictions fund).
- Strict funding and reimbursement streams serve as a barrier to pilot project development.

The system going forward should continue to emphasize strengths and address the weaknesses while making use of the existing and diverse network of providers around the state. In conclusion, providers are motivated and anxious to talk about innovation, service delivery enhancements to improve outcomes, etc. That should be encouraged in the future grant process.

As the Governor's Behavioral Health Planning Council reviews and provides recommendations related to improving the SABG system, it is essential that the Council seek out the SUD expertise available within the current SUD network. The data and information that these experts can provide will assist in the development of informed strategic decisions.

Diana Marsh [KDADS]

From: KDADS BHS
Sent: Thursday, August 24, 2017 9:24 AM
To: Kimberly Reynolds [KDADS]
Subject: FW: grant

From: Kristen Becker [mailto:kristen.becker@sackansas.org]
Sent: Wednesday, August 23, 2017 12:03 PM
To: KDADS BHS <KDADS.BHS@ks.gov>
Subject: grant

To Whom It May Concern,

1. Asking the state to consider grant funds for Recovery Centers (such as SACK Crossover facilities in Wichita and Hutchinson). Presently these facilities are not funded and are supported through our self-pay revenue with the exception of some funded positions i.e. SB-6 and ICM Peer mentors.
2. I am recommending that peer mentoring services be funded in the form of a grant (with increased supportive funding) rather than as it is now which is fee for service. The reimbursement for peer mentoring services is very minimal and the billing is intensive. This is the reason that few programs provide much peer mentoring...the cost of providing the service and billing is cost prohibitive. We will certainly continue to provide the service but it would be nice to be able to provide the service and at least break even. I am committed to providing this service because it saves money and more importantly is beneficial.
3. I recommended that the state fund Crisis Centers such as the Community Crisis Center here in Wichita where COMCARE and SACK provide Crisis Mental Health Services and SACK provides Sobering and Detoxification services in one facility.

Thank you,
Kristen Becker, KCPM

Questions to Consider

Federal block grant treatment funding will not increase in the next two year cycle. With that context, KDADS is seeking our input on the following four questions:

1. What are the unmet service needs/critical gaps in the state's current system?
 - *In some counties there is a major gap for clients who need medication management and mental health services (therapy/case management) if they do not have money or insurance. Currently some community mental health centers will not accept clients in or coming out of intermediate treatment.*
 - *In rural counties there is a major gap in agencies that provide services for SUD. As a result clients need to drive far away to get minimum treatment. Transportation funds and or peer mentoring could fill this gap.*
 - *The severity of use and amounts is increasing. There is a huge need for medical and social detox. Community stakeholders are frustrated there are no services available for these clients. Hospitals feel overwhelmed and unable to manage this burden alone.*
 - *SUD treatment that is effective and proven through best practice for adolescents is non-existent unless you live in a Wichita or Kansas City.*
 - *Many Block Grant-funded clients meet medical necessity for reintegration level treatment but are unable to access services at that level of care because of low reimbursement rates. The inability to access RI treatment results in higher levels of relapse.*

2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?
 - *Treatment providers who are surviving in this funding climate are doing more treatment and provide more services for less money. This is getting more difficult as the needs seem to be increasing.*
 - *We are working with increasing numbers of dually diagnosed clients.*

3. What measurable changes/enhancements would we want to see over the next two years?
 - *Block Grant clients should be funding the same rate as Medicaid. Block Grant should not compute a stop gap, but fund all those who meet criteria.*
 - *Block Grant should invest money in prevention and early intervention. These grants and funds are almost non-existent.*
 - *Funding for adolescents is the same as adults, but best practice suggests different approaches. Block Grant should provide different services for adolescents and their families.*

4. What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?

- *The KCPC system and software is old and out of date. KDADS has decreased staff who trouble shoot problems. Getting someone funded takes more time and effort that takes away from client care. Invest in a user-friendly KCPC and increase efforts by giving incentives to agencies to have better access to care so people can get into treatment quickly.*

This information is feedback from treatment providers, community partners, and administration at Pawnee Mental Health Services. Pawnee has nine certified SUD facilities in our catchment area. The feedback includes input from individuals in a larger community like Manhattan, as well as rural and frontier areas served by Pawnee.

1. What are the unmet service needs/critical gaps in the state's current system?

- Long waits for inpatient
- Lack of level II treatment in rural areas of the state.
- Lack of case management services.
- Lack of detox coverage.
- Work force shortage.
- Low reimbursement.

2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?

- Coordination between providers
- Treating priority population

3. What measurable changes/enhancements would we want to see over the next two years?

- Better use of technology to provide treatment.
- More use of case management services
- Shorter wait time for inpatient treatment
- Access for all areas to the continuum of treatment services.

4. What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?

- Quality over quantity of treatment providers. Are there pockets of block grant funded centers clustered together? Try to evenly distribute them throughout the state. If there are 3 block grant funded centers in a small area each of those centers is trying to support the agency with the help of block grant funds. It would be more economical to have one agency providing tx services.
- Instead of pouring so much money into inpatient treatment, incentivize for agencies willing to provide case management services to help clients. It seems like many clients go to inpatient and return to the same environment. More case management could help them find employment, new housing, and support that a therapist might not be able to. If the system can prevent as many people needing inpatient treatment than their will be shorter wait times.
- Funding to start new initiatives that will reach the target population and reach rural/frontier areas.

Diana Marsh [KDADS]

From: Kelsee Torrez [KDADS]
Sent: Monday, August 28, 2017 7:09 PM
To: Kimberly Reynolds [KDADS]
Subject: Fwd: Kansas Block Grant
Attachments: image001.png; ATT00001.htm; MH SAPT Block Grant Assessment & Plan '18-'19 notes.docx; ATT00002.htm

Begin forwarded message:

From: Renee Geyer <rgeyer@compassbh.org>
Date: August 28, 2017 at 3:42:50 PM CDT
To: "Kelsee Torrez [KDADS]" <Kelsee.Torrez@ks.gov>, Lisa Southern <lsouthern@compassbh.org>
Subject: RE: Kansas Block Grant

Kelsee,

I wasn't sure where to go with this, but here's some information that could help strengthen the application based upon Compass and Rural/Frontier Subcommittee work that I'm aware of. Maybe it will be helpful.

Best,
Renee Geyer, MMC - Grant Coordinator
Compass Behavioral Health
204 S. College - Scott City, KS 67871
620.872.5338 phone – 620.872.2879 fax
www.compassbh.org “Attention is the rarest and purest form of generosity.” -Simone Weil

Mental Health/Substance Abuse Prevention and Treatment (SAPT) Block Grant - Assessment and Plan *

Information for consideration...

Add the following information on Criterion 4, page 5. (Compass Behavioral Health and COMCARE are the two jurisdictions involved)

One mechanism for ensuring that Kansas youth receive integrated services for their multiple needs is through the SAMHSA-funded Transforming Lives through Supported Employment project currently in year three. The goal is to support and enhance employment opportunities for adults (including employment age youth) with a severe mental illness. Partnerships between KDADS, Kansas State University (KU) and two local jurisdictions are strengthening our current Supported Employment infrastructure and enhancing the implementation of the evidence based practice, Individual Placement and Support (IPS) throughout the state. IPS youth service outcomes include improved behavioral health status and functionality, along with the addition of employment as part of their recovery. Creation of the Supported Employment Coordinating Committee to coordinate activities across state departments and consult the grantee on statewide infrastructure measures is promoting supported employment and working towards sustainability.

Criterion 3: Children's Services, page 4 & 5

Kansas is fortunate to have two foundations working within the state as change-agents on identified issues.

The United Methodist Health Ministries Fund has a focus on creating a "Foundation for Success: Healthy Social & Emotional Development in Early Childhood" that stresses the importance of early brain development. Approaches include universal screening and access to timely and appropriate services to support success in life. The Fund is continuing work on developing systematic, universal social and emotional health screenings for Kansas children six and under. Twelve coalitions working in regional areas covering much of western Kansas have provided thousands of screenings for children, using the Ages and Stages Questionnaire: Social Emotional (ASQ:SE) and several coalition projects have also successfully promoted the Edinburgh Depression screening for prospective and newly-delivered mothers. Mental health centers and other providers have significantly improved their capacity to do work with very young children through trainings and awareness developed through these coalitions.

The Sunflower Foundation focuses on "Healthy Living" projects that emphasize the importance of the *built environment* as a means to promote lifelong healthy behaviors such as increased physical activity and improved food choices; "Health Care" projects that focus on improving access to health care for growing numbers of uninsured and underinsured, with an emphasis on community-based health services and health disparities; and "Advocacy" projects that help nonprofits become engaged in the public policy process and more effectively promote the populations that they serve.

The Tower Mental Health Foundation of Kansas created as a result of an agreement between the attorney general's office and the Menninger Foundation in 2007, offers support to organizations that provide mental health services in Kansas.

Collaborative efforts that focus on child and youth mental health, including substance abuse and suicide prevention are the focus of this year's grant criteria. Applications must include a combination of two or more entities that will collaborate on innovative and effective community resources to address these issues.

Add to the following information on Criterion 5, page 7.

Mental Health First Aid is mentioned, but there is no recognition of the widespread use. Trainers have access to a site listing instructors in Kansas. I believe there are MANY, and if so that number will heighten Kansas support and use of Mental Health First Aid.

5) Does the state any activities related to this section that you would like to highlight. -page 61

SAMHSA-System of Care project has a strong focus on the use of trauma informed evidence based practices, trauma education for providers and community services, and the importance of creating environments that will not trigger or inflict additional trauma.

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state. - page 65 (Compass Behavioral Health has 13 counties and the other 3 CMHC's serve 1 county each for a total of 16)

Re: incorrect SOC information

The project is working with sixteen (*not fourteen*) counties in the state. Eight are frontier (with less than 6 persons per square mile), three (*not five*) are rural (with 6 to 19.9 persons per square mile), (*add*) and three are densely settled rural (with 20 to 39.9 persons per square mile). The sixteen counties include the largest and poorest in the state, in addition to the smallest county in the state. All 16 (*not 14*) will see growth.....

Add: ESEK information

Kansas was also awarded a Transforming Lives through Supported Employment (ESEK) cooperative agreement from SAMHSA. Over five years through two evaluation sites, Kansas is strengthening and enhancing services and supports to promote employment as a part of recovery and road towards economic self sufficiency for employment age youth and adults with mental health needs. The ESEK will strengthen, enhance, expand and sustain an evidence based, participant guided and empowering ESEK approach for addressing the needs of youth and adults with SMI. More than 3,000 youth and adults will be impacted over five years of the Kansas ESEK. Supported Employment is working with fourteen counties in the state. Eight are frontier (with less than 6 persons per square mile), three are rural (with 6 to 19.9 persons per square mile), two are densely settled rural (with 20 to 39.9 persons per square mile), and only one is urban (with over 150 per persons or more per square mile). All fourteen counties will see expansion and enhancement in supported employment opportunities for their youth and adults who want to gain employment as part of their recovery. In addition, use of the Outreach, Access and Recovery (SOAR) model for people experiencing or at risk of homelessness assists

individuals in applying for Social Security (SS) benefits. Economic self-sufficiency may occur through employment alone, or be obtained by combining employment with SS assistance.

2. Describe activities intended to reduce incident of suicide in your state.

Add information on Mental Health First Aid – I think Kansas trainers may also have access to how many trainings each has conducted. If so that data would be great to add.

The Tower Mental Health Foundation of Kansas, created as a result of an agreement between the attorney general's office and the Menninger Foundation, is soliciting projects on child and youth mental health, including substance abuse and suicide prevention for this year's grants. Applications must include a combination of two or more entities that will collaborate on innovative and effective community resources to address these issues.



Miracles, Inc.
Administration & Advocacy
1015 E. 2nd Street
Wichita, Kansas 67214
Phone: (316) 303-9520
Fax: (316) 303-9602
Email: rwmiracles@aol.com
www.wichitamiracles.org
***316-619-7908 (24 hr on-call for all programs)**

Miracles, Inc.
Residential Family Behavioral Health Center: Miracles House
Residential Treatment Program (women with children; pregnant; children's services)
Admission-(316)264-5900
Fax: (316) 265-2881
Contact: Charity Dennison

Sanctuary House Women's Homeless Housing (THP) Program
(co-occurring disorders)
Admission-(316)303-9520
Contact: Carol West

Women's Outpatient Behavioral Health Program
(women & families)*Co-occurring disorders
Phone: (316) 303-9520
Fax: (316) 303-9602
Contact: Mallory Foos

Peer to Peer Mentoring Project
1015 E. 2nd Street
Wichita, Kansas 67214
Phone: (316)-303-9520
Contact: Carol West

Shelter Plus Care Permanent Supportive Housing Program (men, women and families)
Phone: (316) 303-9520
*homeless support services

Steel Magnolias Youth/Adolescent Outpatient Program
1015 E. 2nd St.
Contact: Pamela Vaughn

Magnolia Place: Permanent Supportive Housing
Contact: Pamela Vaughn
(316)303-9520

Homeless Outreach Services
Contact: Zenobia Ross
(316) 303-9520

8/26/17

Kimberly Reynolds
BHS Block Grant
Program Manager
KDADS Behavioral Health Commission
503 S. Kansas Avenue
Topeka, Kansas 66603

RE: FY 18-19 SAHMSA SAPT Block Grant Assessment and plan; Response to SAT Gaps

Dear Ms. Reynolds:

Thank you for considering my input regarding the SAPT Block Grant Assessment and plan, as well as response to SAPT system gaps and needs. I have reviewed the Block Grant and have feedback/information for your review. I would also like to formally submit Miracles, Inc. response to questions about gaps and SAT needs (last page)

Assessment and Plan:

On page 10 and 11 women's specific treatment and housing services were addressed. I would like to submit additional information regarding activities of women's specific programs. In regards to additional strengths (not asking for program identifying info.)

Miracles, Inc., as one of the 11 women's specific programs located in Wichita, Kansas provides the following services that you may want to include under strengths, etc.

Homeless services in addition to CABHI, Oxford Houses, Rapid Re-housing:

Miracles, Inc. additional housing services provided by SAT (designated women's/family program):

1. Transitional Housing for women with SPMI and homelessness (8 beds) 15 years.
2. Transitional Housing for female youth (ages 18-24) with a disability (co-occurring mental illness and homelessness (6 beds) 2 years.
3. Collaborative partner (sub recipient) in a HUD grant with United Way of the Plains and Open Door (homeless outreach center) to provide mental health and substance abuse 'therapy' individuals and groups, case management and peer support for 16 chronically homeless individuals (18 months).
4. HUD recipient to provide 13 paid (leased) units for addicted and homeless youth aging out of foster care or otherwise homeless (begins August 1, 2017).
5. Only Substance Abuse Treatment Program to provide Shelter Plus Care housing certificates plus support services for any homeless individual, couple or family in Wichita under a collaborative with the City of Wichita Housing Authority (18 years).

Hopefully, adding under housing or women's treatment specific programs there are collaborative partnerships with local housing authority, the shelter system, and HUD to provide essential housing services to women/women with children, individuals and couples in the State of Kansas would strengthen that section. I believe this is very important as many of the current 'housing' programs have barriers for women and men seeking immediate, safe and supportive housing. These barriers include lack of employment, disability without Medicaid, and individuals

that are not able to meet the eligibility requirements of the other programs. In essence, individuals without the ability to work due to a current disability and/or unable to pay rent/fees in the near of foreseeable future are assisted by our programs, filling that gap for immediate housing for homeless substance abuse treatment consumers.

These programs developed over an 18 year period close the gap for the most severely disabled SAT consumers that otherwise would be in the shelter system without needed treatment, support services, peer mentoring, or transportation. As you may know, HUD is eliminating emergency shelter funding in favor of permanent housing programs which leaves many addicts in very precarious situations. There are waiting periods and other application requirements the most seriously disabled are not able to navigate. As you know, many women, couples, families and men may have a serious co-occurring disability but have so precariously housed and avoidant of medical professionals they are unable to work but have no disability application in process.

In addition, Miracles, provides access to a substance abuse counselor in the only 'Drop In' Center for homeless in Wichita, Kansas and nearby areas. This enables easy access to the chronically homeless with a low barrier encounter with an addiction professional. We started that initiative 4 years ago. The homeless 'Drop In' Center operated by United Methodist Urban Ministries AKA Open Door had TANF and MH company representative agents but no substance abuse agents, who have dramatically enhanced the center's programming, as the overwhelming majority of homeless persons were also suffering from untreated addiction.

Again, on the topic of women's specific program strengths, Miracles, Inc. sought outside funding for a 'family case manager' so that pregnant, post partum, women/women with children could get additional assistance in rebuilding their lives prior to exiting inpatient treatment. We have provided this additional service for over 18 years. Lastly, Miracles (Miracles House) inpatient and reintegration center also collaborates with local funding sources to provide a licensed therapist to treat the over 80% of women entering treatment with a co-occurring mental disorder. As a result we are able to provide more comprehensive care for families that are recovering from dual disorders. *Evidenced Based Practices-if you are interested I would be happy to write about the evidence based practices and data collection we have for outcomes, consumer satisfaction, and reports.

'People with a mental disorder are more likely to experience a substance use disorder and people with a substance use disorder are more likely to have a mental disorder when compared with the general population. According to the [National Survey of Substance Abuse Treatment Services \(N-SSATS\)](#), about 45% of Americans seeking substance use disorder treatment have been diagnosed as having a co-occurring mental and substance use disorder. SAMHSA supports an integrated treatment approach to treating co-occurring mental and substance use disorders. Integrated treatment requires collaboration across disciplines. Integrated treatment planning addresses both mental health and substance abuse, each in the context of the other disorder. Treatment planning should be client-centered, addressing clients' goals and using treatment strategies that are acceptable to them. Integrated treatment or treatment that addresses mental and substance use conditions at the same time is associated with lower costs and better outcomes such as:

- *Reduced substance use*
- *Improved psychiatric symptoms and functioning*
- *Decreased hospitalization*
- *Increased housing stability*

- *Fewer arrests*
- *Improved quality of life'* -SAHMSA

Sincerely,

Rhonda Walker, LMSW, LCAC

C.E.O./Co-Founder

P.S. My response to the 4 questions posed by KDADS are on the following page (page 4) please receive and add to other comments sections. THANKS

7/26/17

Miracles, Inc.

Comments on State of Kansas Federal Substance Use Disorder Block Grant

In response to the 4 questions posed by the Kansas Department for Alcohol and Drugs Services, please find Miracles, Inc. Behavioral Health Center comments.

What are the unmet service needs/critical gaps in the state's current system?

1. Detoxification beds: treat all substance dependence diagnoses
2. Housing: there is a critical problem for some consumers to access to safe and affordable housing immediately after discharge/exit from residential treatment. Miracles created housing programs for consumers that are homeless, unemployed, have a poor credit history, need additional support due to disability that have zero income, at our own expense.
3. Stigma: Reduce stigma within the child protection/child welfare system, corrections, and within the medical profession, which not only result in needless child removal towards adoption, but also contributes to the ongoing avoidance of women seeking substance abuse services.
4. Access to Care & Peer Mentoring: Miracles, Inc. spends a great deal of time and financial resources providing access to care services prior to the admission and immediately following transition (gap) to lower levels of care and peer mentoring services.
5. Co-occurring disorders: There is not an additional reimbursement rate for providing a 'dual disorder' treatment program. Over 85% of women who enter treatment have a diagnosed mental illness. In providing holistic and comprehensive treatment services to this population of women/women with children, our staff is very stretched as we are already helping supplement services to assist, homeless, medically fragile, indigent, disabled, and primarily methamphetamine addicted consumers.
6. Workforce Issues: It takes an average of 6 months to find a qualified substance abuse addiction counselor.
7. Gender Specific Treatment Challenges: The cost of providing SUD treatment to women and women with children is 3 x expenses for multiple challenges and needs they face.
8. KCPC: It is burdensome to have a requirement to amend a KCPC from another provider by hand, and we are concerned the appropriate information, as it can't be electronically amended becomes 'our program' information when data is pulled from the KCPC. Often times diagnosis, income status, mental health history are incorrect, therefore the data applied to our project is incorrect. It may take days for another provider to transfer a file due to case load issues, etc.
9. Treatment Choice: Consumers continue to be 'told' where to go rather than given options, especially in regard to consumers that are assessed by entities that have contracts with other referral agents. This is also true of consumers that prefer a faith-based choice (Charitable Choice), that are not given the option. In order to help identify the source of the issue, Miracles has created a database for the exit interview that asks important consumer choice of provider questions.

10. Parity

What are we currently doing now with the SUD treatment block grant that we want SAMHSA to know about?

Funding a comprehensive array of services

Allocating dollars to provide pregnant, post partum, and women/women with children priority treatment and ensuring services are comprehensive to meet the needs of families

Creation of a priority system for treatment admission for the most vulnerable and effected consumers of SUD services

Increasing access to services in rural areas by funding new programs

Supporting programs with a collaborative spirit and mutuality

Requesting feedback from providers and consumers on a regular basis

Effective reimbursement system with strategies for accountability in place

Creation of a level of care system in order to provide the right amount of SUD care to the suffering addict

Continuing to fight stigma and fund prevention programs to offset the enormous social pressure to use drugs in primary grades

Creating training and support for Peer Mentoring services including advocating for recovery oriented systems of care

Advocating for programs to develop their own collaborative relationships with mainstream resources in order to aid the consumer to be successful, healthy and have a greater quality of life

Continuing to fund grass roots community based services, to meet the consumer where they live, grow and play

Providing an electronic payment system that is effective

Creating an assessment system with continued stay reviews to ensure the consumer is paired with the correct service according to medical necessity

Providing state wide meetings and quarterly meetings to enhance provider relations

What are we currently doing now with SUD treatment block grant funding would benefit the state's consumers?

Development of ROSC

Providing grants to aid the indigent and suffering addict with a focus on assisting those with the most critical need enter treatment first

Establishing program standards to ensure consumers get quality care in a world where many other resources are limited or nonexistent.

Implementation of a consumer satisfaction process

Creating an environment where consumers have a choice of where they go and a grievance process if they believe they are treated unfairly

Providing a number for consumers to call to address consumer concerns outside of the treatment program system

Ensuring individual counselors are licensed and qualified to provide addiction treatment services

Licensing and site visit reviews to help the program identify and develop corrective action plans to address deficiencies.

Miracles is currently enhancing our evidence based models of care including IDDT training system wide, and have created a trauma informed system of care. Miracles initiated strengths based interventions in 1993, and continue to provide our unique bio-psycho-social-spiritual model to all. The agency has created a highly integrative model with partnering with city housing authority, Wichita/Sedgwick County Continuum of Care Committee, providing outreach to local shelters and the drop in center, in order to serve consumers that have cut off contact with traditional helping systems. We stretch the block grant dollars to ensure we are also providing quality services and good performance outcome measures.

Miracles has managed to provide transitional housing programs for women that are unable to access other housing programs due to multiple barriers and partnered with a psychiatric clinic to assist with the increasing number of women who are experiencing serious mental health issues.

What measureable changes/enhancements would we want to see over the next two years?

Expansions of ROSC to include pre-treatment and long term follow up reimbursement for peer mentoring services

Supporting existing programs by developing enhancement grants to the residential program sites, due to the ever increasing 'nursing home' type requirements placed upon free standing, community based facilities that are essential, yet do not have the resources that 'hospital/CMHC' may have.

Ensuring referral agents are providing treatment choice and include charitable choice programs with documentation that can be reviewed by KDADS especially in regard to consumers that are 'mandated' by the courts or the department of children and family services, as they are very vulnerable and afraid.

Fight Stigma- develop an association throughout Kansas communities where family members are able to pick up the role of advocate similar to programs in the mental health system. Continued education by a variety of stakeholders that engage with local, state and national initiatives to decrease stigma.

Pay for performance

Support and/or create excellent tele-medicine and other technology for rural communities

Create opportunities for the development of local advisory and other committees rather than having a small number all in Topeka

Incorporation of a strengths based model into the existing site visit reporting model to highlight the positive aspects of a particular program.

Thank you very much for giving me the opportunity to provide feedback.

Sincerely,

Rhonda Walker

Diana Marsh [KDADS]

From: Rick Cagan
Sent: Wednesday, August 30, 2017 2:52 PM
To: Kimberly Reynolds [KDADS]
Cc: Rick Cagan
Subject: Block Grant comments

Kim

I am offering these comments regarding the Mental Health Block Grant application.

First, I have always been concerned about the process used to inform the public about the opportunity to comment. While the Department's interest in soliciting comments has been more involved this year than in years past, the overwhelming amount of content with the application at over 100 pages makes it very tough for most people to address the proposal. I am hopeful that in future years the Department will give serious consideration to an executive summary which highlights the main issues in the proposal and creates a streamlined process for gathering public input.

We are deeply concerned about the lack of clarity about what the Mental Health Block Grant is actually funding. It's important for all mental health stakeholders that there be transparency about the allocations of Block Grant dollars to Community Mental Health Centers, CROs, NAMI, Keys, the CAC, and other program emphases.

There also needs to be transparency about how the decisions about these allocations are made. Over the years in which I participated as a member of the Governor's Behavioral Health Services Planning Council, there was never any give and take within the Council relative to a proposal from the state agency about how Block Grant dollars were to be allocated. It was always my understanding that the Council was to play a decision-making role relative to the Block Grant. However, this is something that I never witnessed.

We would like to offer very strong support for the block grant funding which is allocated to mental health centers for early intervention in response to the first episode of psychosis. While the federal guidelines call for a 10% allocation, we would like to see commitments at a higher level. This is consistent with the Department's focus on prevention. Ultimately, we need to have some level of focus on early intervention at all community mental health centers.

On a more personal level, we have been informed by KDADS that the federal reduction to the Block Grant (still pending in Congress) is approximately 26 percent. We have also been informed by the agency that only 25 percent of the contract with NAMI Kansas was funded by

the Block Grant in FY 2017. Arguably, that would suggest that a reduction in the area of 6.5 percent would be in order when in fact the reduction in funding imposed on NAMI Kansas was closer to 19 percent. That seems disproportionately harsh. We would like to see a reconsideration of this funding allocation, assuming that the 26% reduction is adopted in the federal budget. We would also like assurances from KDADS that should any portion of the federal block funding be restored that a comparable percentage of our reduction in funding would also be restored.

Thank you for your consideration of these comments. I look forward to learning more about how the application is received and how these and other comments are integrated.

Rick Cagan

Rick Cagan
Executive Director
National Alliance on Mental Illness- NAMI Kansas
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(800) 539-2660
(785) 233-4804 FAX
rcagan@namikansas.org

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[Join NAMI](#) and make a donation to support our work on peer support, education, and advocacy

**NAMI KANSAS OFFICES ARE NOW LOCATED AT 501 SW JACKSON STREET, SUITE 400 IN TOPEKA.
PLEASE USE THE PO BOX ADDRESS FOR ALL CORRESPONDENCE.**

Diana Marsh [KDADS]

From: Sandra Dixon <sdixon@dcca.org>
Sent: Wednesday, August 23, 2017 10:10 AM
To: Kimberly Reynolds [KDADS]
Subject: FW: block grant work group discussed yesterday

Easier to find than I thought..from Rodney,

From: Rodney Shepherd [mailto:rodneys@cornerhouseinc.org]
Sent: Monday, June 26, 2017 4:02 PM
To: Sandra Dixon <sdixon@dcca.org>
Subject: RE: block grant work group discussed yesterday

Sandra,

I hope this is what you needed, at any rate it is the best my little pea brain can do on such short notice!

Rod

1.What are the unmet service needs/critical gaps in the state's current system?

There is a delay in getting services approved especially if the client comes from another provider or their funding changes from another source to Block Grant.

It is often difficult to get KCPCs from the state data base if an assessment was completed by another provider or a client was in services elsewhere. It requires multiple call logs, phone calls and costs a great deal of labor for clinicians.

Waiting periods for Intermediate Services are often up to two months.

At times we have to start waiting list even for Outpatient clients because we are beyond our capacity to serve and in our area there are often no options for referral to another provider.

2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?

We provide a lot of case management type services to clients free of charge, as well as offering free Alumni and interim groups.

3.What measurable changes/enhancements would we want to see over the next two years?

We would like to see a major overhaul of the state's data system (KCPC) we need a system with better access for all the providers in the state that doesn't cause extra labor and can interface with providers EHRs to avoid double entry of data and improve turnaround time for service approvals. The system should also provide easy access to data that can be used to improve client treatment protocol.

Changes in requirements for what we could bill for services, for example being able to bill for services provided to Level II.1 clients that have not been compliant with the total requirements of their treatment. We provide services but if the client misses a group or individual session the facility is unable to bill for services they did provide.

4. What changes/enhancements to the use of SUD treatment block grant funding would benefit

the State's consumers?

We need to simplify the requirements and process to get people into treatment. It takes far too long to get someone into treatment.

From: Sandra Dixon [<mailto:sdixon@dcca.org>]

Sent: Thursday, June 22, 2017 12:31 PM

To: rodneys@cornerhouseinc.org; victor@sackansas.org; Shane Hudson <shudson@c-k-f.org>

Cc: Steve Denny (sdenny@fourcounty.com) <sdenny@fourcounty.com>

Subject: block grant work group discussed yesterday

Hi guys,

Good to see you all yesterday. Attached is an email and documents from KDADS regarding the block grant work group we discussed yesterday, as well as an invitation to participate that is being distributed today. You will likely get the invitation letter through other means (ACC, KCC or KAAP), but because you've already shown interest in this, I'm sending you the entire packet. Please let me know if you, or someone on your team, wants to be included in the conference calls so I can be sure the contact information gets on the distribution list.

Thanks
Sandra

Sandra J. Dixon LMSW
Director of Behavioral Health Services
DCCA
3312 Clinton Parkway
Lawrence, KS 66047
(785) 841-4138



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Diana Marsh [KDADS]

From: Shane Hudson <shudson@c-k-f.org>
Sent: Friday, July 07, 2017 9:13 AM
To: Sandra Dixon
Subject: RE: block grant work group discussed yesterday
Attachments: KCC Report 2017.docx

Below are my initial responses to the questions that were sent. Please see attachment for a copy of the KCC Report in case you would like to pull some statements from that report. I have not updated the report with the suggestions offered at the Governor's Council as of yet.

1. What are the unmet service needs/critical gaps in the state's current system?
Critical gaps in the state's current system include lack of availability and process for patients to receive concurrent mental health (therapy and psychiatry) services from SUD providers while in treatment. There is also a lack of infrastructure for patients to receive peer support services prior to the beginning of treatment and following treatment. Patients should be able to work with peers prior to admission to treatment, during treatment, and following treatment in order to secure community resources and have regular ongoing structure and support from SUD staff as they navigate their recovery. When considering mental health services patients are often not able to receive the right service at the right time within the same location as their SUD services. Without the services mentioned above, patients are facing long waiting lists for mental health services and are navigating the system of services and access on their own, which has not been leading to favorable health outcomes historically.
2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?
Currently, we are utilizing the SUD block grant to provide the best access to treatment services as we are able to offer. Patients are receiving the full continuum of care and are working with peer support services as often as possible within the confines of the current reimbursement structure.
3. What measurable changes/enhancements would we want to see over the next two years? (4. What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?)
 - Support reimbursement for the flexible, responsible, supervised use of the full contingent of addiction service providers, including peer mentors and person centered case managers.
 - Support a global payment model that would allow providers to define the appropriate care for each patient while managing per member per month funds and tracking quality outcomes. Fee-for-service models negatively affect providing individualized care plans to consumers due to restrictions on covered services. Meanwhile, providers have staff and resources that could greatly benefit the consumer if there were more flexibility created by global payments (this would include provision of mental health therapy and psychiatry).
 - Support initiatives that allow professionals with specialty training in addiction counseling to provide more integrative services to clients with co-occurring conditions.

From: Sandra Dixon [<mailto:sdixon@dcca.org>]
Sent: Thursday, June 22, 2017 12:31 PM
To: rodneys@cornerhouseinc.org; victor@sackansas.org; Shane Hudson
Cc: Steve Denny (sdenny@fourcounty.com)
Subject: block grant work group discussed yesterday

Hi guys,

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Thanks
Sandra

Sandra J. Dixon LMSW
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Diana Marsh [KDADS]

From: KDADS BHS
Sent: Friday, August 18, 2017 12:00 PM
To: Kimberly Reynolds [KDADS]
Subject: FW: My input on the Federal Block Grant Funding for Kansas

From: Valerie Worley [mailto:valerie.worley@sackansas.org]
Sent: Friday, August 18, 2017 11:33 AM
To: KDADS BHS <KDADS.BHS@ks.gov>
Subject: My input on the Federal Block Grant Funding for Kansas

I do drug and alcohol assessments at Winfield Correctional Facility. My main goal is get people into treatment before they release from the facility and encourage recovery so they don't come back to the prison.

Unfortunately, even when I have willing participants in the assessment who want residential treatment, I am not able to place them in the level of care they need due to the shortage of beds for AAPS funding. For example at Mirror Inc in Newton, they only have 4 beds a months to use with AAPS funding. I have a higher percentage of clients that need residential treatment so these people get under served, relapse with drug use and end up coming back to Winfield Correctional Facility. I am sure the other care coordinators at the other prisons can give the same story. It would save taxpayers money if more money went into treatment to avoid recidivism instead of putting more in the prison system. That is my input on this Block Grant. Thanks for your time.

Valerie J. Worley BA, LAC
Care Coordinator - WCF - KDOC Re-Entry
Substance Abuse Center of Kansas
Phone 620-705-6056 Fax 316-267-3843
valerie.worley@sackansas.org

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To Whom I concern,

Wings is for me is place to go to hang out, meet your friends, learn things and place to go to be alone without dramas. Wings is fun place to go. ~~to go~~ I go to wings because I want to learn things about anger management, stress, heal KS and pathways to recovery.

love,
Alisha Ballester

Wings Upon the Prairie means alot to me.

The reasons why are:

They help me stay away from bad influences like drugs+ alcohol and help me cope with my mental illness and disability.

They teach me how to cook on a budget and eat healthy meals. They teach me how to budget my money. Without Wings Upon the Prairie I wouldn't have the resources to make my life better and stable.

William D. Buckel

Community run organization

Working together for healthier communities. My CRO is a place where I go to be safe and cared for. We need to change the conditions in which we live, with the hope that changing those conditions will change people's behavior and more distant outcomes. We have peer support and different groups that I take a great joy in receiving the material others have to offer. Being part of a group helps develop important personal and interpersonal skills. These include the ability to think critically and solve problems, and the assumption of personal and group responsibility. My CRO is a place where I can express myself through art and other activities, or just by being able to talk openly with peers and caring adults.

Patricia Smith

Block Grant feedback:

1. What are the unmet service needs / critical gaps in the state's current system?

A. Pertaining to **no new** additional dollars:

- Getting into inpatient tx in a timely manner. In some cases inpatient might be brief and more stabilization time.
- Replace the KCPC with a less time consuming and web based instrument;
- Providers need to be able to access from the KCPC / assessment system: stats, and have access to the client's prior assessment immediately; Need assessment system where information is more readily available and integrated. Recommend updating assessment process / KCPC system.
- Providers being able to provide more CM services across the state; Reimbursement also needs to be worthwhile. Block grant rates are lower than MCD rates. Recommend payment be the same as MCD. Then more Providers might be more willing to provide some of these services.
- Transportation reimbursement needs to improve and / or provide money for bus tokens,...
- Provide training for Providers for trauma awareness, elderly and opioid users.

B. Pertaining to if there was to be **an increase** in the amount of block grant dollars:

- More Recovery Centers using peer mentors across the state;
- Increase the number of social detox beds across the state;

2. What are we currently doing now with the SUD treatment block grant funding that we want SAMHSA to know about?

- a) Providing counseling for clients with trauma needs;
- b) Providing therapy addressing co-occurring needs;
- c) More Providers across the state are providing evidence based treatment; Need to continue to encourage providers to use re-search based, evidence based approaches;

3. What measurable changes/enhancements would we want to see over the next two years?

A. Pertaining to **no new** additional dollars:

- Move out of fee for service to case rate or outcome based, especially for peer mentoring;
- Replace the KCPC with a less time consuming and web based instrument;
- Providers need to be able to access from the KCPC / assessment system stats, and have access to the client's prior assessment immediately; System where information is more readily available and integrated. Recommend updating assessment process / KCPC system.

- B. Pertaining to if there was to be an **increase** in the amount of block grant dollars:
- Recovery centers across the state to be able to offer more peer mentoring and interim services.

4. What changes/enhancements to the use of SUD treatment block grant funding would benefit the State's consumers?

- a) Money available for MAT services for clients for alcohol, opioids and other needed substances.
- b) Money for transportation needs such as bus tokens,...
- c) Provide dollars to assist in finding ways to access med providers to work with Providers to assist with MAT services. This might include telemedicine.