

Kansas

UNIFORM APPLICATION

FY 2022/2023 Only Application Behavioral Health Assessment
and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 08/24/2022 11.15.58 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State DUNS Number

Number 878195098

Expiration Date

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

Agency Name Kansas Department for Aging and Disability Services

Organizational Unit Behavioral Health Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

II. Contact Person for the Grantee of the Block Grant

First Name Andrew

Last Name Brown

Agency Name Kansas Department for Aging and Disability Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

Telephone 785-291-3359

Fax 785-296-0256

Email Address andrew.brown@ks.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 8/27/2021 5:50:09 PM

Revision Date 8/22/2022 4:15:53 PM

V. Contact Person Responsible for Application Submission

First Name Cissy

Last Name McKinzie

Telephone 785-296-4079

Fax 785-296-0256

Email Address Tamberly.Mckinzie@ks.gov

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

Footnotes:

Laura Howard, Secretary

Laura Kelly, Governor

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

March 15, 2021

To whom it may concern,

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Synar Report) and the Community Mental Health Services Block Grant until such times as this delegation of authority is rescinded.

Sincerely,

A handwritten signature in cursive script that reads "Laura Howard".

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

State Information

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

Fiscal Year 2022

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
 Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the 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.
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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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Laura Howard

Signature of CEO or Designee¹: _____

Title: KDADS Secretary

Date Signed: _____

mm/dd/yyyy

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

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

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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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Laura Howard

Signature of CEO or Designee¹: *Laura Howard*

Title: KDADS Secretary

Date Signed: 08/02/2021

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

August 30, 2019

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

RE: Delegation of Signatory Authority, Kansas Combined Block Grant Application

To Whom It May Concern,

As the Governor of the State of Kansas, for the duration of my tenure, I delegate authority to the current Secretary of the Kansas Department for Aging and Disability Services, Laura Howard, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG).

Respectfully,


Governor Laura Kelly

State Information

Disclosure of Lobbying Activities

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

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

Name

Laura Howard

Title

Secretary

Organization

Kansas Department for Aging and Disability Services

Signature:

Laura Howard

Date: 08/02/2021

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Secretary for the Kansas Department for Aging and Disability Services (KDADS) is also the Secretary for the Kansas Department for Children and Families (DCF). In her role as Secretary, she represents the agencies in front of the Legislature but does not lobby.

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404



www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Ric Dalke, Vice Chairperson

GOVERNOR LAURA Kelly

August 24, 2021

To Whom It May Concern,

During the past year, the Kansas Governor's Behavioral Health Service Planning Council (GBHSPC) has continued to focus on ensuring that Behavioral Health Services are integrated and meet the needs of Kansas children, adults, and their families who are experiencing mental health, addictions, and co-occurring disorders. GBHSPC members continue to participate in subcommittees and task forces. Currently, the GBHSPC has ten active subcommittees. The subcommittees are: Housing and Homelessness, Justice Involved Youth and Adults, Supportive Employment and Vocational Services, Prevention, Children's, Rural and Frontier, Service Members Veterans and Families, Evidence Based Practice, Problem Gambling and Gaming 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.

As additional support for recommendations in mental health and substance use disorder programs and recovery services in Kansas with oversight reviews and recommendations for the Block Grant in Kansas, the GBHSPC will be adding two additional subcommittees this year. The new subcommittees are the Aging Populations, and the Peer Services Subcommittees.

Each of the Subcommittees provided their yearly reports and recommendation to the Secretary and Leadership team of the Kansas Department for Aging and Disability Services. The reports are now available on the Behavioral Health Commission Website.

The reports from 2020 from the subcommittees have served as a vital source of information and for the development of recommendations for several special government taskforces in the past year. The reports were utilized by the Kansas Legislature's Mental Health Modernization legislative committee for development of a ten-year planning recommendation to the legislature. The 2021 reports from the GBHSPC subcommittee will be submitted to the committee for further review and recommendations in this ongoing process as the Kansas Legislature plans to continue to convene this committee in the FY22 session.

This letter is confirmation that the Kansas FFY2022 and FFY2023 Substance Abuse Prevention and Treatment and Mental Health Block Grant Application have both been reviewed and approved by the Kansas Governor's Behavioral Health Service Planning Council (GBHSPC).

Sincerely,

A handwritten signature in black ink that reads "Sherman Wes Cole". The signature is written in a cursive style.

Sherman Wes Cole
Chair, Governor's Behavioral Health Services Planning Council

State Information

Disclosure of Lobbying Activities

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

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

Name

Laura Howard

Title

Secretary

Organization

Kansas Department for Aging and Disability Services

Signature:

Date:

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

Footnotes:

The Secretary for the Kansas Department for Aging and Disability Services (KDADS) is also the Secretary for the Kansas Department for Children and Families (DCF). In her role as Secretary, she represents the agencies in front of the Legislature but does not lobby.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

Footnotes:

**FFY2022 - FFY2023 Kansas Substance Abuse Prevention and Treatment (SAPT) Block Grant and
Mental Health Block Grant (MHBG) Application**

Section II: Planning Steps

Step One Narrative

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

Substance Abuse and Mental Health

- *Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.*

Kansas

Centrally located in the continental United States, Kansas is a state with a population estimate by the U.S. Census Bureau in 2019 of almost 3 million people (2,913,314) with population density ranging from urban areas to rural and frontier (<https://www.census.gov/quickfacts/fact/table/KS,US/PST045219>).

The U.S. Census Bureau QuickFacts for 2019 estimates age distribution in Kansas of twenty-four percent (24.0%) of the population are under 18-years-old and just over sixteen percent (16.3%) are 65 years old and over. It is estimated that a little over half of the population is female (50.2%).

Race distribution is estimated at: White alone (86.3%), Hispanic or Latino (12.2%), Black or African American alone (6.1%), Asian alone (3.2%), Two or more races (3.1%), American Indian and Alaska Native alone (1.2%), and Native Hawaiian and other Pacific Islander alone (0.1%).

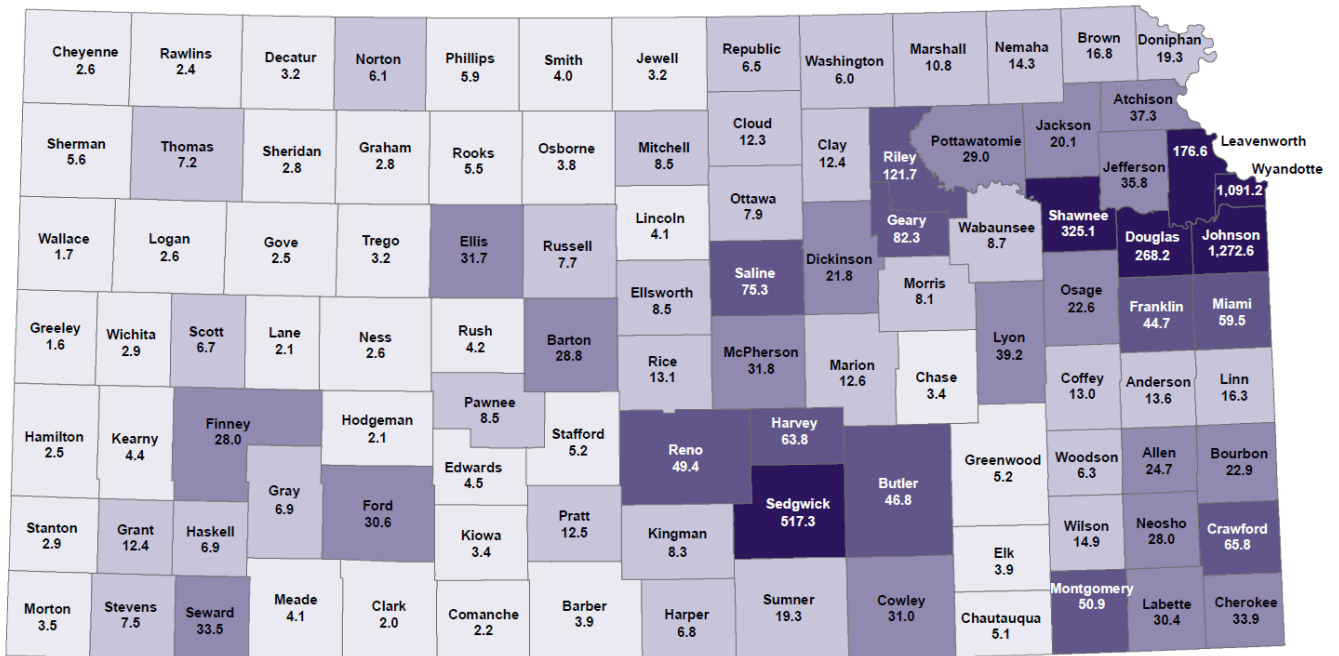
	Kansas	United States
White alone	86.3%	76.3%
Hispanic or Latino	12.2%	18.5%
Black or African American alone	6.1%	13.4%
Asian alone	3.2%	5.9%
Two or more races	3.1%	2.8%
American Indian and Alaska Native alone	1.2%	1.3%
Native Hawaiian and other Pacific Islander alone	0.1%	0.2%
White alone, not Hispanic or Latino	75.4%	60.1%

Over ninety percent (91.0%) of the population are high school graduates or higher. Nine percent (9.0%) are persons with a disability under age 65. Over ten percent (10.9%) of Kansans are persons without health insurance under age 65 years. Persons in poverty is estimated at over eleven percent (11.4%).

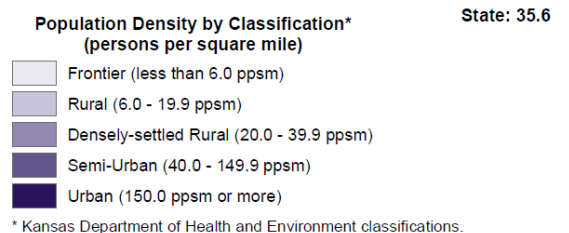
	Kansas	United States
Persons with a disability under age 65	9.0%	8.6%
Persons without health insurance	10.9%	9.5%
Persons in poverty	11.4%	10.5%

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

Population Density Classifications in Kansas by County, 2019

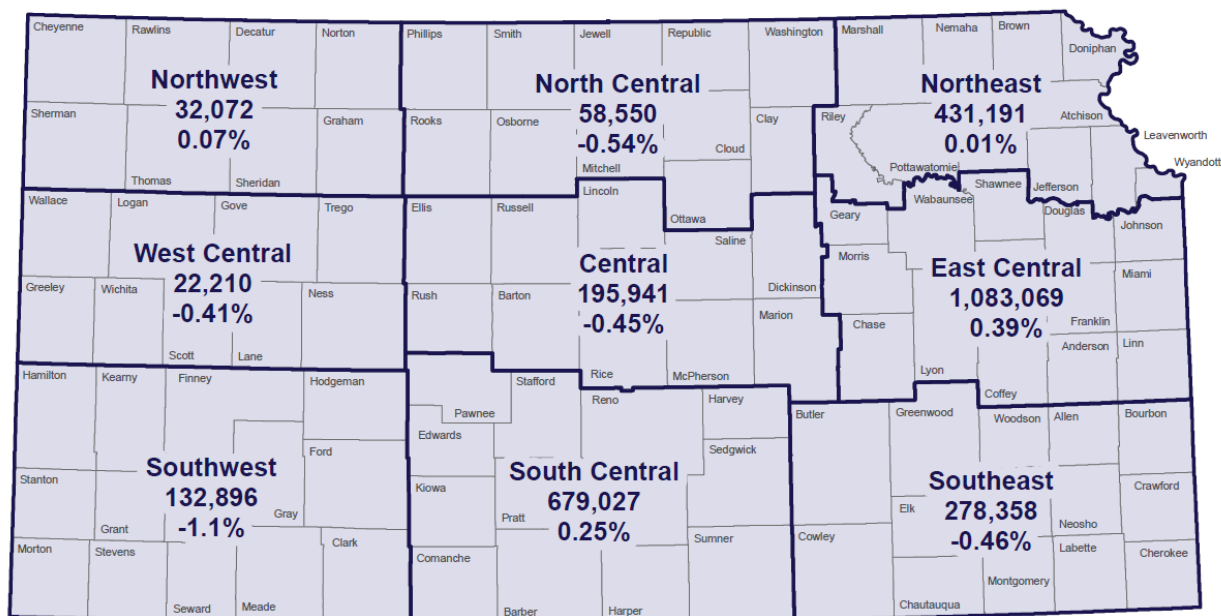


Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2019.



Kansas population by region with percent of change for 2019 is also illustrated in the map embedded below from the Kansas University Institute for Policy & Social Research. The highest increase in population reported is in the east central region of the state. The highest decrease in population reported is in the southwest region of the state.

**Population of Kansas by Region, July 1, 2019
and Percent Change, 2018-2019**



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau.

State: 2,913,314
0.07%

State of Kansas

On January 14, 2019, Laura Kelly was sworn in as the 48th governor of the State of Kansas. Dr. Lee Norman is the Secretary of the Kansas Department of Health and Environment (KDHE) appointed by Governor Laura Kelly. Secretary Norman has been in a leadership role for the State in response to the COVID-19 pandemic. Jeff Zmuda was appointed by Governor Kelly to be the Secretary of the Kansas Department of Corrections in 2019. Laura Howard was appointed and continues in her role as the Secretary for the Kansas Department for Children and Families (DCF) and the Kansas Department for Aging and Disability Services (KDADS). Janis DeBoer is the Deputy Secretary of the Kansas Department for Aging and Disability Services and continues in her role. Scott Brunner is the Deputy Secretary of Hospitals and Facilities at KDADS.

The Coronavirus Pandemic (COVID-19)

Kansas announced its first presumptive positive case of COVID-19 on March 9, 2020. Governor Laura Kelly issued an emergency declaration for the State of Kansas in response to COVID-19 (coronavirus) on March 12, 2020 ([Link](#)) and announced the first COVID-19 related death in Kansas. It was recently found that the first documented COVID-19 death in Kansas was actually two months prior with a single COVID-19 death on Jan. 9, 2020. By the end of the State Fiscal year (7/1/20), KDHE reported there were 14,990 cases from 96 counties with 272 deaths. By the end of the Federal Fiscal year (9/30/20), there were 59,749 cases of COVID from all 105 Kansas counties with 678 deaths reported. As of August 11, 2021, there have been 344,937 cases reported from all 105 Kansas counties and 5,286 Kansans have died from COVID-19 ([Link](#)). In response to the pandemic, KDHE has created a public section on their website with

coronavirus response information ([Link](#)). KDADS has also created a COVID-19 Resource Center on the KDADS website for public access ([COVID-19 \(ks.gov\)](#)) .

KDHE is also the Medicaid Single State Authority for the State. KDHE and KDADS administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waiver programs: Autism, Frail Elderly, Intellectual/Developmentally Disabled (I/DD), Physical Disability, Serious Emotional Disturbance, Technology Assisted, and Brain Injury. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance use disorder, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019. The current Governor has made efforts to expand Medicaid in Kansas. As of July 2021, the Kansas legislature has not expanded Medicaid.

Kansas Department for Aging and Disability Services (KDADS)

Under Secretary Howard, KDADS was reorganized into five commissions: Financial and Information Services Commission, Aging and Disability Community Services and Programs Commission, State Hospital Commission, the Survey, Certification and Credentialing (SCC) Commission, and the Behavioral Health Services (BHS) Commission with a new Strategic Vision.

The Strategic Plan under Secretary Howard and Deputy Secretary DeBoer includes the following eight target areas:

1. Modernize: Modernize the continuum of care in the state through technology, collaboration, and innovation including the roles of intuitional settings in the care of continuum and the most integrated community alternatives.
2. Self-direction and Self-determination: Revitalize self-direction offerings/ support self-direction and self- determination through programming and policies.
3. Decision-making: Improve consumer-driven decision-making and program design.
4. Employment: Increase meaningful and community-integrated employment opportunities for populations served by KDADS.
5. Housing: Implement comprehensive approaches to link target populations to accessible community-based housing.
6. Workforce: Improve workforce development across the state.
7. Data: Movement toward data-informed continuous quality improvement.
8. Prevention: Adopt strategic prevention framework.

State Hospital Commission

The Kansas Department for Aging and Disability Services (KDADS) is responsible for the administration of Larned State Hospital and Osawatomie State Hospital for Kansans suffering from mental illness and for the Kansas Neurological Institute and Parsons State Hospital and Training Center for individuals with

intellectual and developmental disabilities. The State Hospital Commission was created on June 2, 2019, by Secretary Howard. Dr. Mike Dixon is the Commissioner of the State Hospital Commission.

In alignment with the KDADS Strategic Plan, The State Hospital Commission has a new Electronic Medical Records system in process to modernize the records system and improve data processes. The Commission also has developed a new program, in conjunction with the Behavioral Health Services Commission, to keep people who need care screened for State Hospitalization closer to home when the State Hospitals are full. The new program is State Institutional Alternatives and allows local psychiatric hospitals to accept involuntary and voluntary patients as an extension of the State Hospitals.

Survey, Certification and Credentialing Commission (SCC)

The primary function of the Survey, Certification and Credentialing Commission is to protect public health through the licensure and inspections of adult care homes as defined by K.S.A. 39-923. The commission develops and enforces state regulations related to adult care homes, as well as implements federal certification activities for Medicaid- or Medicare-certified nursing homes. Field staff working out of regional offices across the state conduct annual, unscheduled inspections of adult care homes on a rotation basis as well as unannounced inspections in response to consumer or provider-reported complaints received by the commission's Adult Abuse, Neglect, and Exploitation hotline. Lacey Hunter is the Commissioner of the Survey, Certification and Credentialing Commission. Behavioral Health provider licensing and certification fall under her direction. KDADS field staff working out of regional offices across the state work directly with behavioral health providers to complete and ensure compliance with licensing standards and requirements. This is done by licensing site visits with each of the licensed programs throughout Kansas. During these visits, clinical files are reviewed for compliance, a review of policies and procedures is completed, as well as, an inspection of the physical location.

Aging & Disability Community Services and Programs Commission (A&D CSP)

Amy Penrod is the Commissioner of the Aging & Disability Community Services and Programs Commission. The Aging & Disability Community Services and Programs (A&D CSP) Commission manages a system of community-based supports and services for persons with disabilities, which are delivered through the Medicaid Managed Care system (KanCare) in partnership with organized networks. These services include programs for those with physical disabilities, intellectual/developmental disabilities, frail elderly and children with autism. It is responsible for coordinating intra-agency KDADS activity around KanCare. The Commission works with each KDADS Commission to ensure that client services are monitored appropriately. The Commission coordinates with all three KanCare Managed Care Organizations (MCOs) regarding KDADS-specific program areas (home and community-based service waivers and behavioral health).

A&D CSP also administers a variety of community-based programs for the aging population through contracts and grants of state and federal funds. The programs administered include Older Americans Act, congregate and home-delivered meals, caregiver programs, in-home services, Senior Care Act services, and Client Assessment, Referral and Evaluation (CARE) program, as well as quality assurance programs for the Older Americans Act and Senior Care Act. In addition, it is responsible for the Aging and Disability Resource Center, or ADRC, the single-entry point for older adults and persons with disabilities to connect with local experts who can help them choose a long-term care option. The Commission oversees and implements grants that assist individuals who are aging or have a disability

under Senior Health Insurance Counseling for Kansas (SHICK), Senior Medicare Patrol (SMP), Lifespan Respite and Community Transition Opportunities. The SHICK program assists individuals with questions related to Medicare. The SMP program educates the community about reporting Medicare/Medicaid and health-care fraud and abuse and how to identify and report scams. The Commission's Community Transitions Opportunities program works with nursing facilities to identify residents who wish return to living in a community setting.

Financial and Information Services Commission (FISC)

The Financial Information Services Commission is responsible for various administrative functions that support other KDADS Commissions. The Accounting Division is responsible for processing all agency payments and monitoring expenditures. It also monitors KDADS' grants to other organizations. The Budget Division prepares the KDADS budget, monitors legislative activity related to the budget and handles requests for budget information. The Information Services Division maintains the KDADS computer network and various web application systems. In addition, the Commission provides technical support to agency staff and business partners. The Fiscal and Program Evaluation Division is KDADS' auditing, reporting and data analysis group. It is responsible for managing nursing facility reimbursement programs. Brad Ridley is the Director of the Financial and Information Services Commission.

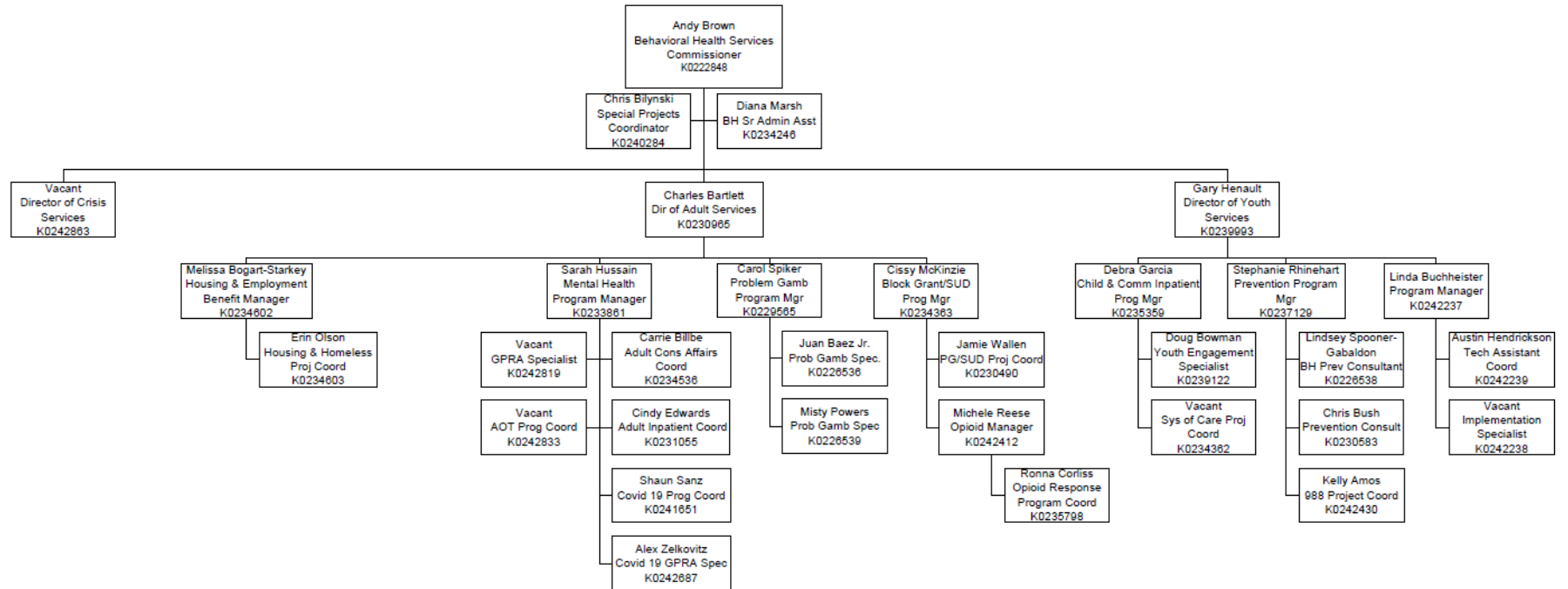
Behavioral Health Services Commission (BHS) Staffing and Structure

Andy Brown is the Behavioral Health Services (BHS) Commissioner. Mental Health (MH), Problem Gambling (PG), and Substance Use Disorder (SUD) Prevention, Treatment, and Recovery services fall under Commissioner Andy Brown's direction. The Commissioner of BHS is the Single State Authority (SSA) for SAPT (Substance Abuse Prevention and Treatment) and the State Mental Health Authority (SMHA). The BHS Commission partners with care providers, communities and community mental health centers to help Kansans with behavioral health, substance use disorder and other addictions services. KDADS is responsible by statute and holds the authority and responsibility for coordinating mental health care and substance abuse/addiction services across the state. The Commission works in close coordination with the Governor's Behavioral Health Services Planning Council.

As of August 2021, the current Behavioral Health Services Commission Organizational chart and responsibilities is shown below. However, it should be noted that KDADS and BHS will be going through a small but important reorganization over the next several months. Much of the existing BHS structure will remain the same but the size of the BHS Commission will increase with a few new positions added and a few staff transferred to the BHS Commission from other Commissions.

Kansas Department for Aging and Disability Services Behavioral Health Services

June 16, 2021



Directly under the supervision of Commissioner Brown, there is one Behavioral Health (BH) Senior Administrative Assistant, a Special Projects Coordinator position, the Director of Adult Services, a Director of Youth Services and a Director of Crisis Services (new).

Directly under the supervision of the Director of Youth Services is the Prevention Program Manager and the Child & Community Inpatient Program Manager, and Disaster Relief Program Manager. The Prevention Program Manager is the National Prevention Network (NPN) representative for Kansas and supervises two Prevention Consultants and a 988 Project Coordinator. The Prevention team manages all the substance use disorder (SUD) prevention services, as well as, mental health promotion initiatives including suicide prevention. This includes the management of SAMHSA prevention grants and management and oversight to all aspects of the SAPTBG prevention set-aside. This team also partners with other state agencies to ensure our state is compliant with all aspects of the federal Synar regulations and partners with other staff to integrate prevention to all behavioral health services.

The Child and Community Inpatient Manager supervises a Youth Engagement Specialist and a System of Care Project Coordinator. The Child and Community Inpatient Manager oversees the Psychiatric Residential Treatment Facilities (PRTFs) within the State of Kansas. Kansas expanded to nine PRTFs within the State in July 2021. Ember Hope Youthville of Newton, Kansas is opening a 12 bed PRTF for females living within a 60-mile radius of the facility. This PRTF will be working towards recommendations from the NRI study completed in 2019 and will be supported by additional funding legislated during the last session of the Kansas Legislature.

The Disaster Relief project is new this year and is focused on providing trauma-informed training to parents and teachers as a result of the public health disaster. The Disaster Relief Program Manager supervises a Technical Assistant Coordinator and an Implementation Specialist (vacant).

The Director of Adult Services is the National Treatment Network (NTN) representative for Kansas. Under the Director of Adult Services is a Housing & Employment Benefit Manager, a Mental Health Program Manager, a Problem Gambling Program Manager, and the Block Grant/SUD Program Manager. The Block Grant/SUD Program Manager is also the State Opioid Treatment Authority (SOTA) representative for Kansas.

The Housing & Employment Benefit Manager supervises a Housing and Homelessness Project Coordinator.

The Problem Gambling Program Manager supervises two Problem Gambling specialist field staff.

The Mental Health Program Manager supervises the Adult Consumer Affairs Coordinator, the Adult Inpatient Coordinator, a COVID-19 Program Coordinator, a COVID-19 GPRA Specialist and two vacant positions (AOT Program Coordinator and a GPRA Specialist).

The Block Grant/SUD Program Manager supervises an Opioid Manager and a Problem Gambling/SUD Project Coordinator. The PG/SUD Project Coordinator is the Women's Treatment Coordinator for the State. The Opioid Manager supervises an Opioid Response Program Coordinator.

BHS Programs and Services

Prevention System Infrastructure and Services

With intentional effort to move toward a more integrated and community-focused approach to behavioral health, in 2016, KDADS started the Kansas Prevention Collaborative (KPC). Following SMHSA’s lead KDADS provides funding directly to community coalitions to plan and implement prevention strategies locally. Oversight of the Kansas Prevention Collaborative is provided by KDADS Prevention Manager and Prevention Specialists. In addition to guiding the work of the KPC contractors and funded KPCCI communities, the role of KDADS is grant administration, fiscal accountability, and monitoring.

Four Kansas contractors provide state and local services and supports including community training and technical assistance, data collection, analysis and evaluation, community documentation, and communication and connection. Services provided by the Collaborative partners are designed to support coalition capacity development, increase engagement and involvement, and expand opportunities including fiscal and other resources to communities across the state. Contractors and services are included in the table below:

Contractor	Services Provided
DCCCA, Inc.	Statewide training and technical assistance to community coalitions, community initiatives, and KDADS projects focused on behavioral health concerns.
Learning Tree Institute at Greenbush	Statewide, regional, county, and school district data collection, analysis, and evaluation, including administration of the Kansas Communities That Care Student Survey.
University of Kansas Center for Community Health & Development	Evaluation tools and expertise through the Community Check Box documentation system and management of the KPC WorkStation. Sensemaking sessions for coalitions to develop their capacity for monitoring and evaluation.
Wichita State University Community Engagement Institute	Statewide behavioral health education, resource, and information dissemination, consumer outreach and advocacy. Communication hub and facilitation of a statewide prevention coalition.

Partner	Role
Headquarters, Inc.	KDADS does not spend SABG funds on suicide prevention but does partner with Headquarters, Inc. for their expertise and guidance on suicide prevention throughout the state. Headquarters, Inc. also provides counseling, education, and resources to improve public health and generate awareness.

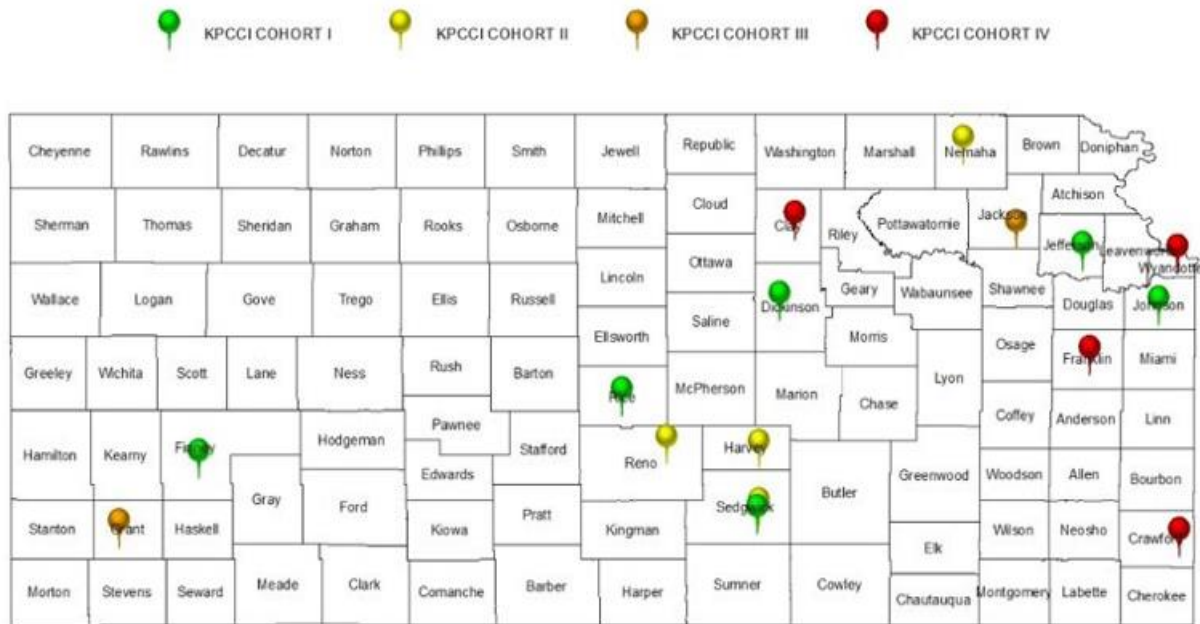
Community Coalitions

Each year a group or cohort of KPC community coalitions are funded for a year-long planning grant. This ensures time for training to apply the Strategic Prevention Framework (SPF) planning process, including comprehensive needs assessment, capacity development, and appropriate strategy

selection. The coalitions then apply for a three-year implementation grant to put their tailored strategic prevention plans into action including monitoring and annual evaluation of activities and outcomes. Their work focuses on increasing readiness of the community to address substance misuse, increasing coalition capacity to implement prevention activities, and decreasing underage drinking, marijuana use, and related risk factors. *KDADS does not spend SABG funds on suicide prevention.* However, the focus of prevention efforts that target shared risk factors are more likely to contribute to multiple related outcomes.

In June of 2020 the first cohort of coalitions completed the new KPC funding cycle. The map below shows the location and distribution of KPC grantees implementing prevention strategies in Kansas. In July 2021 the KPC sixth cohort group was funded to develop a prevention plan.

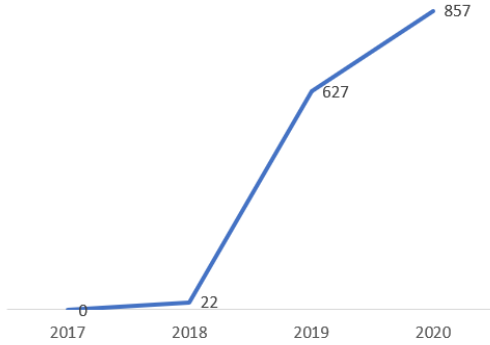
KPCCI Grantees by Cohort



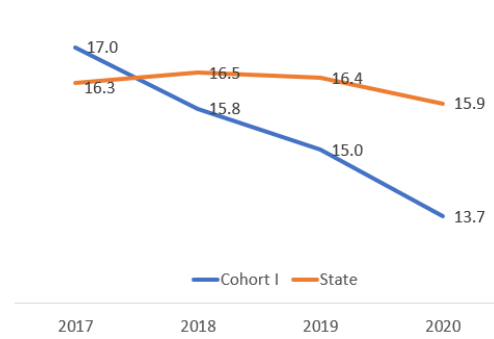
The figures below show the number of services provided by the coalitions in Cohort I that targeted youth alcohol and marijuana use and the associated outcomes. A statistically significant reduction in student alcohol and marijuana use was demonstrated in Cohort I grantees and reduction occurred at a faster rate than the state average. As prevention services were provided and implementation activities increased in funded communities, youth alcohol and marijuana use decreased. In July 2021 the KPC sixth cohort group was funded to develop a prevention plan.

KPCCI Cohort I Outcomes- Reduced Alcohol Use

**Past 30-Day Student Alcohol Use
Number of Services Provided**

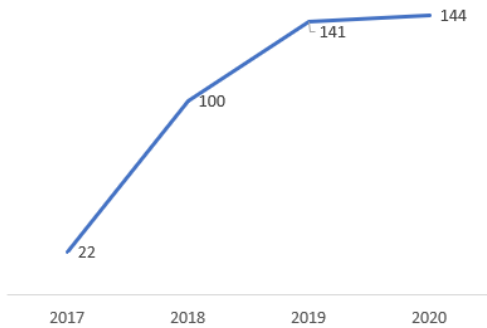


**Past 30-Day Student Alcohol Use
Percentage Reporting Any Use**

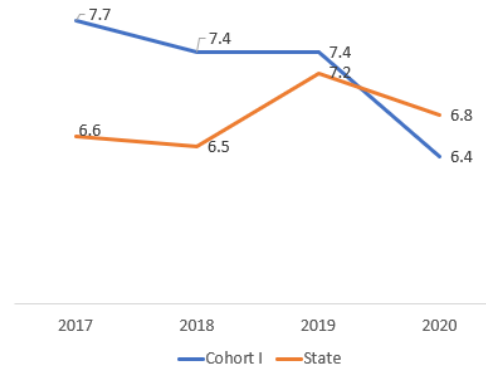


KPCCI Cohort I Outcomes – Reduced Marijuana Use

**Past 30-Day Student Marijuana Use
Number of Services Provided**



**Past 30-Day Student Marijuana Use
Percentage Reporting Any Use**



KDADS and the KPC provide supports through the SPF, with an emphasis on cultural competence and sustainability within each step. Community coalitions must demonstrate an ability and willingness to participate in all required training and technical assistance opportunities provided by the KPC. In addition, KDADS and the KPC provide support to achieve future application of their efforts which include capacity building and sustainability planning.

Prevention Efforts Across the Lifespan

The *Kansas Young Adult Survey (KYAS)* was administered in 2017 and 2019 and is currently being collected in 2021. The survey focuses on the hard-to-reach population of young adults aged 18-25 both in college and not in college. The survey asks about health, mental health, stress, substance use, and driving under the influence of various substances. This statewide survey provides valuable information needed to monitor behavior and attitudes and to plan for prevention. The KPC is particularly interested in monitoring electronic cigarette use which is particularly high among young adults. Many of the survey's questions follow those of the KCTC Student Survey which allows the state to continue to monitor and understand substance use and risk patterns beyond K-12 and into adulthood.

The *Kansas Behavioral Health Profile* provides data for statewide needs assessment. The profile contains data for youth and adults with multiple age breaks reported across the lifespan. Prevalence and consequence data are reported for the following indicatory categories: alcohol, tobacco, marijuana, prescription drug misuse, illicit drug use, problem gambling, mental health, and other related indicators. This profile provides information needed to identify data gaps and behavioral health priorities for all age groups. Finally, the KPC website (kansaspreventioncollaborative.org) offers substance use and mental health resources specific for older adults.

Addressing Diversity

Aligned with SAMHSA's focus on health disparities, KDADS FY2020 block grant prioritized a community-focused effort on data-driven identification of sub-populations in need or at high risk. To assist in this assessment process, the KPC provides coalitions with local data reports that include prevalence and consequence data disaggregated by gender, race, and ethnicity. Once the needs assessment is complete, KPC contractors support the development of community-level **Health Disparities Impact Statements**. Prevention planning for disparate groups along with targeted implementation prevention strategies will help improve behavioral health outcomes for targeted at risk sub-populations.

KDADS is taking strides to expand data collection for **sexual and gender minorities**. In FY 2022 school districts can choose to participate in a new module of the Kansas Communities That Care (KCTC) Student Survey that asks students in 6th, 8th, 10th, and 12th grades about their gender identity and sexual orientation. This option will allow students to self-identify and will provide inclusive options that validate the LGBTQ community. The state plans to use this information to inform prevention needs and identify supports for this population.

Kansas is home to four federally recognized tribal nations. Kansas Census data indicates that 1.2% of the population is **American Indian/Alaska Native** alone. The Kansas Prairie Band Pottawatomie Nation is one of the KPC funded coalitions through its Boys & Girls Club. Their mission is to assist in the development and enhancement of the spiritual, mental, emotional, physical, and social wellbeing of all young people in the surrounding area by providing a safe and positive place for kids. The KPC supports the Tribe's unique culture and heritage providing necessary modifications to provide effective prevention strategies for this population.

Cultural competence training is a required component of the SPF planning step for all funded coalitions. Additional web-based e-learning modules and toolkits on cultural competence are also available through

the KPC on demand to access at a coalition's convenience. This training prepares coalitions to assess the needs of diverse racial, ethnic, and sexual minorities in their community through the SPF process.

In 2021, the KPC supported a six session **Connecting Cultures Series** designed to reduce and eliminate behavioral health disparities in Kansas by welcoming meaningful conversations about culture in an educational setting. The sessions included speakers from communities of people in Kansas who have been marginalized and experience behavioral health disparities. Sessions held June – August 2021 included panels and individual local and national experts sharing their passions, hopes, ideas, and culture to promote healing and improving behavioral health

Prevention System Strengths

The Kansas prevention system is based on the mindset that local communities solve local problems with the appropriate resources and support, and community coalitions are given the tools to sustain their efforts. This mindset proves to be one of our biggest strengths. Community engagement, ownership and utilization of the data-driven SPF process guides the prevention support infrastructure in Kansas called the Kansas Prevention Collaborative (KPC).

There are many Prevention System Strengths resulting from the development of the KPC:

Experienced and Dedicated Workforce

The Collaborative consists of one contractor to support data collection, statewide and community level assessment, and outcome evaluation; one contractor to support the documentation of statewide and community level process data and evaluation; one contractor to facilitate communication and coordination between state and community partners; and one training and technical assistance provider to provide direct support to community coalitions receiving block grant dollars. These contractors work in tandem with KDADS to ensure Kansas meets federal block grant requirements and identified outcomes. Staff from each of the four contractors are part of the *KPC Training Team* that develops and delivers training needed for grantees to successfully develop and implement their strategic plans. Opportunities, resources, and supports are provided to funded and non-funded coalitions statewide. A *Workforce Survey* is conducted annually to assess stakeholder satisfaction with KDADS, KPC contractors, and services provided. The results are used to improve training and technical assistance and to guide additional prevention supports.

High Quality Data

The hallmark of the SPF is the use of data to guide decision-making. Kansas prevention has long-standing, high quality data sources for state and local assessment, planning, and evaluation. This includes data that covers the lifespan.

- The *Kansas Communities That Care (KCTC) Student Survey* has been administered annually since 1994-95 and tracks adolescent substance use, bullying, school climate, and social-emotional/character development. It also has optional modules to monitor youth depression, suicide thoughts, plans and attempts. This comprehensive data collection method serves as the main source of outcome data for the KPC grantees and is available publicly for the state and for counties, and available with a password for school districts and buildings. www.kctcdata.org
- A hard-to-reach population is Young Adults aged 18-25, particularly those not in college. The *Kansas Young Adult Survey (KYAS)* was administered in 2017 and 2019 and is currently being

collected in 2021. Many of the survey's questions follow those of the KCTC which allows the state to continue to understand substance use and risk patterns beyond K-12 and into adulthood. kctcdata.org/YoungAdultsDisplay.aspx

- The *Community Check Box* (CCB) is a web-based recording, measurement, and reporting tool used to support participatory evaluation of community health and development initiatives. The CCB supports KDADS coalition grantees and contractors in online documentation of their work, including their efforts to develop, implement, and or provide support for prevention strategies and activities. Lists of accomplishments, graphs, success stories, and characterization of community and system changes are available on demand for all those doing and supporting the work. <https://ctb.ku.edu/en/community-check-box-evaluation-system>).
- *Kansas Behavioral Health Indicators Dashboard (KBHID)*
The purpose of the KBHID is to provide online behavioral health information for Kansas counties to use in the development of strategic prevention planning and to assess community behavioral health needs and disparities. This data system is a function of the work of the State Epidemiological Outcomes Workgroup (SEOW) and includes relevant data from numerous Kansas and National data sources. Data are updated on an ongoing basis as they become available through various agencies. Where county data are not available or not able to be published, Kansas data are compared to national comparison data. www.kbhid.org
- *Kansas Behavioral and Mental Health Profile*
As part of the State Epidemiological Outcomes Workgroup, the Kansas Behavioral and Mental Health Profile is designed to provide an in-depth, data-focused perspective on the extent of substance abuse consumption patterns and related consequences, with information presented that derives from state health agencies, treatment agencies, law enforcement and revenue agencies. The document's purpose is to illustrate the current state of behavioral and mental health which support a data-informed prioritization process as part of a comprehensive state and community level assessment. This report is being update for 2021. https://www.kdads.ks.gov/docs/default-source/csp/bhs-documents/kansas-behavioral-health-profile-2018.pdf?sfvrsn=bf7407ee_0

Web-Based Resources

- *KPC Website*
The Kansas Prevention Collaborative includes partner support to develop, support, maintain, and update a behavioral health communication hub promoting consistent and coordinated messages. This is done with a combination of technology tools and platforms, united by the KPC's website, made available to the public and for use by coalitions and offers many services and resources. www.kansaspreventioncollaborative.org
- *Kansas Prevention Collaborative Workstation*
The Kansas Prevention Collaborative WorkStation is a SharePoint based tool that supports quarterly report development and provides storage and data dashboards. The WorkStation enables users to easily respond to reporting requests, share materials, make announcements, access tools, learn from others' success stories, and access guidance from peer and contractor discussion in a secure hosting environment. In short, the KPC WorkStation solves needs for community and contractor online collaboration.
- *Kansas Suicide Prevention Resource Center Website*

The Kansas Suicide Prevention Resource Center (KSPRC) at www.kansassuicideprevention.org provides information related to suicide prevention in Kansas. Information available includes suicide rate and death data, listings for the suicide prevention coalitions in Kansas and links to resources related to preventing suicide in specific populations. Additionally, information on suicide warning signs, risk factors and safety plan components are available. The KSPRC website also includes a listing of available support groups for suicide loss survivors across the State of Kansas.

- ***Kansas Gambling Help Website***

The Kansas Responsible Gambling Alliance (KRGa) website (<http://www.ksgamblinghelp.com/>) provides information about no-cost treatment and other resources available for the problem gambler as well as their affected family and friends. There is a short self-assessment tool and information about the warning signs of problem gambling. This website also provides the Helpline phone number so those interested in treatment can find a counselor near them. A description of the voluntary exclusion program is provided with the phone number for the Kansas Racing and Gaming Commission (KRGc) if more information is desired. The website also contains information about the statewide Kansas Coalition on Problem Gambling (KCPG) and the state's four gaming region Task Forces: Northeast, Southwest, Southeast and South Central.

Statewide Coalitions

- Started in 2016, PreventionWorkS is a statewide prevention coalition that connects individuals and groups engaged in prevention efforts across the state. Quarterly meetings provide opportunities for collaboration and integration of behavioral health promotion and prevention of substance abuse, suicide, and problem gambling.
- The *Kansas Coalition on Problem Gambling* meets monthly with the state's four Problem Gambling Task Forces and other stakeholders.
- Starting in September 2021, the new *Kansas Suicide Prevention Coalition* will convene to build a strong infrastructure to support suicide prevention. The coalition will represent both public and private sectors and people with lived experience of suicide attempts, thoughts, and loss. The coalition will provide opportunities partners to collaborate, align their suicide prevention efforts, and implement supported interventions.
- State Epidemiological Outcomes Workgroup (SEOW) brings together a group of data experts to support the State's prevention infrastructure. The work of the SEOW is described in detail below.

Governor's Behavioral Health Service Planning Council (GBHSPC) Prevention Subcommittee

The Prevention Subcommittee serves as a broad voice for behavioral health to provide feedback and guidance related to KDADS BHS prevention initiatives. The group developed and is currently updating the *Kansas Behavioral Health Prevention Plan* a statewide plan to address behavioral health prevention. Several workgroups exist within the Subcommittee. In 2019, Kansas created the Evidence-Based Strategies Workgroup (EBSW) whose purpose is to support Kansans through promoting the use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services. Following the Center for Substance Abuse Prevention's (CSAP's)/Substance Abuse Mental Health Services Administration's (SAMHSA's) criteria of evidence-based, the workgroup developed an *EBS Matrix* of effective and comprehensive prevention strategies as a resource to prevention

stakeholders. This matrix offers a blend of environmental strategies and curricula-based prevention education programs that allow coalitions to 1) Distinguishing proven programs from those without evaluated effectiveness, 2) Comparing program costs and benefits to calculate return on investment, 3) Prioritize funds, 3) Help implement and expand proven approaches, 4) Sustain support for evidence-based policymaking.

Substance Use Disorder Treatment Services

The Kansas Department for Aging and Disability Services (KDADS) license behavioral health providers in Kansas. Licensing standards identify expectations and guidelines for the development and operation of substance use disorder (SUD) treatment programs licensed/certified by the State of Kansas. When new providers apply for a license and during regular site visits, KDADS staff verify compliance with these standards. The standards are rigorous and cover a range of areas, including but not limited to, client rights, confidentiality, client record review, incident reports, member accessibility, program environment and safety, assessment, treatment planning, updates and discharge planning/follow-up.

Kansas contracts with three Managed Care Organizations for Medicaid and an Administrative Services Organization (ASO) for Block Grant substance use disorder treatment services. KDADS monitors the Medicaid plans and the ASO that oversee, authorize and reimburse for SUD treatment services.

Beacon HealthOptions, formerly Value Options, oversees Substance Use Treatment Block Grant services. As the current Administrative Services Organization (ASO) for Kansas, Beacon Health Options manages: 1) Statewide substance abuse services for individuals identified with a Substance Use Disorder who meet SABG treatment fund eligibility, 2) Problem Gambling treatment (funded through the Problem Gambling and other Addictions Grant Fund), 3) Treatment for Third and Subsequent DUI Clients (Funding by KDOC), 4) the Help Line for SUD and Problem Gambling (PG) Treatment services and 5) State Opioid Response (SOR II) grant treatment and recovery support funds.

Utilizing a combination of funding sources (SAT Block Grant, State general funds, and State fee funds), 13,418 people (unduplicated) received treatment services under the substance use disorder block grant in state fiscal year (SFY) 2020. For SFY 2021 (7/1/20 – 6/30/21), 9,145 people received treatment services. The reduction in people served can be contributed to COVID-19 impacts. Examples include court closures resulting in reduced number of referrals, facility closures for cleaning due to staff or patient illness, residential centers reducing people to one per room versus two to accommodate social distancing, and workforce shortages. The primary reason people access Block Grant treatment services in Kansas (both inpatient and outpatient treatment levels of care) is for amphetamine dependency.

Beacon contracts with licensed substance use disorder providers to provide treatment services. There are 44 Block Grant providers in 106 locations throughout Kansas. One of these providers is a Federally Recognized tribe. Services paid under the Block Grant include both inpatient and outpatient services: ASAM Level 0.5 Early Intervention, ASAM Level 1: Outpatient, ASAM Level 2 Intensive Outpatient Services or Partial Hospitalization and ASAM Level 3: Residential or Inpatient services. There are approximately twenty Kansas Block Grant providers contracted and credentialed to provide Peer Support services.

There are five Designated Women's Facilities (DWFs) in Kansas in nine locations across the state. DWFs undergo the same rigorous licensing requirements as described above. Designated Women's Facilities

receiving Block Grant funds give priority admission to pregnant women, women with dependent children and women using IV drugs. DWFs provide a full continuum of services as follows:

- 1) Treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate,
- 2) Provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care,
- 3) Provide or arrange for child care while the women are receiving services,
- 4) Provide or arrange for primary pediatric care for the women's children, including immunizations,
- 5) Provide or arrange for gender-specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting,
- 6) Provide or arrange for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect,
- 7) Provide or arrange for sufficient case management and transportation services to assure that the women and their children have access to the services provided by (2-6) above.

DWFs also provide pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of services to include: case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments, employment and training programs, education and special education programs, drug-free housing for women and their children, prenatal care and other health care services, therapeutic day care for children, Head Start and other early childhood programs.

The Kansas Department for Aging and Disability Services (KDADS) also licenses methadone clinics in Kansas. There are a set of standards specific to methadone clinics which includes onsite reviews of policies, procedures, and client records.

The ASO and the Medicaid plans contract with Substance Use Disorder providers to provide a full continuum of services for those who inject drugs. The ASO maintains and manages the State's substance use disorder hotline and waitlist for residential treatment. The ASO ensures those who inject drugs and other priority populations are given priority in accessing care.

Kansas methadone clinics are located primarily in urban areas. Half of the clinics (5) accept some form of insurance or are in the process of contracting to accept insurance. Medicaid plans are highly encouraged to contract with Methadone clinics. There is one methadone clinic in the ASO network under the Block Grant program.

Kansas has received State Targeted Response (STR) or State Opioid Response (SOR) grants since 2017 to assist in addressing the opioid crisis. In 2016, five million (5,002,532) Schedule II-IV prescriptions (controlled substances) were dispensed according to data from K-TRACS (Kansas Tracking and Reporting of Controlled Substances), the Kansas prescription drug monitoring program. In comparison, there were a little more than 4 million (4,150,070) Schedule II-IV prescriptions (pills and capsules) dispensed in 2020. Illicit opioid use and related deaths continue to be a concern with 320 deaths from opioids reported in 2020 (159 deaths were reported in 2016). Kansas is using the SOR funding to invest in expanding access to treatment, particularly evidence-based treatment, and to reduce the number of

opioid and stimulant related deaths across the state. KDADS' Behavioral Health Commission oversees and monitors grant activities. Prevention activities funded through the grant include the use of most forms of broadcast media throughout the state – television, radio, digital signage, and social media formats, as well as, activities by local community prevention groups. KDADS is also using SOR award funding to provide medication-assisted treatment (MAT) services to uninsured patients in Kansas. Currently, there are around 40 grantees across the state providing treatment services for Kansans in all 105 state counties, including rural and frontier areas, as well as, urban areas. Treatment service providers are diverse and range from a university medical center to substance use disorder treatment providers, methadone clinics, regional alcohol and drug assessment centers, and community mental health centers. Recovery services are also funded through the grant including for people transitioning from correctional and other rehabilitative programs back into the community with access to sober living group homes, MAT, peer support, employment helps, and other services that can move them towards a successful recovery.

Kansas is fortunate to have a strong network of Oxford Houses throughout the state. 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 Houses in Kansas include men only, women only, men with children, and women with children. According to the Friends of Recovery site (https://www.friendsofrecovery.com/oxford_houses), "Unlike traditional halfway houses, there are no staff. An Oxford House is a self-run and self-supported recovery house. The concept is the same that underlies 12-step programs. Addicted individuals 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."

Further, "having houses in good neighborhoods with a safe environment for recovery to flourish may be the single most important reason for the Oxford House success. Using this cost-effective way to improve the chances of recovery from addiction may be the best way to show the community that recovery works and that recovering addicts can become model citizens. Oxford Houses have an 80% success rate, nationally." The State of Kansas has supported the efforts of FORA for many years. In 2001, there were 19 Oxford Houses in Kansas. The number has grown over the years to 141 Houses that are providing 1189 beds for members. For a comprehensive list of Kansas Oxford Houses, please see: <http://www.friendsofrecovery.com/wp-content/uploads/2019/07/2019-Phone-List-1.pdf>.

In Kansas, there is a Kansas Tuberculosis Control Program within the Kansas Department of Health and Environment. State laws and regulations require that cases of tuberculosis be reported to the local or state health department. The Kansas Tuberculosis Control Program provides, free-of-charge, anti-tuberculosis medications to local health departments for the treatment of TB disease. Additionally, preventive medications for individuals with TB infection are provided at no cost to local health departments or other medical providers. In order to receive medications for a patient afflicted with TB infection, the health care provider or local health department must provide the state program information about the diagnostic screening of the patient (skin test and chest x-ray results). For

individuals with active TB disease, the local health department must provide information about the diagnostic screening of the patient along with information about the patient's treatment, potential contacts to the patient, and other detailed information as requested on an ongoing basis.

For substance use disorder Block Grant treatment services, KDADS maintains a policy on our website specifically related to Tuberculosis to ensure compliance with the federal regulation to facilitate the provision of TB services and to create the necessary linkages between substance use disorder providers and local health care providers. Contractual agreements with the ASO and in the ASO's provider agreement with providers also include language about TB referrals. Contract language with the plans and in provider agreements include compliance related activities.

Many substance use disorder providers are dually licensed as Community Mental Health Centers (CMHCs) enabling them to coordinate both mental health and substance use disorder care for those with co-occurring diagnoses. These dually licensed CMHCs are eligible to take advantage of the recent Kansas Legislative support to encourage development of Certified Community Behavioral Health Clinics (CCBHC) in Kansas. The Kansas Legislature set aside funding to develop the certification process and technical assistance to help CMHCs become CCBHCs creating integrated care (physical, mental and behavioral health) for their consumers.

Many SUD providers are partnering with Federally Qualified Health Centers (FQHCs) and other primary medical providers to offer SBIRT (Screening, Brief Intervention and Referral to Treatment) services, integrated treatment, and facilitated access to ongoing medical care. Substance abuse treatment (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 upon clinical need/medical necessity through the contracted plans.

The Kansas SAT provider network possesses many strengths. The SAT Block Grant providers serving Kansans are very experienced in their field with long histories of serving those with behavioral health issues. Increasingly, providers offer services utilizing evidence-based models of care. A number of Kansas SAT Block Grant providers also offer counseling that specifically address trauma experienced by consumers. Strong ASO oversight of Block Grant funded SAT providers and extensive data collection processes help to ensure that providers offer effective services that meet the needs of the person seeking services.

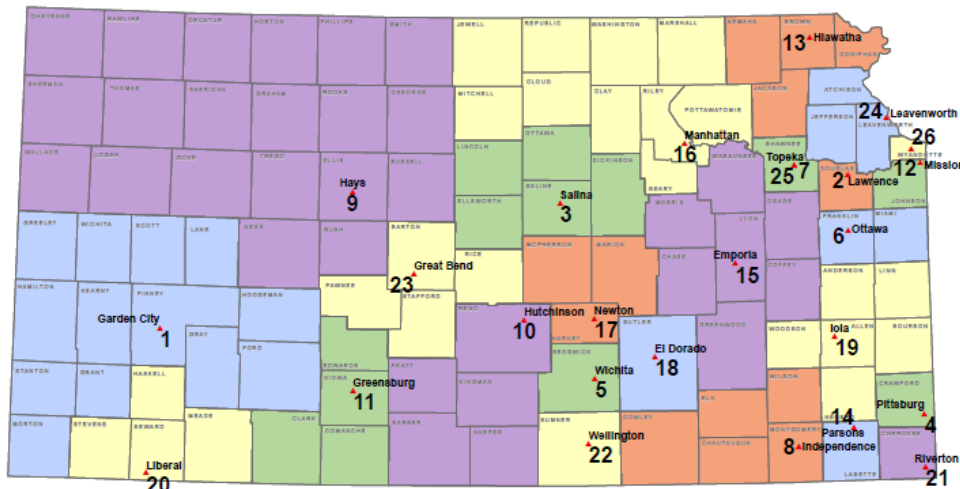
Mental Health Services

42 U.S.C. § 300x-1 - U.S. Code - Unannotated Title 42. The Public Health and Welfare § 300x-1. State plan for comprehensive community mental health services for certain individuals

Criterion 1: Comprehensive community-based mental health systems - The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities

Community Mental Health Centers (CMHCs) are charged by statute with providing the community-based public mental health services safety net in Kansas. Under Kansas Statutes Annotated (KSA) 19-4001 et. Seq., and KSA 65-211 et. Seq., twenty-six licensed Community Mental Health Centers (CMHCs) currently operate in the state. One of the 26 CMHCs specializes in children’s services – Family Service and Guidance Center. The following map shows the catchment areas for all 26 CMHCs.

Community Mental Health Centers of Kansas



Source: Association of Community Mental Health Centers of Kansas, Inc. (www.acmhck.org)

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 CMHCs operate under extensive state licensing regulations; are subject to licensure site reviews; and provide extensive data routinely to the Kansas Department for Aging and Disability Services (KDADS). The CMHCs also conform to Medicaid and Medicare standards and audits. As of July 1, 2021, licensed CMHCs are eligible to take advantage of the recent Kansas Legislative support to encourage development of Certified Community Behavioral Health Clinics (CCBHC) in Kansas. The Kansas Legislature set aside funding to develop the certification process and technical assistance to help CMHCs become CCBHCs creating integrated care (physical, mental and behavioral health) for their consumers.

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals with mental health problems in the least restrictive environment. The Centers provide services to all those needing it, regardless of economic level, age or type of illness. The Centers strongly endorse treatment at the community level to allow individuals to continue functioning in their own homes and communities, at a considerably reduced cost to them, third-party payers, and/or the taxpayer.

CMHCs provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. For Medicaid, the CMHCs contract with the three KanCare managed care health plans. For the Mental Health Block Grant services, the CMHCs contract with the State. The 2020 Kansas Medicaid Mental Health Consumer Perception Survey results show strengths of the CMHC system:

- adults (93%) and youth (90%) have general satisfaction with CMHC services
- youth (96%) participation in treatment planning

- adult (93%) service quality and appropriateness
- youth (97%) cultural sensitivity

CMHCs provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. Per the State Automated Information Management System (AIMS), CMHCs served over 144,000 consumers during the past two fiscal years as the table below indicated.

State Fiscal Years	Adults (over 18)	Children/Youth (under 18)	Total Consumers Served
2020	102,527	42,434	144,961
2021	103,538	41,020	144,558

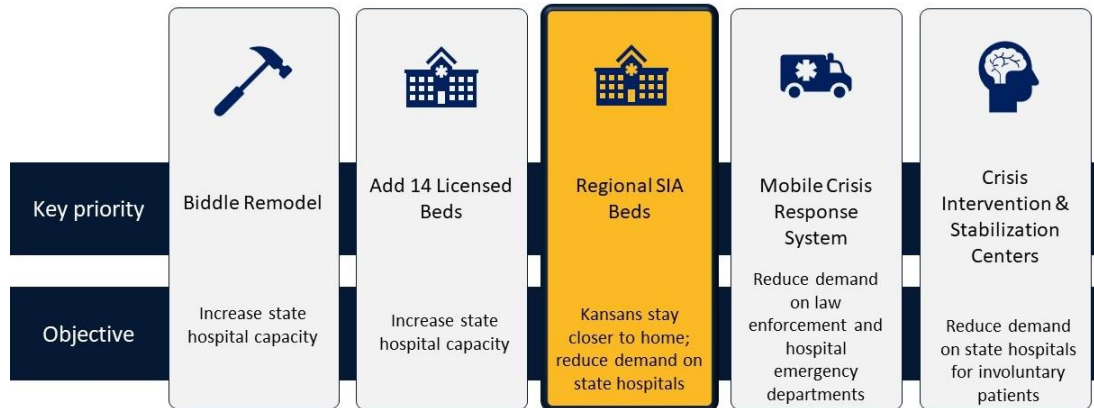
Services provided by CMHCs are evidenced based practice as the capacity of CMHC allow and include: evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education, consultation, treatment and rehabilitation services, and 24-hour emergency services. Community-based mental health services also include assistance in securing employment services, housing services, medical and dental care, peer support and other supports. There are dually licensed CMHCs and SUD providers in Kansas who also offer substance use disorder treatment in their catchment areas.

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.

Kansas law designates CMHCs as the gatekeepers for admission to state mental health hospitals. Under contract, CMHCs also carry out similar functions for nursing facilities for mental health, psychiatric residential treatment facilities and Medicaid-funded community hospital psychiatric services.

Crisis Centers

Stabilization services in Kansas are called Crisis Stabilization Units (CSU). With the support of Kansas legislation, 6 CSUs are fully operational and located in Hays, Kansas City, Salina, Manhattan, Topeka, and Wichita. The development and expansion of CSUs is ongoing with two programs under development in Lawrence and Leavenworth. All CSUs are under the management of the Community Mental Health Centers (CMHC) throughout the state and serve the catchment areas of the CMHCs. The graphic below shows the connection between CSUs, Mobile Crisis Response, State Institutional Alternative (SIA) beds, and state hospital capacity expansion.



The size of the CSUs and services vary but the scope of work and outcomes reporting is uniform throughout the CSUs as established by the grant agreements with the CMHCs. The goal of CSU programs is to stabilize individuals, improve psychological symptoms of distress, and engage the individual earlier in the mental health or substance use crisis. Service delivery at CSUs is evidenced based practices of Recovery Oriented Systems of Care, Strengths Based Case Management principles, and Trauma Informed Care. Each of the CSUs have rapid drop-off and walk in availability, provide immediate triage, timely assessment, short term stabilization recliners or beds, (up to 23 hours). Participants are provided with therapeutic services meeting physical and mental health needs, medication assessment, discharge planning and referral. When needed participants may be provided with longer-term stabilization stays. Longer term placement is usually 3 to 5 days, but some stabilization centers may provide up to 14 days of stabilization services. The CSU programs also provide sobering Beds with peer supports for up to 23 hours and some provide availability of Social Detox or referral to Social detox placement.

Short Term Respite Care is available through the Serious Emotional Disturbance (SED) Waiver and provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. Short Term Respite Care can be provided in the participant’s home or place of residence or provided in other community settings including Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds.

OneCare Kansas

The Health Homes program for Kansas is called “OneCare Kansas”. OneCare Kansas provide coordination of physical and behavioral health care with long-term services and supports for people in KanCare with chronic conditions. OneCare Kansas expands upon medical home models to include links to community and social supports. OneCare Kansas focuses on the whole person and all his or her needs to manage his or her conditions and be as healthy as possible. All the caregivers involved in a OneCare Kansas member’s health communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. OneCare Kansas is intended for people with certain chronic conditions and can be members who also receive Medicare along with Medicaid. OneCare is an opt-in program. The target population recently significantly expanded to include additional ICD-10 codes. Specifically, there are now more asthma, bipolar, and schizophrenia ICD-10 codes, and major depressive was added as a Severe Mental Illness qualifying diagnosis. This population expansion went into effect on 4/1/2021.

Member materials including a member brochure in both English and Spanish can be found on the KanCare website in the OneCare section: <https://www.kancare.ks.gov/consumers/onecare-ks-members/materials-for-members>

Consumer Run Organizations (CROs)

Kansas has built an infrastructure of Consumer Run Organizations (CROs) to promote recovery through peer support recovery supports to those who currently or in the past have accessed mental health services, especially those with severe and persistent mental illness. Nine CRO's were awarded funding from KDADS for FY2022. 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. Typically, a CRO provides an array of services to its members that include leadership, education, training and research opportunities, one-on-one peer support, peer support groups, 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 seek to provide a safe, healing and trauma-free environment which enhances wellness and promotes resiliency. Peer support is distinct from other social supports in that the persons providing support can draw from their own recovery journey to inspire hope in others who are facing similar situations. There are currently nine CROs that receive funding by KDADS across the state of Kansas.

The Community Support Medication Program (CSMP) is a payment source of last resort for uninsured/underinsured Kansans in need of mental health medication. Medications could include mood stabilizers, sleep aids/anxiety meds, benzos, and ADHD medication and are distributed on a first-come, first-serve 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) At-risk need 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 and epidemiology - The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

According to the Behavioral Health Barometer for Kansas, Volume 6 ([Link](#)) based on 2017 - 2019 Federal Survey data, Kansas's annual average prevalence of past-year SMI among adults aged 18 or older (6.1%) was similar to the corresponding regional average (5.6%) but higher than the national annual average percentage (4.8%). In Kansas, an annual average of 130,000 adults aged 18 or older in 2017-2019 had SMI in the past year. The annual average percentage in 2017-2019 increased from the annual percentage in 2008-2010.

Also, according to the BH Barometer Volume 6, during 2017 – 2019, the annual average prevalence of past-year SMI in Kansas of young adults (aged 18 - 25) was 10.5% (or 34,000) similar to the regional average (9.0%) but higher than the national average (7.9%).

Criterion 3: Children's services - In the case of children with serious emotional disturbance, the plan--

(A) subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act [[20 U.S.C.A. § 1400 et seq.](#)]);

(B) provides that the grant under [section 300x](#) of this title for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and

(C) provides for the establishment of a defined geographic area for the provision of the services of such system.

As described above in Criterion 1: Comprehensive community-based mental health systems, Community Mental Health Centers (CMHCs) are charged by statute with providing the community-based public mental health services safety net in Kansas. Under Kansas Statutes Annotated (KSA) 19-4001 et. Seq., and KSA 65-211 et. Seq., twenty-six licensed Community Mental Health Centers (CMHCs) currently operate in the state. One of the 26 CMHCs specializes in children's services – Family Service and Guidance Center.

Another mechanism for ensuring that Kansas children receive integrated services for their multiple needs is with 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). To be eligible for a waiver, one must be determined: 1) Eligible for the specific waiver program 2) Functionally eligible via a functional assessment and 3) Financially eligible. The single "point of entry" that completes each functional assessment varies depends on which waiver is being applied for.

Serious Emotional Disturbance (SED) Waiver

The local community mental health center (CMHC) is the single point of entry for the SED Waiver. Services provided under the SED Waiver are for children 4 to 18 years of age who experience serious emotional disturbance 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.

Parents and children are actively involved in planning for all services. Local Community Mental Health Centers provide services covered by the program. Children who meet eligibility requirements will receive a medical card and are eligible for Medicaid physical and behavioral health services.

SED Waiver Services include:

- Wraparound Facilitator: A person who works with the family and their identified supports to set treatment goals and decide on services for the child and family.
- Parent Support and Training: Services designed to provide education, assistance, and other support to parents and families.

- Independent Living Skills Building: Staff supported development of the skills needed in order to live independently.
- Attendant Care: A staff person who helps the child with daily tasks.
- Professional Resource Family Care (Crisis Stabilization): Intensive support services provided to the child outside the home in a safe environment.
- Short Term Respite Care: provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. Short Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings including Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds.

Autism Waiver

The Autism Waiver provides support and training to parents of children with an Autism Spectrum Disorder (ASD) diagnosis to help ensure children with ASD can remain in their family home. Autism Waiver Services include:

- Family Adjustment Counseling: Family Adjustment Counseling offers guidance and assistance for family members of a child with Autism Spectrum Disorder (ASD). These services are provided by a Licensed Mental Health Provider (LMHP) and help the family in coping with the child's diagnosis and daily needs, by offering a safe and supportive environment to express emotions and ask questions.
- Parent Support and Training (Peer to Peer): Parent Support and Training assists family members to acquire the knowledge and skills needed to understand and address the specific needs of and treatment for the child in relation to ASD and develop the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom and behavior management.
- Respite Care: Respite Care offers temporary direct care and supervision of the child to provide relief to families and caregivers of a child with ASD. A respite care provider assists with normal activities of daily life in order to meet the needs of the primary caregiver as well as the child.

The following three services were previously part of the Autism Waiver and are now part of state plan services that a child can access with a medical card. The child does not need to be on a waiver to begin or to continue to receive these services:

- Consultative Clinical and Therapeutic Services (provided by an autism specialist): Consultative Clinical and Therapeutic Services focus on improving of behavioral challenges related to the diagnosis of autism spectrum disorder (ASD). They teach skills to help the family and paid support staff or other professionals with meeting the needs of the child with ASD. The autism specialist assesses the child and family's strengths and needs, develops the Individual Behavior Plan/Plan of Care (IBP/POC), coordinates services, provides training and technical assistance, and monitors the child's progress within the program.

- Intensive Individual Supports: Intensive Individual Supports services are provided to a child with autism spectrum disorder (ADS) to assist in acquiring, retaining, improving, and generalizing skills needed to successfully function in their home and community. This may include development of skills such as social skills, language and communication, motor skills, engagement, cognitive skills, and behavior skills.
- Interpersonal Communication Therapy (ICT): Interpersonal Communication Therapy (ICT) works to improve social communication symptoms related to the diagnosis of an autism spectrum disorder (ASD). ICT includes the development of skills such as conversation, unplanned communication, understanding of verbal and nonverbal communication.

To be eligible for the Autism Waiver, an individual must meet the following criteria: 1) Be 0-5 years old (at time of application; they can apply until their sixth birthday) 2) Be diagnosed with an Autism Spectrum Disorder, Asperger’s Syndrome or a Pervasive Developmental Disorder – Not Otherwise Specified and 3) Be financially eligible for Medicaid. Autism Waiver services are typically limited to three years. An additional year of service is available in some cases based upon a review process. Requirements for this one-year extension of services beyond the three-year initial limit include the following: 1) The child must meet eligibility based on a Level of Care assessment at the annual review of the third year of services, and 2) Data collected by the KanCare managed care organization must demonstrate a need for continued Autism Waiver services.

Kansas Department for Children and Families (DCF) Mobile Crisis Response Service for Kansas Families

In February 2021, the Kansas Department for Children and Families (DCF) awarded a contract for statewide mobile family crisis response and support services. This mobile crisis response service allows DCF to better serve families and caregivers who have children experiencing emotional crisis or other behavioral health symptoms including substance use disorder.

Mobile crisis response service ensures Kansas children and young adults between 0-20, have access to a comprehensive crisis system that anticipates needs and provides recovery-focused interventions in all phases of the crisis continuum. The centralized behavioral health crisis services include on-the-phone or in-person rapid community-based mobile crisis intervention services; hotline with 24 hour a day, seven day a week assessment and screening, and up to eight weeks of stabilization services and connection to community-based referrals and services.

Per Secretary Howard, “This crisis response model gives DCF the capability to provide any child or youth in Kansas who are experiencing a behavioral or psychiatric emergency with rapid community-based mobile crisis intervention services regardless of health care insurance or status.”

Young adults between the ages of 18 to 21 who were formerly in the foster care system also are eligible for the services.

Youth Leaders in Kansas (YLINK)

YLINK stands for Youth Leaders in Kansas. Currently, there are fourteen local community-based groups working on a wide range of mental health topics and community service projects. Each local group determines their own unique area of focus while developing leadership skills and supporting their

communities. Examples include suicide prevention, avoidance of substance usage by youth, stigma reduction, anti-bullying efforts, and LGBTQ+ issues. KDADS is currently exploring ways to expand the YLINK concept to other Kansas communities. A Youth Advisory Council is in development, comprised of Kansas youth from the YLINK groups, who will serve as youth advisors to the Governors Behavioral Health Services Planning Council (GBHSPC). The plan is for the Youth Advisory Council to become a sub-committee to the GBHSPC.

Disaster Relief Grant

Disaster Relief Grant

The Disaster Relief project is new this year and is focused on providing trauma-informed training to parents and teachers as a result of the public health disaster. The Disaster Relief Grant was awarded to KDADS in September 2020. Through this grant, KDADS has provided many trainings that support children's mental health and the identification of disorders that need further services. KDADS has made these trainings sustainable by training the trainers to provide these trainings after the grant ends. We have 10 new Youth Mental Health First Aid trainers, 8 Teen Mental Health First Aid trainers, 14 Question, Persuade and Refer (QPR) trainers. These trainings are being offered free of charge through the grant to the communities, schools and professional organizations that work with children. KDADS has provided Attachment Based Family Therapy to many therapists throughout the state and will have this training offered and implemented in future classes offered through Emporia State University to counseling students. KDADS has trained 3 faculty at Emporia State University (ESU) in Youth Mental Health First Aid. ESU has agreed to implement a required training program that will be offered to all graduating teachers and counselors, allowing individuals entering the workforce to come into it trained in mental health first aid. KDADS has also created trainings that are offered to teachers, faculty, parents and children on different aspects of mental health. These trainings are created, so that sustainability is possible. Mental Health America and the Mental Health Association of Southeast Kansas provide these trainings and will continue to do so after the grant ends.

System of Care

Kansas was awarded a System of Care grant 2016-2020. A no cost extension was applied for and received for the period of September 2020 – March 2021. KDADS has applied for a second grant award for the period of September 2021 – September 2025. This application is for further expansion state-wide of the system of care principles and will focus on providing wrap-around care and support crisis services.

Criterion 4: Targeted services to rural and homeless populations - The plan describes the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

KDADS currently offers several programs to assist individuals who are homeless or at risk of homelessness and experiencing a serious mental illness (SMI). The Kansas Department for Aging and Disability Services (KDADS) is the Single State Authority for Behavioral Health Services in the State of Kansas. KDADS has recently merged our Housing, Employment and Benefits programming division within our Commission. KDADS has embraced the Housing First Model throughout our Behavioral Health Provider networks within the state.

Our Housing, Employment and Benefits division help provide technical assistance and training on the following Evidenced Based or Promising Practices: Social Security Outreach Access and Recovery (SOAR) and Housing First. The State hopes to kick off IPS Supported Employment again in late 2021 or early 2022. Our Commission contracts with local Community Mental Health Centers (CMHCs) and Substance Use Disorder provider agencies across the state. Each of the CMHC's contracts now require each center to have a certified SOAR staff to assist people with re-connecting and connecting homeless or at risk of homelessness consumers back to their federal SSA and Title 19 Medicaid benefits, if eligible. COMCARE, our largest Community Mental Health Center in the State, has a SOAR representative that participated in a National SOAR training event for Children/SOAR. This representative continues to work with the Behavioral Health Authority to create a statewide system to assist children and transitioned aged youth with benefit application and employment through Vocational Rehabilitation Services, IPS Supported Employment, or Federal Programs under the CHAFFEE Act. Our State Psychiatric Hospitals are following Center for Medicaid Services (CMS) recommendations for discharge planning and our Psychiatric State Hospital's discharge teams are also working daily to connect discharging consumers back to SSA and Medicaid. The State Behavioral Health Authority (KDADS) and State Medicaid Entity Kansas Department of Health and Environment (KDHE) are working together through a policy to ensure that eligible Medicaid consumers can have access to their Medicaid benefit and Managed Care Organizations on the day of discharge from the hospitals and/or institutions.

In 2016 KDADS the Behavioral Health Authority embraced the Housing First Model and have been receiving training and fidelity consultation from the team from Pathways to Housing and Sam Tsemberis. KDADS continues to explore our efforts in expanding the Housing First Model across the state. In July of 2019, KDADS and the State Medicaid Authority Kansas Department of Health and Environment (KDHE) opened a per diem Medicaid billing code for reimbursement. This code is specific to Housing Supportive Services using the Housing First Model. This billing code is identified in our State as Operation Community Integration, and the target population for this code are: consumers exiting institutions, consumers who can be diverted from inpatient psychiatric placement, consumers exiting residential treatment facilities, SED/transitioned aged youth who may or may not be exiting foster care or juvenile corrections custody and Medicaid high utilizers. Several of our provider agencies that provide behavioral health supportive services for the Youth/Transitioned Aged will be invited to participate in a Housing First training with Sam Tsemberis in late 2021 and we will be inviting the local Continuum of Care (COC) programs from those regions to also participate in that training. We hope that our Housing First training will be funded through a technical assistance award from SAMHSA under the PATH grant. We currently have six Community Mental Health Center locations in the State where the SOAR staff work directly with the IPS Supported Employment specialist so disabled consumers who wish to return to employment can be referred directly to an IPS Supported Employment and Vocational Rehabilitation services, to assist them with access to employment and benefits planning through a Certified Work Incentive Specialist (C-WICK). Our Behavioral Health Authority KDADS works directly with a transition team from the Home and Community Based Services (HCBS) Waivers Commission to coordinate services within HUD's Continuum's of Care. KDADS Behavioral Health Commission has recently hired a new Veterans Program Manager who will be working with the VA and the HUD VASH programs in our State. The U.S. Department of Housing and Urban Development-VA Supportive Housing

(HUD-VASH) Program is a collaborative program between HUD and VA that combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.

KDADS Behavioral Health Children's Division is working closely with the Department for Children and Family Services (DCF) and our Partners at Kansas Statewide Homeless Coalition. DCF and the Kansas Balance of State (KS BoS) team have recently entered a Memorandum of Understanding (MOU) to ensure consumers discharging from foster care within the Balance of State Catchment areas, are given the Vi-SPDAT and connected to their local COC's to assist with Housing Services. The VI-SPDAT stands for Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool. It helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention to who is eligible and in greatest need of that intervention.

In 2020 when the COVID pandemic hit our State, KDADS in partnership with the Kansas Statewide Homeless Coalition (KSHC) and KSBoS, decided we would have to pivot and pivot quickly to be able to accommodate all the demands that were hitting our systems for people in need of housing and supportive services. KSBoS created a private referral form that would lead to a remote phone VISPDAT assessment to ensure that individuals who are homeless/or at risk of homelessness had immediate access to the VISPDAT assessment tool. Individuals and families who were found to be eligible were referred to an appropriate coordinated entry list for housing supports. KDADS, in partnership with the KSHC set up a phone-in referral process to ensure that homeless/or at risk of homelessness consumers who were disabled had immediate access to the HUD required screenings. If the consumers were eligible, they were referred to their local COC's for follow-up recommendations based on the outcome of the HUD screen.

In late 2020, KDADS partnered with a local Domestic Violence Shelter in the Leavenworth, Kansas area and the Community Mental Health Center to ensure that persons and families escaping domestic violence and/or sex trafficking victims were connected to mental health and housing services in an expedited manner. The local domestic violence shelter in the Leavenworth, Kansas area sends the referral to KDADS. KDADS refers to the Community Mental Health Center who refers the cases over to the Kansas Statewide Homeless Coalition who does the HUD screening. This program began in late November and in less than three months we have been able to connect nine women and children to community-based services and, if needed, have them screened for Housing Support Services through the local COC. All this work is done shortly after the consumer admits to the shelter and before they are ready for discharge from the residential domestic violence shelters to prevent homeless discharges. KDADS currently has a variety of state/federally funded programs that have been designed to help consumers with a behavioral health diagnosis sustain and/or obtain housing and to avoid un-necessary psychiatric or correctional institutional placements. KDADS targeted Supportive Services Housing programs are briefly described below. These programs are targeted for consumers that are homeless or at risk of homelessness and have a behavioral health diagnosis including mental health and substance abuse disorders.

Projects for Assistance in Transitioning from Homelessness (PATH)

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 SMI secure safe and stable housing, improve their health, and live a self-directed, purposeful life. Kansas currently has a total of five PATH providers. Two of the providers are located within HUD's Balance of State region. The other three provider agencies are in Metropolitan/Urban regional areas where the State has a higher number of behavioral health homeless/at risk of homelessness consumers.

Supported Housing Fund (SHF) Program

The Kansas Department for Aging and Disability Services Behavioral Health Services Commission funds the Supported Housing Fund Program (SHF) with state general funds. The SHF is a one-time or emergent need benefit able to provide "tenant-based housing first" assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is accomplished by providing temporary flexible funds for their housing needs. In FY2019, funds from the Supported Housing Fund program assisted approximately 95 individuals per month in obtaining or maintaining housing.

Interim Housing Program

The Interim Housing Program is a Bridge Housing program that has been designed, to assist consumers with building the skills necessary to obtain/sustain long-term permanent housing using the Housing First Support Services Model.

The Behavioral Health Services Commission funds the Interim Housing Program. As a response to policy to prevent discharging individuals into homelessness, Kansas' mental health system saw a need to create more "interim" housing options for individuals leaving Nursing Facilities for Mental Health or State Psychiatric Hospitals who are without permanent housing arrangements. In FY 2019, BHS funded six Interim Housing (IH) projects across the state. Interim Housing is defined as short-term housing that is used until a more permanent housing arrangement can be made.

Unlike the Supported Housing Fund Grant, which provides tenant-based assistance, these funds provide "project-based rental assistance." Project-based housing provides immediate assistance, without the need for the individual to undergo a housing search, traditional tenant screening process, and acquisition of the furniture and items necessary to establish a household while still in-patient in a hospital setting. Upon entering the IH project, the CMHCs Housing and Homeless Specialists and other case managers immediately begin providing the assistance necessary for the resident to obtain more permanent housing.

Collectively, the FY2019 IH grantees prevented homelessness for 85 individuals. Of those individuals who exited the program, 80% moved into a community-based living situation by the end of the grant term. Approximately 50% of the individuals assisted in the Interim Housing Units were chronically homeless.

Operation Community Integration

This Program is a Medicaid Supportive Housing Services Per Diem Code that has been designed to connect Behavioral Health Medicaid eligible consumers to Housing Supportive Services that will help them with symptom management along their recovery journey and as they work with HUD systems to obtain and sustain housing. This program utilizes the Housing First Supportive Services Model.

Community Support Medication Program

This program was designed to provide funds and/or a short-term payor sources to ensure that consumers who do not have insurance or the ability to pay/afford their medications have access to medically necessary mental health medication for un-insured and under-insured consumers.

SOAR Medicaid

Programs that work with the State Hospitals and the Social Security Administration to ensure that homeless consumers that are at risk of losing housing are working with the Social Security Administration to sustain SSA benefits if they are residing in the state hospitals for less than 90 days. Our state Medicaid Authority, KDHE is working with the county jails, state hospitals and state correctional facilities to ensure that eligible Medicaid consumers exiting institutions have immediate enrollment to Medicaid to ensure access to medications and MCO supportive services necessary to obtain and sustain housing and full community integration.

Kansas Statewide Homeless Coalition (Coordinated Entry HUD Access Points)

In partnership with Kansas Statewide Homeless Coalition (KSHC) on behalf of the Kansas Balance of State Continuum of Care (KSBoS) in 2020 we have begun 2 Pilot Projects in the HUD's 101 counties making up the Balance of State Region to ensure that homeless or at risk of homeless consumers are connected to HUD's VISPDAT assessment tool. The KDADS team and the Kansas Statwide Homeless Coalition work in partnership to ensure that consumers are connected to their Community Mental Health Centers, or local Substance Abuse Provider networks for Behavioral Health Supports. The CMHC pilot sites are now working directly with the KSBoS and KSHC to better coordinate supportive service care for homeless or at risk of homeless consumers. In 2021 KDADS and KSBoS will also be working a mainstream benefits training committee that will be looking at developing a statewide process for SOAR certification and training for the State's COC's and the Behavioral Health Provider networks who want to provide the Promising Practice of SOAR.

The Emergency COVID-19 grant award

The COVID 19 emergency grant was awarded by SAMHSA in Federal Fiscal Year 2020. This grant provides direct mental and behavioral health services to individuals impacted by the COVID-19 pandemic. This fund has been designed to assist in providing long-term stability for persons in the State of Kansas. The Grant allocated funds can be used to help fund Oxford Housing for individuals recovering from Substance Use Disorders. These funds are available to the CMHCs targeted by the Grant for disbursement to individuals impacted by COVID-19. Also, important to note about this grant is that the

term impacted does not mean contracted. The grant allows for self-reporting from consumers as to their impact. CMHCs will ask if the need for treatment has been impacted by COVID. If the response is “yes”, then the person qualifies.

The SAMHSA State Opioid Response II (SOR) grant

This award includes funds to support community recovery housing for clients transitioning from Kansas correctional facilities or other rehabilitation programs. These clients shall participate in outpatient treatment services for opioid or stimulant use disorders under the supervision of a licensed Kansas provider. The program goal is to assist each client in remaining abstinent and capable of securing stable employment, as well as, community accountability.

Criterion 5: Management Systems - The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 300x of this title for the fiscal year involved.

Except as provided for in paragraph (3), the State plan shall contain the information required under this subsection with respect to both adults with serious mental illness and children with serious emotional disturbance.

Kansas Train Learning Management System

Kansas, including KDADS, uses the TRAIN national learning network that provides thousands of quality training opportunities to more than one million professionals who protect and improve the public's health. Powered by the Public Health Foundation (PHF), the TRAIN Learning Network brings together agencies and organizations in the public health, healthcare, and preparedness sectors to disseminate, track, and share trainings for the health workforce on a centralized training platform.

Mental Health First Aid

To ensure that emergency health staff and first responders are able to train others in their arenas of work, KDADS staff attended Youth Mental Health First Aid training of facilitators. KDADS staff then facilitated several trainings. 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.

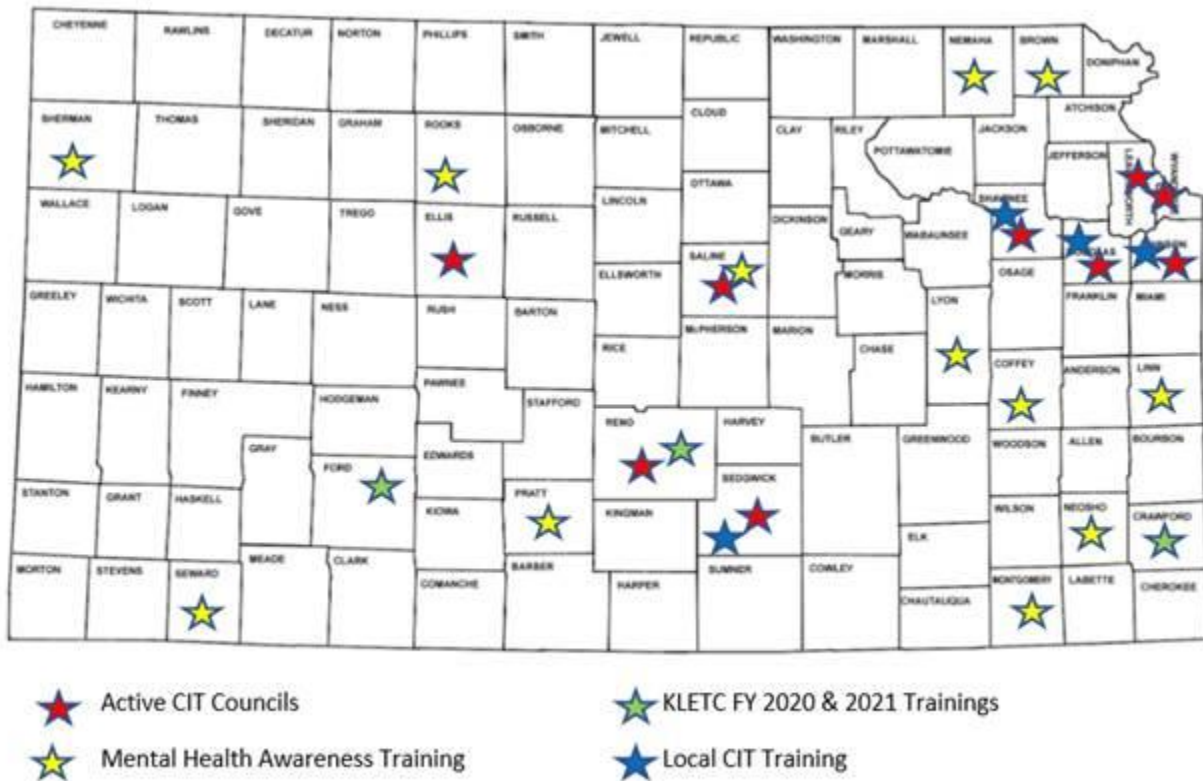
Crisis Intervention Training (CIT)/Veterans Services

KDADS has a comprehensive and proactive approach to train law enforcement, first responders and other professionals around the state in the areas of mental health and crisis intervention includes three projects: 1) Crisis Intervention Teams, 2) Mental Health Awareness Training, and 3) the Stepping Up initiative.

Crisis Intervention Teams - The Behavioral Health Services Commission and the Governor's Behavioral Health Services Planning Council have provided grant funding to CIT and veteran's programs. This funding created a new staff position and the ability to train hundreds of law enforcement professionals in the state of Kansas on Crisis Intervention and Veteran Programs Training. KDADS has partnered with the Kansas Law Enforcement Training Center (KLETC) located in Hutchison, KS. KLETC provides the

curriculum and classroom presenters, student room and board, snacks and finally a 40-hour certificate and CIT pin for their uniform. In FY19, we have trained over 180 personnel stretching over 19 counties with a focus on the rural and frontier areas with little resources. KLETC trained 63 officers in FY20 prior to restrictions and challenges presented by the COVID-19 pandemic.

Many smaller jurisdictions across the state do not have the personnel or resources to commit to the full 40-hour training by KLETC. To meet these community's needs, BHS also funds an 8-hour mental health awareness training. This training is provided at no cost and is available to police, corrections officers, fire departments, and dispatch staff.



The Stepping Up initiative - A national partnership between The Council of State Governments Justice Center, the National Association of Counties, and the America Psychiatric Association Foundation. The initiative aims to reduce the number of people in jail as a result of their mental illness. Kansas just launched (January 2021) the technical assistance project for the Stepping Up initiative to inspire counties to become Stepping Up communities. The goal of this project is to facilitate better solutions for linking people with mental illness to treatment and services while improving public safety.

Problem Gambling Services

The Kansas gambling industry is currently represented by four state-owned casinos, five tribal casinos, charitable gaming and the Kansas Lottery. In 2007 the Kansas Legislature enacted the Problem

Gambling and Addictions Grant Fund. Two percent of the monthly net revenue from the four state-owned casinos is deposited into this fund. Resources to fund problem gambling specific services are limited however as the funding allocated for these services have remained at less than ten percent of the total dollars deposited into this fund. The dollars that are allocated for problem gambling services are used statewide to provide treatment for problem gamblers and their concerned others, prevention resources, education and awareness, and research and evaluation. During the state fiscal year for 2020, approximately \$287,000 was spent to provide treatment services and helpline crisis services for those accessing services; \$194,000 was spent to provide prevention resources and education services at the community level, \$44,500 was spent to provide education, awareness and workforce development at a statewide level, and \$199,000 was spent in statewide administrative costs. Kansas currently has forty-two state certified gambling counselors, two gambling prevention specialists and one program administrator.

Diversity

Kansas MH and SA Block Grant Disparity Statement

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

	U.S. Census 2019 Estimates	Mental Health Estimates* FY2018	SUD Estimates** FY2018
Kansas Population	2,913,314	144,344	13,201
<i>By Race</i>			
White (non-Hispanic)	75.4%	76.74%	75.65%
African American	6.1%	8.18%	13.33%
American Indian/Alaska Native	1.2%	2.64%	2.77%
Asian	3.2%	.92%	.53%
Native Hawaiian/Other Pacific Islander	.10%	.22%	.43%
Other (other races, two or more races, unknown, etc.)***	3.1%	11.32%	7.29%
<i>Ethnicity</i>			
Hispanic or Latino	12.2%	6.78%	11.89%
<i>By Gender</i>			
Female	50.2%	52.72%	39.02%
Male	49.8%	46.61%	60.98%

* The Mental Health Block Grant Population and Services report for services during 7/1/2017 to 6/30/2018 used to estimate percentages of people served in Community Mental Health Services.

** The Substance Abuse Block Grant Population and Services report for services during 7/1/2017 to 6/30/2018 used to estimate percentages of people served in Substance Use Disorder Services.

***For the Block Grant Reports, this category includes other races not listed, two or more races, and unknown races.

Kansas varies from frontier areas to urban communities. Total population of Kansas estimated in 2019 at 2,913,314 by the Census Bureau Population Estimates Program with racial identities of 75% white, 6% African American, 1% American Indian/Alaska Native, 3% Asian, .1% Native Hawaiian/Other Pacific Islander, 3% other (other races, more than 2 races, and unknown race, etc.). Many Kansans do not claim an ethnicity, however, 12% identify as Hispanic/Latino.

Population and Services Reports for Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) for July 1, 2017 – June 30, 2018 were utilized to develop estimates of service population by race and gender. The report chosen is pre-pandemic and pre-data system change for SABG and better reflects the potential of population to be served at Community Mental Health Centers and Substance Use Disorder providers.

Disparate populations for MHBG include African American, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander are all over-represented in mental health services in comparison to their Kansas population totals. For the SABG, the same populations are over-represented in substance use disorder services.

1. A Quality Improvement Plan Using Our Data

Services and activities in Kansas attempt to be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community especially consideration of African American, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander as they are overrepresented in Kansas mental health and substance use disorder services. Kansas Department of Aging and Disability Services continues to collaborate with the local stakeholder groups for mental health and substance use disorder services in planning the design and implementation of program activities to ensure the cultural and linguistic needs of grant participants are effectively addressed, particularly the disparate population.

A continuous quality improvement approach used to analyze, assess and monitor key indicators as a mechanism to ensure high-quality and effective program operations. Data used to monitor and manage program outcomes by race, ethnicity, and gender within a quality improvement process. Programmatic adjustments made as indicated to address identified issues, including behavioral health disparities, across program domains.

A primary objective of the data collection and reporting monitor/measure project activities in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings integrated into program planning and management on an ongoing basis (a “self-correcting” model of evaluation).

2. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

a. Diverse cultural health beliefs and practices

Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the African American, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander subpopulations.

b. Preferred languages

Translated materials used for non-English speaking clients as well as those who speak English but prefer materials in their primary language. Key documents translated as needed.

c. Health literacy and other communication needs of all sub-populations identified in your proposal

All services programs will be tailored to include representation of African American, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander subpopulations. Training available to ensure capacity to provide services that are culturally and linguistically appropriate.

The Kansas Department for Aging and Disability Services (KDADS) recognizes the unique needs and access challenges faced by racial and ethnic minority communities in Kansas. Thus, keeping abreast on research and best practices that impact race, ethnicity, religion, geography, sexual orientation, and gender identity, and socio-economic status is an ongoing focus. Being culturally competent is a major step to enhance awareness and ensure inclusion in meeting behavioral health needs. Committees and coalitions are created to be inclusive of racial and ethnic minorities, including American Indians/Alaskan Natives to ensure processes and policies are reflective of practices, beliefs, and needs.

The Kansas Citizen's Committee on Alcohol and other Drug Abuse (KCC) is a subcommittee of the Governor's Behavioral Health Services Planning Council. The subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as, the Secretaries of relevant state agencies. The Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC) bylaws require the membership to constitute a representative cross-section and shall take race, ethnicity and gender into consideration. The KCC has made recommendations in their annual report to the Secretary for a loan forgiveness program to help recruit a more diversified workforce.

Additionally, KDADS contracts with Beacon Health Options (BHO) to administer the SABG. Beacon's provider contract requires that services shall be provided by qualified staff and shall be clinically appropriate, and available for: (a) pregnant IVDU women, pregnant women, and (b) IV drug users; and (c) individuals with a positive TB screen or at high risk of tuberculosis; and (d) individuals at high risk to/or afflicted with HIV. Providers shall offer equal access to substance use disorder treatment for all eligible Members regardless of age, sex, ethnicity, disability, race, color, ancestry, political affiliation,

religion, sexual orientation, mental health disability, or national origin. The Provider shall further comply with all provisions and applicable conditions of Title VII of the Civil Rights Act of 1964, as amended; the Age Discrimination and Employment Act of 1967, as amended; the Equal Pay Act of 1963; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990; the Civil Rights Act. Failure to comply with this requirement may result in contract termination. Furthermore, in delivering services, including outreach activities, SAPT Block Grant-funded religious organizations cannot discriminate against current or prospective Members based on religion, religious belief, refusal to hold a religious belief; and refusal to actively participate in a religious practice.

During BHOs Utilization Management, Beacon clinicians treat all cases equitably, and there are no processes or practices that specifically target racial or ethnic minorities differently than non-minorities. Each determination and managed case is considered on its unique merits which include viewing the member in the broad contexts of race, ethnicity, religion, geography, sexual orientation and gender identity, and socio-economic status.

Further, Kansas is rapidly growing the capacity of Peer Mentors through free bi-monthly certification trainings for persons in recovery with lived experience to become certified as Kansas Certified Peer Mentors and begin working for licensed Substance Use Disorder (SUD) programs. These trainings are offered in locations statewide to develop peers in all regions of the state. The peer workforce is much more diversified than the current SUD professional workforce and matches more effectively the diversity of the clients being served. We are actively encouraging providers to utilize peer services and to match mentors with treatment participants to better serve and relate to similar cultural, racial, and environmental factors and whom are knowledgeable about naturally occurring resources in the community to assist in recovery supports.

An additional benefit is that some persons working as peer mentors are continuing to pursue additional education to become licensed as SUD counselors. We have also actively engaged the Kansas Oxford House Alumni Association to receive peer certification training. Kansas has 141 Oxford Houses that operate under the "Oxford House Model", a community-based approach to addiction treatment, which provides an independent, supportive, and sober living environment. Oxford Houses have provided several new participants into the Kansas peer workforce.

HIV-designated state

Kansas is not a FY 2020 HIV-designated state, or a state designated in any of the prior three fiscal years as HIV-designated.

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 M/SUD system of care 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 M/SUD system of care.

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, SUD prevention, and SUD treatment goals at the state level.

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

Footnotes:

**FFY2022 - 2023 Mental Health and Substance Abuse Prevention and Treatment Block Grant
Application**

Section II: Planning Steps

Step Two Narrative

➤ **SABG Instructions (Step Two Narrative)**

From the guidance:

“Step 2: Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet services needs and critical gaps in the state’s current systems, as well as the data sources used to identify the needs and gaps of the 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 these unmet service needs and gaps.” The state’s priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA’s National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Abuse Treatment Services (N-SSATS), the Behavioral Health Barometer, and state data.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Person Who Inject Drugs, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Use Prevention, and, for HIV-designated states, Persons at Risk for HIV. Moreover, a discussion of the unmet service needs and critical gaps in the current system regarding diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American person, Asian Americans, and Pacific Islanders), members of religious minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality must be included. In addition, this narrative must include a description of the composition of the State Epidemiological Outcomes Workgroup and its contribution to the state planning process.

➤ **MHBG Instructions (Step Two Narrative)**

From the guidance:

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

This step should identify the unmet service needs and critical gaps in the state’s current M/SUD 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 M/SUD 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.

A data-driven process must support the state's priorities and goals. 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, 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 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.

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

The Kansas Step 2 response was compiled from several Federal and State resources including Federal Data resources such as SAMHSA's National Survey on Drug Use and Health (NSDUH) and the Behavioral Health Barometer for Kansas (Volume 6), Kansas Legislative Special Committee on Mental Health Modernization and Reform recommendations, Governor's Behavioral Health Services Planning Council and Subcommittee recommendations, and Contractor reporting, research and analysis. A large contribution was from the Boston Consulting Group (BCG), the Kansas State Epidemiological Outcomes Workgroup (SEOW), and Greenbush Education Service Center.

KDADS has determined the identified needs and gaps will be supported through a combination of funding streams and strategies including the Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) standard and additional COVID and ARP funds, along with other State funding and grants. To address the needs and gaps in Kansas's mental health prevention, treatment, and recovery services systems in the context of COVID-19, Kansas applied for and received funding for two programs - the SAMHSA/FEMA Crisis Counseling Program and the Emergency COVID-19 Response grant.

Kansas State Epidemiological Outcomes Workgroup (SEOW)

The State Epidemiological Outcomes Workgroup (SEOW) was created to integrate state efforts toward data collection. The intended purpose of the SEOW is to bring together a diverse group of data experts responsible for data on substance use/misuse and related behavioral health problems to the forefront of the prevention planning process for the state. The SEOW strives to support the State's prevention infrastructure by enhancing the ability to acquire, integrate, disseminate, and utilize a diverse set of behavioral health indicators and epidemiological data to inform and guide prevention efforts and build capacity to address substance abuse prevention, treatment, and mental health outcomes in a coordinated, data-driven fashion. To achieve its mission, the Kansas SEOW is charged with the following

core tasks: Identifying, analyzing, profiling, and sharing data from existing state and local sources; Creating data-guided products that inform prevention planning and policies; Training communities in understanding, using, and presenting data in an effective manner; and Building state- and local-level monitoring and surveillance systems.

The Kansas SEOW meets quarterly. Current membership includes representatives from the following:

- The University of Kansas Center for Community Health and Development
- The Learning Tree Institute at Greenbush
- Kansas Department for Aging and Disability Services Behavioral Health Services
- Kansas Department of Health and Environment
- Kansas Department of Transportation
- Kansas Board of Pharmacy
- The University of Kansas Poison Control Center
- Kansas Board of Emergency Medical Services
- Kansas Racing and Gaming Commission
- Kansas Bureau of Investigation
- The University of Kansas Center for Telemedicine and Telehealth
- Sedgwick County Health Department

The SEOW maintains and updates the *Kansas Behavioral Health Profile* which integrates a data set inclusive of a wide array of behavioral health indicators and serves as a *Statewide Needs Assessment*. The original Profile was developed in 2006 and focused solely on substance use indicators. The profile was updated every two years and with each update, significant enhancements were made to expand the scope of behavioral health and mental health assessment and surveillance data that aligns with the Strategic Prevention Framework (SPF) and the Substance Abuse and Mental Health Block Grant. This included problem gambling, mental health, and treatment indicators. When available, all indicators report data related to the prevalence, treatment, and consequences by age, gender, race, and ethnicity. This is helpful for prevention and treatment focuses across the lifespan.

The 2021 Kansas Behavioral Health Profile has expanded to include *concerning trends* in psychostimulants and pseudo-synthetics drugs and measures of Serious Mental Illness. The updated profile is designed to provide an in-depth, data-focused perspective on the extent of substance abuse health agencies, treatment agencies, and law enforcement and revenue agencies. The intent is to illustrate, as completely as possible, the current state of behavioral and mental health which supports a data-informed prioritization process as part of comprehensive state-level and community-level assessment. Utilizing a broad range of information from multiple sectors, organizations, and data sets allows for the depiction of a more thorough picture of substance abuse-related consequence and consumption patterns.

The SEOW is working toward expanding and existing *Data Inventory* for Kansas which will include information from all available sources across state and private agencies to provide information on data providers, data characteristics, and the availability of data, raw or analyzed. The guide will assist stakeholders in locating behavioral health data to assist in sharing findings and promoting evidence-based prevention and positive outcomes.

In FY2022, the SEOW will look at *two unique populations* through additional statewide data being collected. Data from the Kansas Communities That Care Student Survey will ask questions related to sexual orientation and gender identity. And, the 2021 Kansas Young Adult Survey will have new data for

the hard-to-reach 18 to 25-year-old population. New data from both sources will prove valuable to prevention stakeholders. The SEOW Co-Chairs will be *connecting with regional SEOWs* to review regional patterns and learn about novel approaches. The SEOW is also *building a website* to house resources, planning documents, and data briefs.

Prevention System Needs

KDADS provides funding/grants for community coalitions to plan and implement strategic prevention plans. With the amount of funding available, currently two coalitions are in the strategic planning process and 10 coalitions receive funds to implement their strategic prevention plans. While these grantees have shown desired outcomes reducing underage drinking and youth marijuana use, the *lack of saturation of prevention efforts across the state* makes it difficult to realize impact and report statewide performance levels.

The State Epidemiological Outcomes Workgroup reviews and updates data for the *Kansas Behavioral Health Profile* which is used for assessing and prioritizing areas of need. The profile compiles all available behavioral health data in the state to provide a comprehensive picture of the impact of behavioral health challenges in Kansas. Some of the identified needs include services in rural communities, prevention efforts for young adults, and lack of data on sexual and gender minorities.

KDADS recognizes the challenges and barriers in access to public and behavioral health *services in rural and frontier communities*. Most Americans living in underserved, rural and remote rural areas experience disparities in substance use and mental health services. Related potential barriers to equity include distance, travel time, cost, and time away from the workplace, and often lack of reliable transportation. A shortage of healthcare professionals in rural areas can also limit access by limiting the supply of available services. Prevention data sources including the Kansas Communities That Care Student Survey and the Kansas Behavioral Health Indicators Dashboard and others can be disaggregated by population density to monitor disparities between rural and urban areas. KDADS would like to infuse more prevention knowledge and efforts into rural Kansas communities to increase rural coalition capacity to develop and implement strategic prevention plans. One way KDADS will do this is to increase the number of trainings in rural communities which will be documented and reported in the Community Check Box system to report performance progress toward targets. Training will focus on behavioral/mental health and substance use prevention for youth, young adults, school staff, and families.

In addition to funding current Kansas Prevention Collaborative (KPC) grantees, American Rescue Plan Act (ARPA) funding will allow KDADS to expand prevention efforts to better address rural, underserved racial and minority populations and young adults.

In FY 2021, grantees applied the data-driven Strategic Prevention Framework process to identify and address sub-populations to improve behavioral health outcomes by utilizing the at-risk population assessment and developing a *local Health Disparities Statement*. Data used for review included *census data*, county-level *Kansas Communities That Care Student Survey demographic data*, and county-level data from the *Kansas Behavioral Health Indicators Dashboard (KBHID)*. Use of data from other sources including local county health departments was encouraged. In FY 2022 grantees will be implementing strategies focused on these populations. Through the support of the prevention system, Kansas will

offer additional assistance to communities that will allow them to identify which strategies will be the most effective and sustainable in their community.

Part of the challenge of this process is the lack of systematic statewide data for diverse subpopulations. One step KDADS will take in FY 2022 is to *expand data collection including gender identity and sexual orientation*. For the first time, Kansas school districts will be able to choose to participate in a new module of the Kansas Communities That Care Student Survey that asks students in 6th, 8th, 10th, and 12th grades about their gender identity and sexual orientation. Survey participation requires parental consent, student consent and is completely anonymous. However, new information gathered from the survey can inform prevention needs and identify supports for this youth population.

Another hard-to-reach population is young adults aged 18-25 years. KDADS is gathering information through the 2021 Kansas Young Adult Survey (KYAS) to understand the needs of this population and develop a plan to enhance prevention efforts for this population. There is a lack of prevention strategies to specifically implement, and impact young adults aged 18-25 relative to prioritized substances such as marijuana. KDADS and the Evidence-Based Strategies Workgroup will continue to research effective strategies to address these needs.

Behavioral Health Needs

Nursing Facilities for Mental Health (NFMH)

In Kansas, Nursing Facilities for Mental Health provide residential care and rehabilitation treatment for persons experiencing severe symptoms of mental illness. They provide round-the-clock supervision and care for persons with mental illness needing this level of service. Despite bed capacity of approximately 635 beds available in NFMHs and 261 additional beds available at state hospital facilities (totaling approx. 896 total), KDADS has been notified that more bed space is needed to meet immediate needs.

Mental Health indicators with references to sources prepared by the Kansas SEOW are shared narratively and graphically below including data sources.

Mental Health Indicators
(Included in 2021 Kansas Behavioral Health Profile)

Major Depressive Episodes: Percent of population reporting having at least one major depressive episode in the past year

Why is this indicator important?

The link between mental health and substance abuse is well established. Experiencing episodes of depression or anxiety in the past year is associated with higher rates of substance abuse.

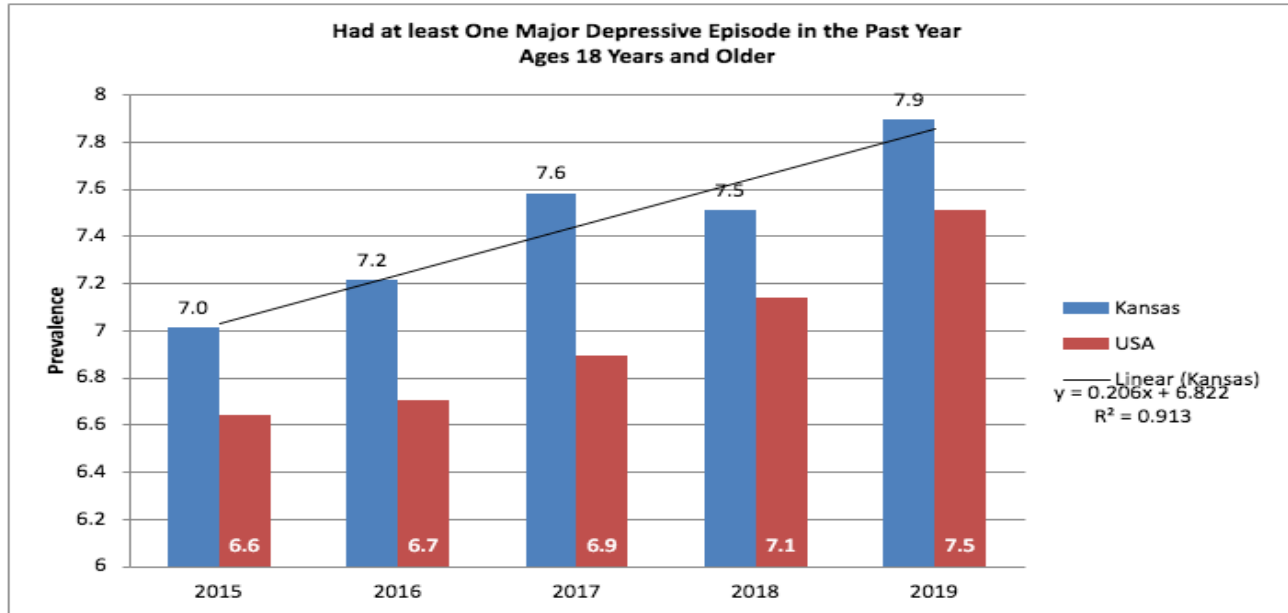
Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 – 2019

Important findings

- Percent of adults reporting having had at least one depressive episode in the last year is higher for Kansas residents than the national average.
- Percent of population reporting depressive episodes has increased over the past 5 years.
- Depressive episodes are most prevalent in the ages 12-17 category.

Graphs of Five-Year Trends



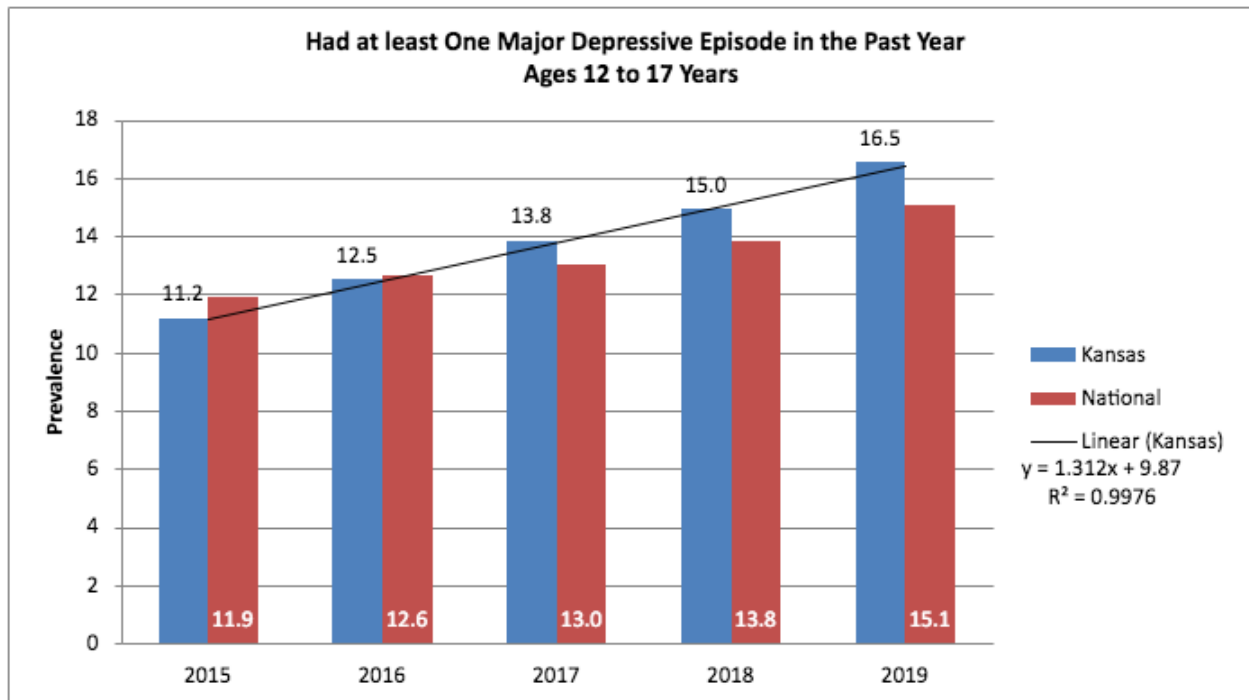


Table 1.1 Percent of population reporting having had at least one major depressive episode in the past year by age group, 2015-2019

Year	Ages 12-17	Ages 18-25	Age 26+	Age 18+
2015	11.2	9.8	6.5	7.0
2016	12.5	10.9	6.5	7.2
2017	13.8	11.9	6.8	7.6
2018	15.0	13.1	6.5	7.5
2019	16.5	14.6	6.7	7.9
5-Year Average	13.8	12.0	6.6	7.4

Depression: Percent of population responding, ‘yes’ to the question “Have you ever been told that you have a form of depression?”

Why is this indicator important?

The link between mental health and substance abuse is well established. Experiencing episodes of depression or anxiety is associated with higher rates of substance abuse.

Where did we get the data?

Centers for Disease Control and Prevention (CDC) Behavior Risk Factor Surveillance System (BRFSS) – 2015 – 2019

Important findings

- Percent of adults reporting having a form of depression has been generally higher for Kansas residents than the national average.
- Percent of population reporting depression has increased over the past 5 years.
- Thirty percent of adults who are multi-racial and 28.8 percent of Native Americans have been told they have a form of depression.
- Depression is most often reported in females and those in the 18-25 age category.
- Percent of population with less than a high school education and with lower income have the largest

Graphs of Five-Year Trends

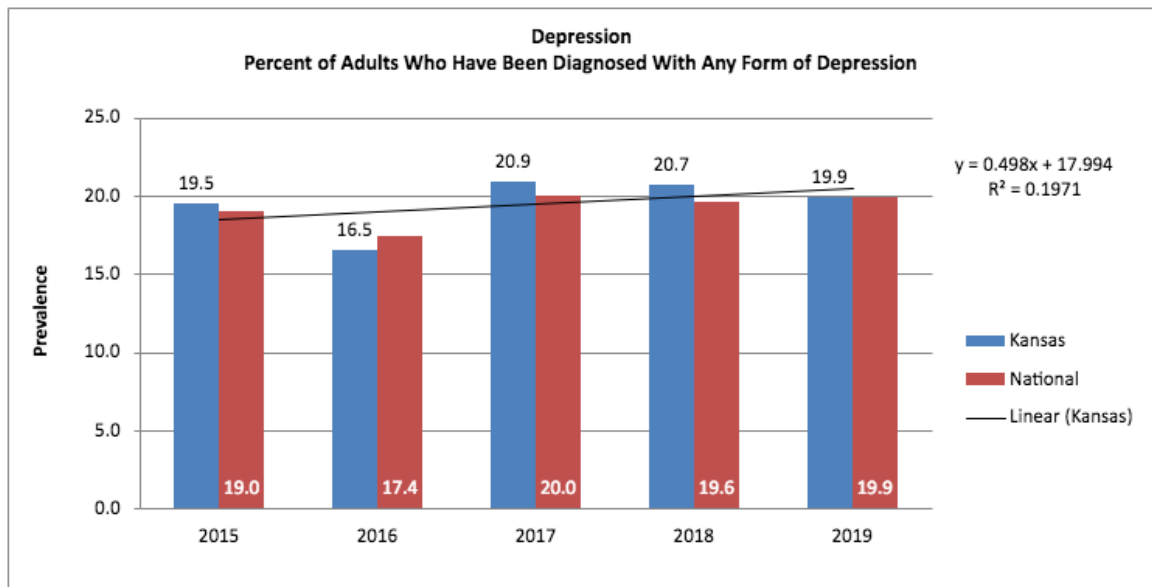


Table 2.1 Percentage of persons aged 18 and older reporting having been told they have depression by race and ethnicity, 2015-2019

Year	Overall	Race						Ethnicity	
		White	African American	Native American	Asian	Other	Multiple Race	Hispanic	Non-Hispanic
2015	19.5	20.0	19.9	36.2	4.5	0.0	31.5	13.9	20.0
2016	16.5	17.1	13.6	23.8	0.0	0.0	25.2	12.6	17.1
2017	20.9	21.3	18.8	31.8	6.6	0.0	37.3	21.1	21.3
2018	20.7	21.1	17.6	28.1	9.1	2.0	28.5	14.8	21.1
2019	19.9	19.9	15.4	24.4	9.2	0.0	28.0	21.6	19.9
5-Year Average	19.5	19.9	17.0	28.8	N/A	0.4	30.1	16.8	19.9

Table 2.3 Percentage of persons aged 18 and older reporting having been told they have depression for the State of Kansas by gender and age group, 2015-2019

Year	Overall	Gender		Age Group					
		Male	Female	18-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65+ years
2015	19.5	13.6	25.2	18.0	20.1	20.3	22.6	20.7	15.6
2016	16.5	11.8	21.0	17.1	17.8	17.8	16.3	18.2	12.7
2017	20.9	15.3	26.4	23.8	20.9	21.6	21.8	22.1	16.7
2018	20.7	14.6	26.6	24.1	23.2	21.1	20.1	22.2	15.3
2019	19.9	14.3	25.3	27.2	22.9	23.4	17.2	19.5	12.3
5-Year Average	19.5	13.9	24.9	22.0	21.0	20.8	19.6	20.5	14.5

Table 2.4 Percentage of persons aged 18 and older reporting having been told they have depression for the State of Kansas by educational attainment and income, 2015-2019

Year	Overall	Education				Income			
		Less than High School	High School only	Some post-graduate	College Graduate	\$15,000 - \$24,999	\$25,000 - \$34,999	\$35,000 - \$49,999	\$50,000 and more
2015	19.5	21.6	19.1	22.2	15.6	27.1	20.9	18.4	14.9
2016	16.5	16.9	17.6	18.3	13.1	20.3	18.1	15.5	12.4
2017	20.9	30.1	20.9	21.8	16.5	30.1	21.3	21.5	15.3
2018	20.7	28.4	21.0	22.0	16.2	30.9	24.4	20.6	14.5
2019	19.9	28.3	18.5	21.1	17.0	27.9	22.8	21.2	15.0
5-Year Average	19.5	25.1	19.4	21.1	15.7	27.3	21.5	19.4	14.4

Suicidal Ideation: Percent of adult population surveyed reporting having had serious thoughts of suicide in the past year

Why is this indicator important?

Suicide is the most tragic consequences of major depressive disorders. Abuse of alcohol or other drugs may increase emotional problems leading to suicidal ideation or suicidal behavior.

Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019

Important findings

- More adults in Kansas report having had suicidal thoughts in the past year than the national average.
- The percentage of those reporting having had serious thoughts of suicide during the twelve months preceding the survey has been increasing over the past five years and is highest for young adults aged 18 to 25.

Graph of Five-Year Trend

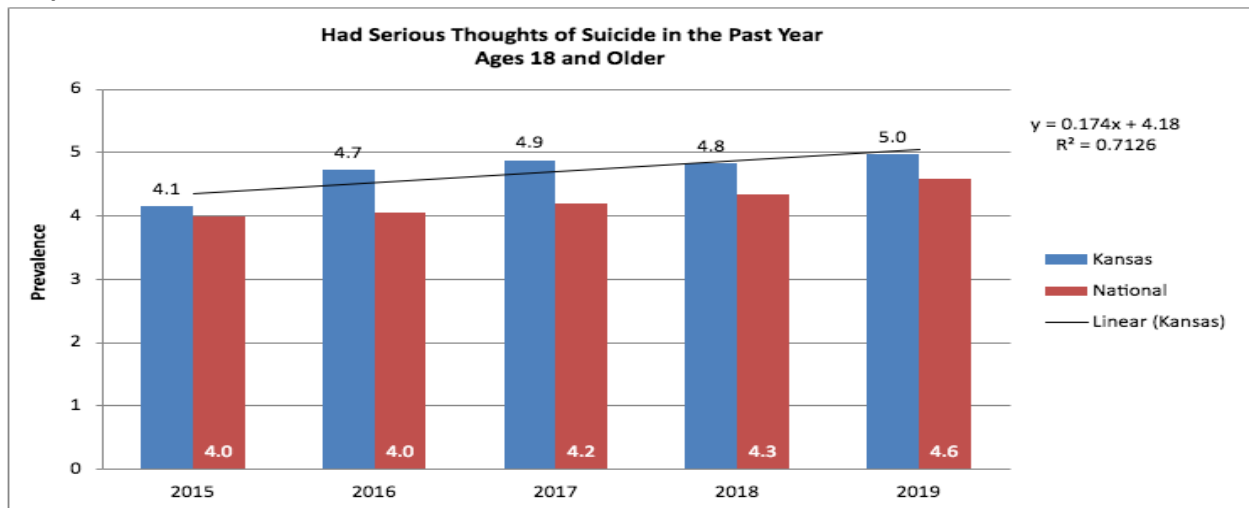


Table 3.1 Percent of adult population surveyed reporting having had serious thoughts of suicide in the past year by age, 2015-2019

Year	18-25	26+	18+
2015	7.91	3.45	4.14
2016	9.34	3.88	4.72
2017	10.29	3.90	4.87
2018	11.75	3.60	4.82
2019	11.39	3.68	4.96
5-Year Average	10.1	3.7	4.7

Persons Served in Community Mental Health Programs: Number and rate per 1,000 people served by Community Mental Health Treatment Centers, 2016-2020

Why is this indicator important?

The number of individuals receiving services is a useful indicator that helps illustrate both treatment capacity and treatment need, although not a standalone indicator of the total extent or pervasiveness of the behavioral health issue in terms of prevalence or incidence.

Where did we get the data?

Kansas Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, Output Tables 2016-2020

Important findings

- The number of individuals served in community mental health programs has remained relatively stable, although the rate per 1,000 in Kansas remains more than double the national average.
- Individuals aged 21-64 constituted 63% of admissions over a five-year timeframe.
- Children aged 0-17 represent the largest rate of those served in Community Mental Health Treatment Centers.

Graph of Five-Year Trend

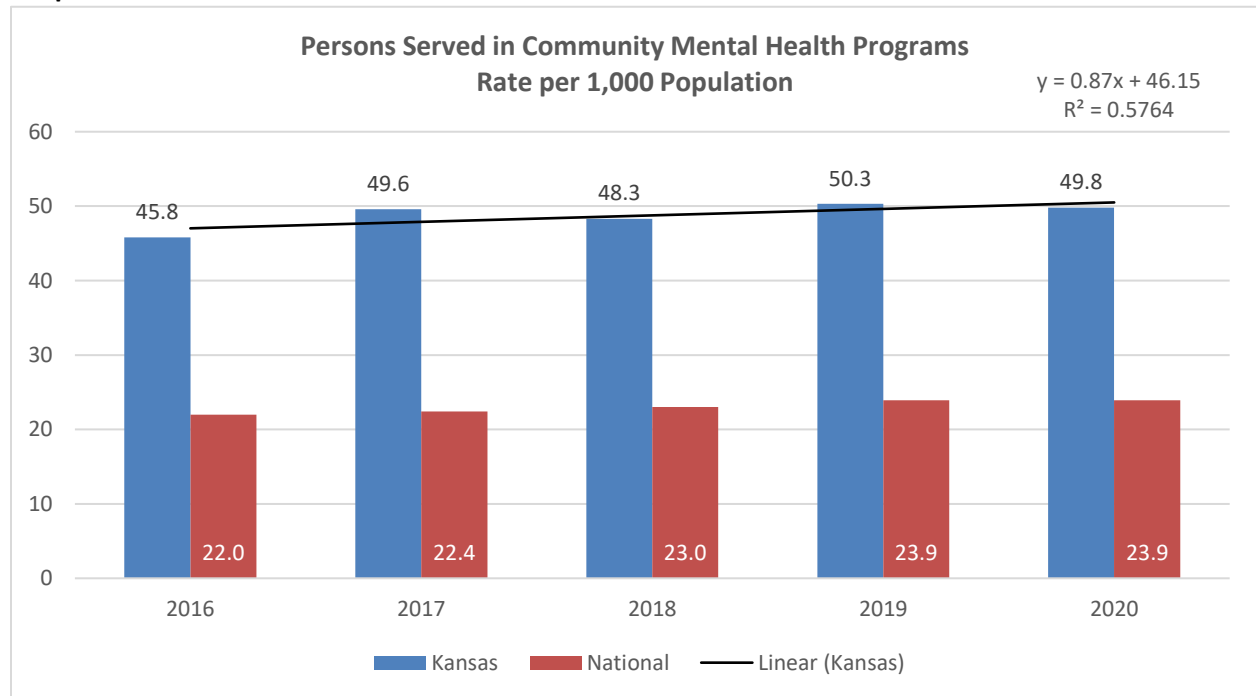


Table 4.1 Persons served in community mental health programs by gender 2016-2020

Year	Female			Male		
	Number	% of Total	Rate per 1,000	Number	% of Total	Rate per 1,000
2016	69,524	51.90%	22.8	62,674	48.00%	21.8
2017	76,095	52.10%	23.1	67,275	47.80%	21.9
2018	74,368	52.20%	47.7	65,630	47.00%	43.1
2019	77,019	52.70%	52.1	68,855	46.60%	46.5
2020	77,003	52.90%	50.9	68,026	46.70%	45.2
5-Year Average	72,810	52.00%	23	64,975	47.90%	21.9

Table 4.2 Persons served in community mental health programs by age 2016-2020

Year	Age 0-17			Age 18-20			Age 21-64			Age 65+		
	#	% of Total	Rate per 1000	#	% of Total	Rate per 1000	#	% of Total	Rate per 1000	#	% of Total	Rate per 1000
2016	8,254	27.5	26.7	8,254	4.5	24.7	81,189	63.5	24.6	7,011	4.5	6.5
2017	9,134	28.0	27.7	9,134	4.3	24.3	88,065	62.8	24.6	7,901	4.8	6.9
2018	8,881	26.8	49.7	8,881	6.2	65.4	85,466	60.9	49.5	8,255	5.3	16.4
2019	9,397	26.5	53.5	9,397	6.3	73.3	88,676	61.0	54	9,091	5.5	18.1
2020	9,385	26.6	52.5	9,385	6.3	71.4	88,762	60.8	52.5	9,714	5.9	18.4
5-Year Average	8,694	27.7	39.4	8,694	4.4	24.5	84,627	63.1	24.6	7,456	4.6	6.7

Persons Served by State Mental Health Authority: Number and rate per 1,000 people (Adults with SMI and children with SED) served by Community Mental Health Treatment Centers, 2016-2020

Why is this indicator important?

Diagnoses of serious mental illness or serious emotional disorder among children and youth at admission to community mental health treatment services serves as an indicator of the number of individuals experiencing behavioral health difficulties, with implications for treatment need and capacity.

Where did we get the data?

Kansas Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, Output Tables 2016-2020

Important findings

- Over a five-year timeframe, individuals under age 18 represented the largest number of persons served by state mental health authority services.
- Males represented the largest number and highest rate of persons served by state mental health authority services over the five-year period as well as on an annual basis.
- The rate of individuals served by the State Mental Health Authority for Native Hawaiian / Pacific Islander was the highest of any racial group (40/1,000) followed by Native American (35/1,000).

Graph of Five-Year Trend

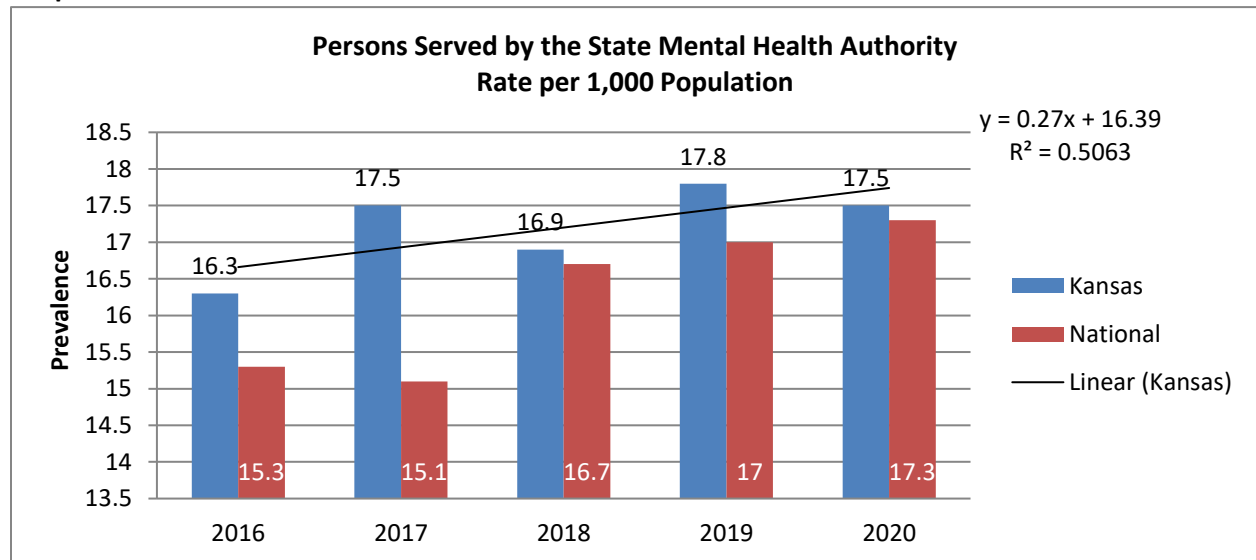


Table 5.1 Persons served by the State Mental Health Authority by age group, 2016-2020

Year	Age 0-17		Age 18-20		Age 21-24		Age 25-64		Age 65 and Over	
	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate
2016	22,711	38.8	3,964	31.4					1,386	3.1
2017	24,765	42.2	4,260	34.2					1,488	3.2
2018	24,343	41.5	3,784	30.4	2,409	16.2	16,941	12	1,512	3.2
2019	25,723	44.1	4,084	32.6	2,590	14	17,676	11.7	1,702	3.5
2020	24,870	43.2	4,163	33.1	2,635	15.3	9,652	12.2	36,841	8.2
5-Year Average	24,482	41.9	4,051	32.3	2,545	15.2	14,756	11.9	8,586	4.2

Table 5.2 Persons served by the State Mental Health Authority by race, 2016-2020

Year	White		African American		Multi-Racial		Native American, etc.		Native Hawaiian / Pacific Islander	
	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate
2016	34,855	13.8	5,225	31.5	1,494	18.0	1,601	46	102	30.9
2017	36,735	14.6	5,659	29.2	2,191	25.9	1,522	44	104	32.1
2018	34,906	13.9	5,235	31.1	2,860	33.1	1,375	39.7	252	73.5
2019	37,240	14.8	5,556	37.8	2,921	33.2	1,366	39.2	103	28.5
2020	5,407	30.3	1,326	0	4,016	0.0	608	6.5	3,113	34.9
5-Year Average	29,829	17.5	4,600	25.9	2,696	22.0	1,294	35.1	735	40.0

Table 5.3 Persons served by the State Mental Health Authority by gender and ethnicity, 2016-2020

Year	Female		Male		Hispanic		Not Hispanic	
	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000
2016	21,450	14.7	25,786	17.7	3,410	10.1	43,737	17
2017	23,195	15.9	27,573	19	3,958	11.7	46,597	18.1
2018	22,634	15.5	26,353	18.1	4,114	11.8	44,477	17.3
2019	23,829	16.3	27,945	19.3	4,495	12.8	46,884	18.3
2020	23,485	16.1	27,540	19	4,523	12.7	46,074	18
5-Year Average	22,919	15.7	27,039	18.6	4,100	11.8	45,554	17.7

Suicide: Number of deaths from suicide per 100,000 population

Why is this indicator important?

Suicide rates are highly correlated to alcohol and illicit drug abuse. Individuals suffering from chronic depression may begin to self-medicate, causing a higher-than-expected suicide rate.

Where did we get the data?

National and trend data from Centers for Disease Control and Prevention, National Center for Health Statistics - CDC WONDER online database, detailed mortality statistics 1999-2018 Multiple Cause of Death Files

Demographic data from Kansas Department of Health and Environment, Center for Health and Environmental Statistics, Office of Vital Statistics, Death Certificates 2015-2019

Important findings

- Rates of death by suicide are highest for white males.
- There is a higher rate of suicide in Kansas than the national average.
- The highest rates within the 25–44-year age range.
- The highest rate increase over the past five years is within the 15-24 age from 5.7 in 2015 to 11.4 in 2019.

Graph of Five-Year Trend

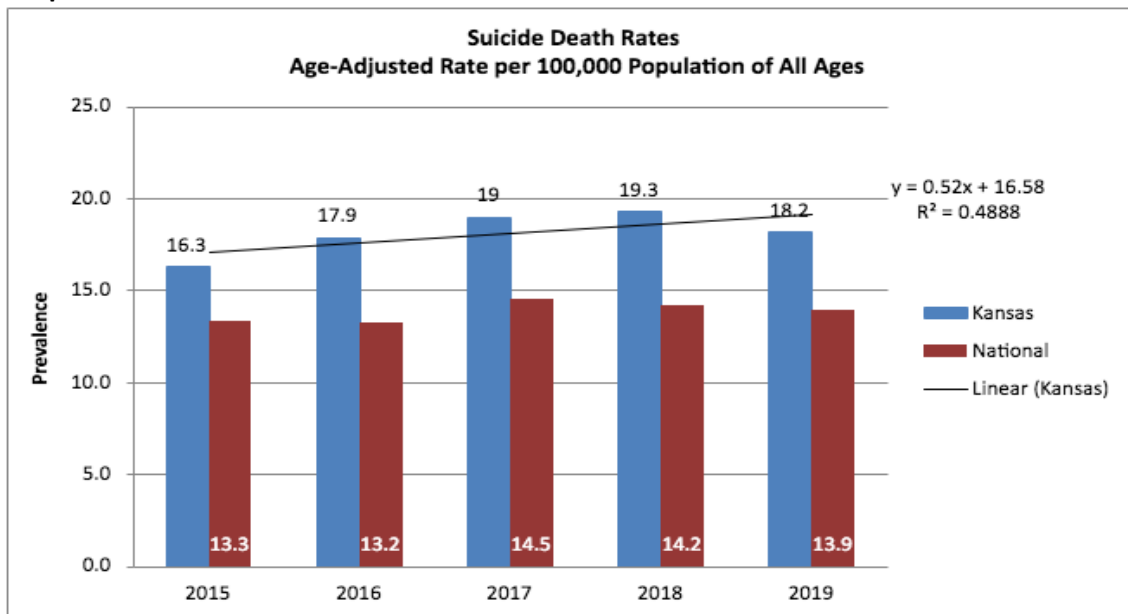


Table 6.1 Suicide death rates by gender, race, and ethnicity, 2015-2019

Year	Overall	Gender		Race			Ethnicity	
		Male	Female	White	African American	Otr	Hispanic	Non-Hispanic
2015	16.3	25.8	7.1	16.9	9.4		8.7	16.6
2016	17.9	28.2	7.9	18.5	12.7		9.9	18.7
2017	19.1	30.1	8.3	19.7	12.1		9.5	20.1
2018	19.3	30.4	8.2	19.9	13.4		9.8	20.2
2019	18.2	29	7.7	19.2	12		12.5	18.4
5-Year Average	18.2	28.7	7.8	18.8	11.9		10.1	18.8

Table 6.2 Suicide death rates by age group, 2015-2019

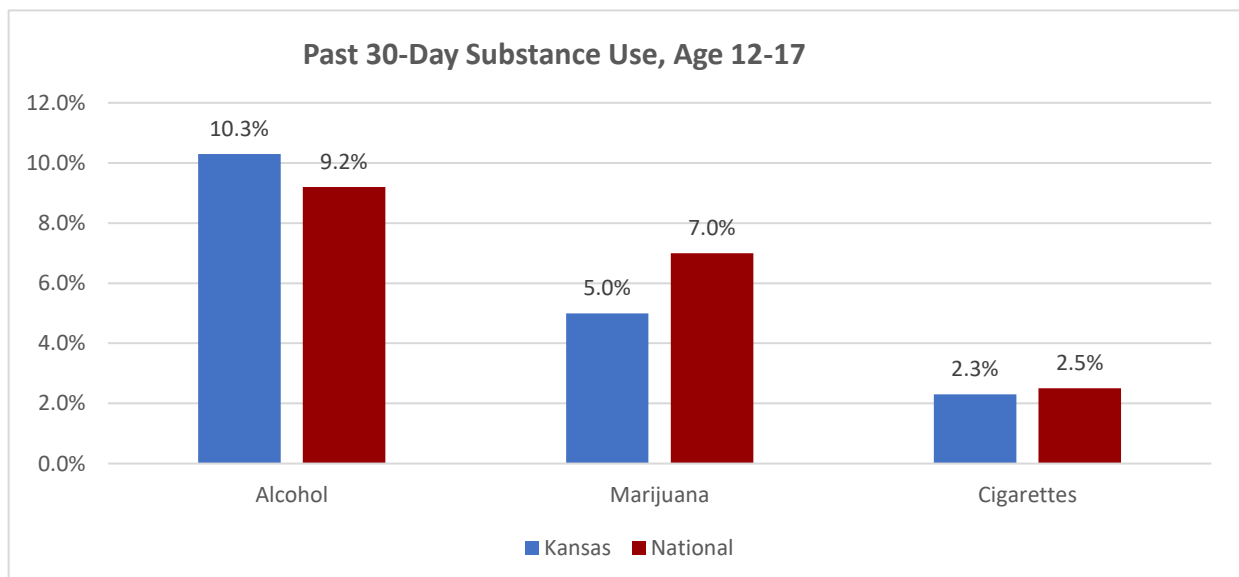
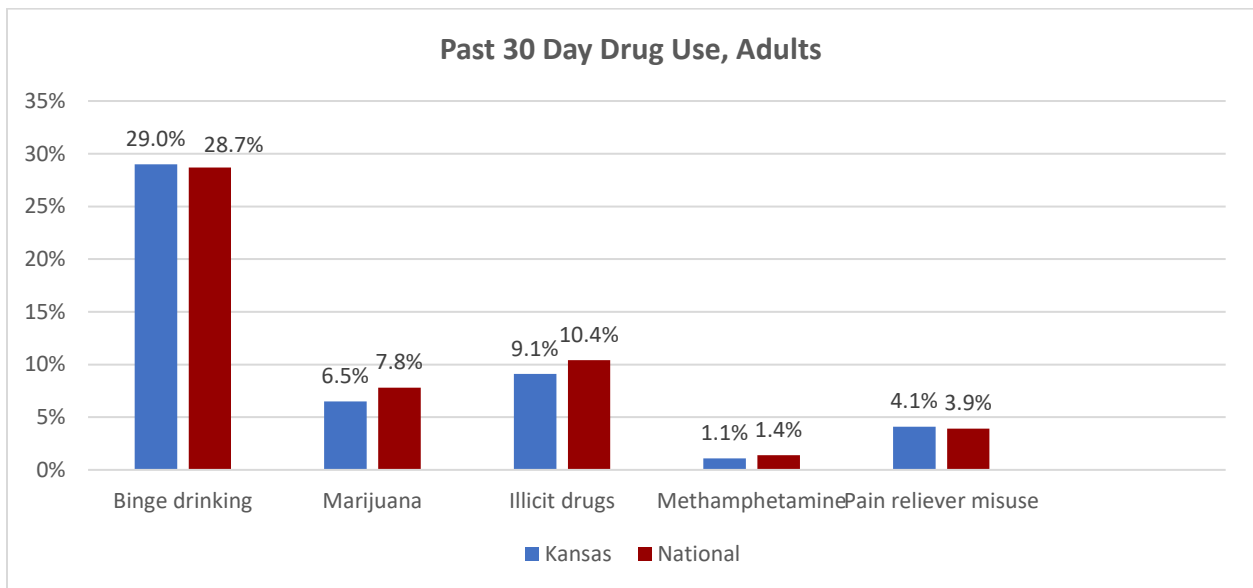
Year	Overall Crude Rate	Age Group				
		Under 15 years	15-24 years	25-44 years Ave	45-64 years Ave	65+ years Ave
2015	16.4	0.0	5.7	9.7	9.2	6.8
2016	17.7	0.0	7.9	12.4	10.2	13.4
2017	19.0	0.0	11.8	13.3	13.9	7.7
2018	19.1	0.0	24.7	28.4	22.4	16.4
2019	18.0	0.0	11.4	13.6	10.0	6.6
5-Year Average	18.0	0.0	12.3	15.4	13.1	10.2

Substance Use: Percentage of persons reporting past 30-day substance use

Where did we get the data? SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019

Important findings:

- Compared to the national average, a slightly larger percentage of Kansas adults report binge drinking and prescription pain relievers misuse.
- A larger percentage of Kansas youth aged 12-17 report more alcohol use, but less cigarette and marijuana use than the national average.

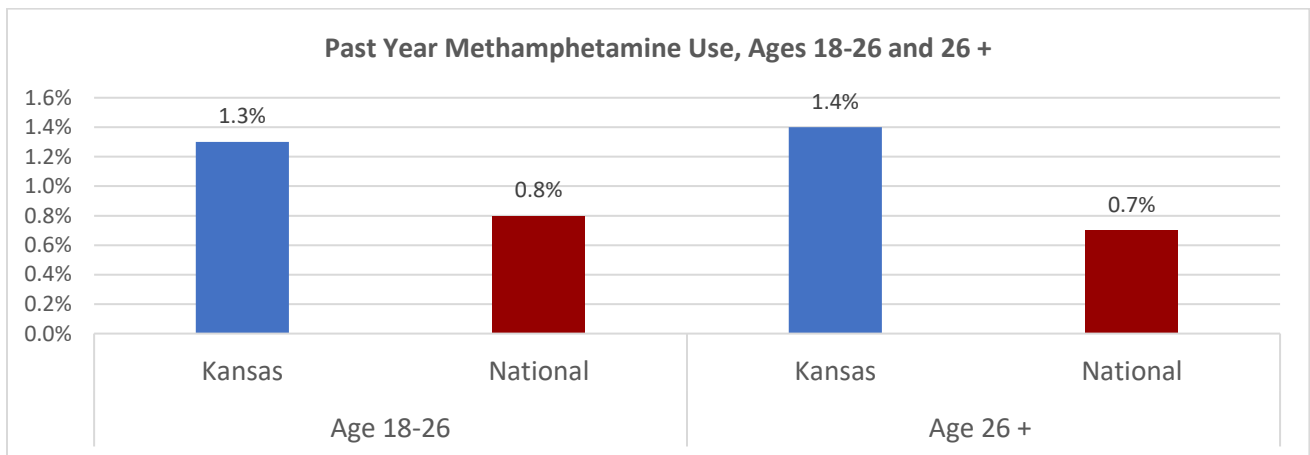


Substance Use: Percentage of persons reporting past year methamphetamine use

Where did we get the data? SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019

Important findings:

- A larger percentage of Kansas young adults and adults over 26 report using methamphetamines during the past year compared to the national average.
- The largest number of Kansas treatment admissions is for a primary diagnosis of methamphetamines.

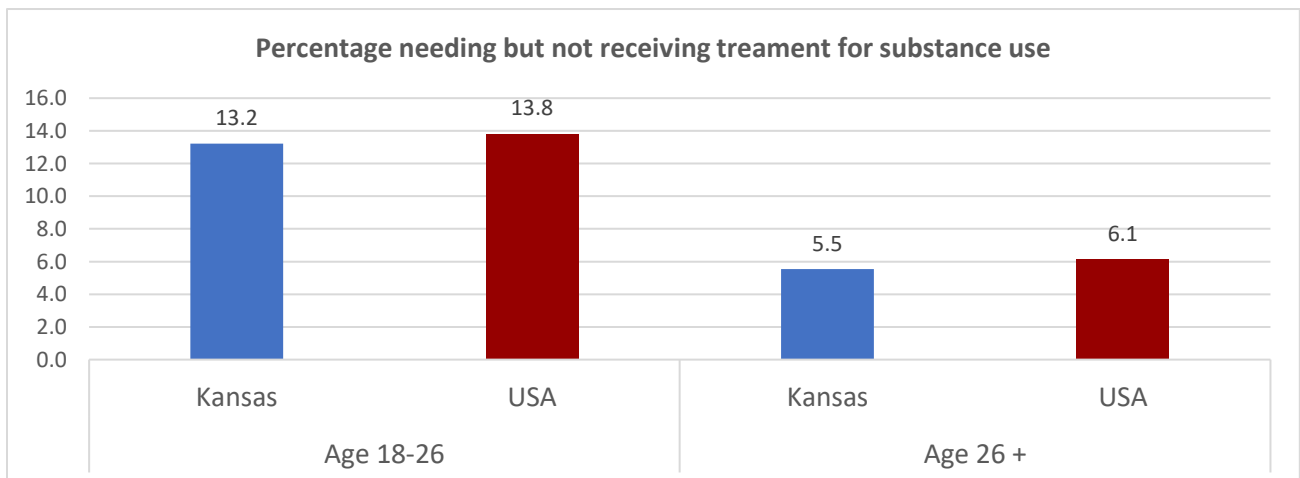


Substance Use Treatment: Needing but not receiving treatment

Where did we get the data? SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019

Important findings:

- Kansas is below the national average for individuals needing but not receiving mental health treatment.



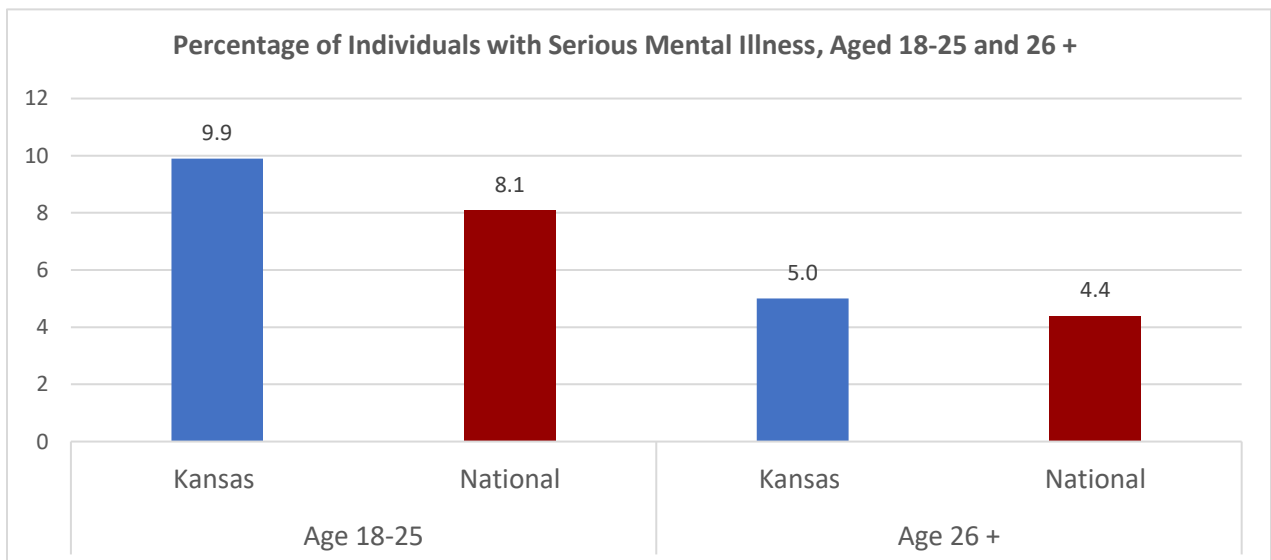
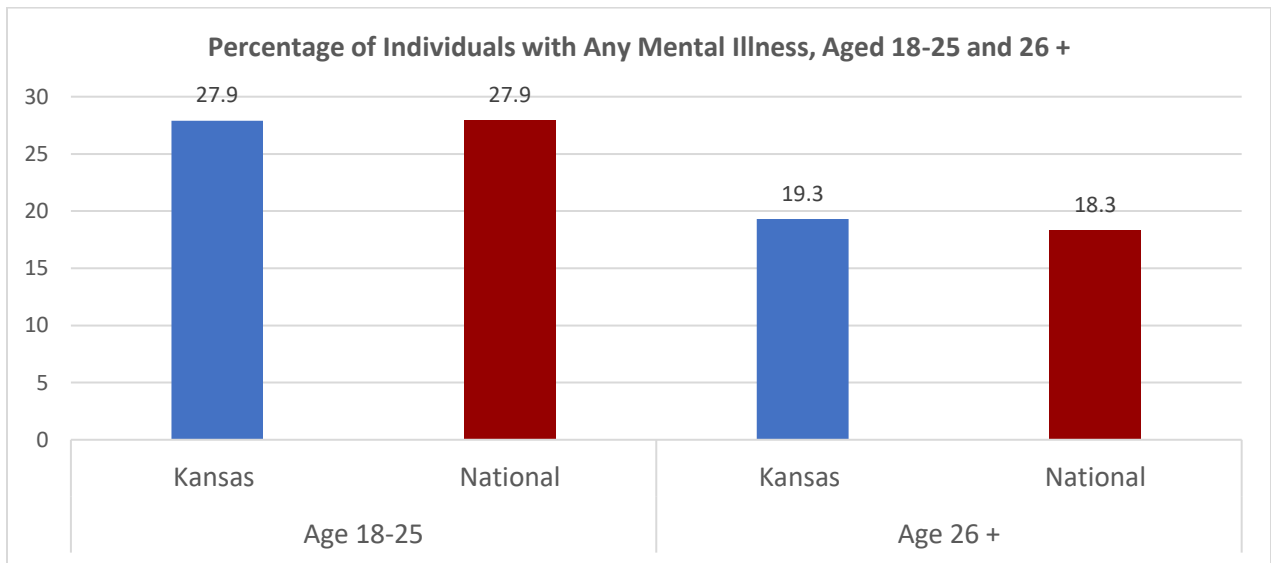
Mental Illness: Percentage of individuals with any mental illness and serious mental illness

Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019

Important findings:

- Compared to the national average, a larger percentage of Kansans over age 26 have mental illness.
- Compared to the national average, a higher percentage of Kansans have serious mental illness. The percentage is particularly higher for young adults aged 18-25.



The 2019 National Survey on Drug Use and Health (NSDUH) data for Kansas is shown in the table below:

MENTAL HEALTH AND SERVICE USE (NSDUH 2018-2019)		
Indicator	Kansas	National Average
Past Year Mental Health Service Use Among Adults Aged 18 or Older with Any Mental Illness (AMI) in Kansas	20.6	19.9

YOUTH SUBSTANCE USE (NSDUH 2018-2019)		
Indicator	Kansas	National Average
Age 12-17 reporting marijuana use in the past month in Kansas and the U.S.	5.0%	7.0%
Age 12-17 reporting cigarette use in the past month in Kansas and the U.S.	2.3%	2.5%
Age 12-17 reporting alcohol use in the past month in Kansas and the U.S.	10.3%	9.2%

SUBSTANCE USE AND SUBSTANCE USE DISORDERS		
Indicator	Kansas	National Average
Past Year Alcohol Use Disorder Among Individuals Aged 12 or Older in Kansas and the U.S.	5.1%	5.7%
Past Year Alcohol Use Disorder Among Individuals Aged 18 and Older in Kansas and the U.S.	5.5%	5.7%
Past Year Substance Use Disorder Among Individuals Aged 18 and Older in Kansas and the U.S.	7.3%	7.7%
Past Year Illicit Drug Disorder Among Individuals Aged 18 and Older in Kansas and the U.S.	2.5%	3.0%

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - Kansas		
Indicator	2017-2018	2018-2019
18 or older reporting illicit drug use in the past month	9.1%	10.4%
18 or older marijuana use in the past year	6.5%	15.0%

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - Kansas		
Indicator	2017 - 2018	2018-2019
18 or older marijuana use in the past month	6.5%	7.8%
18 or older reporting illicit drug other than marijuana use in the past month	9.1%	10.4%
18 or older methamphetamine use in the past year	1.1%	1.4%
18 or older pain reliever misuse in the past year	4.1%	3.9%
18 or older illicit drug use disorder (per DSM-IV) in the past year	2.3%	2.5%
18 or older alcohol use disorder (per DSM-IV) in the past year	5.5%	5.5%
18 or older substance use disorder (per DSM-IV) in the past year	7.3%	7.3
18 or older needing but not receiving treatment at a specialty facility for substance use in the past year	6.8%	6.7%

Boston Consulting Group

Needs and gaps were further identified through efforts of the Boston Consulting Group (BCG) using prior reports such as The Kansas Legislative Special Committee on Mental Health Modernization and Reform Report, Governor’s Behavioral Health Services Planning Committee Subcommittee Reports, and through interviews with Kansas Department on Aging and Disability Services staff. BCG defined key pillars of behavioral health services delivery as (1) prevention/promotion, (2) treatment, and (3) rehabilitation (rehab)/recovery.

In an effort to identify the needs and gaps in Kansas’s behavioral health services continuum including prevention, intervention, access to crisis services, treatment and recovery support services, BCG researched and provided the information detailed below.





- (1) Prevention & Promotion
 - a. Lower performance in both social and economic determinants of health create a higher risk profile for behavioral health challenges than the nation
 - i. Front-line healthcare workers
 - ii. Children out of school
 - b. Increase prevention & promotion activities to mitigate COVID-19 impacts on behavioral health



Prevention & promotion | Prevention of socioeconomic strains in Kansas can help improve correlated behavioral health outcomes

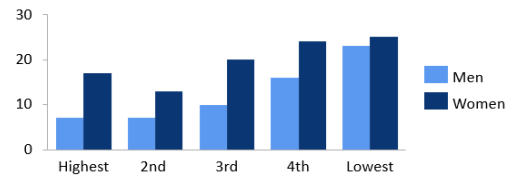
KS ranks 22nd nationally in Economic Hardship Index¹ which measures key socioeconomic measures

As of Dec. 2020 *Indicates KS is less healthy; Indicates KS is healthier*

- 
Percent of households **unable to provide food** due to lack of resources
vs. **11.4% NE**; **9.2% IA**; **11.7% nationally**
- 
Percent **unemployed** civilian population (ages 16-64) – down from 12% at beginning of pandemic
vs. **3.4% NE**; **3.9% IA**; **4.6% nationally**
- 
Per capita income (inflation adjusted)
vs. **\$33.3k NE**; **\$33.1k IA**; **\$35.7k nationally**
- 
Percent of children with **adverse childhood experiences**
vs. **15.3% NE**; **16.7% IA**; **14.7% nationally**

Socioeconomic factors are direct determinants of behavioral health outcomes

Prevalence of any mental illness (AMI) by household income % of general population



Additionally,

- Financial stress increases the risk of family violence by **up to 50%**
- Youth in low socioeconomic households are **2.5 times** more likely to have **depressed mood or anxiety**
- Children of mothers with mental ill-health are **5 times** more likely to have **mental disorders**

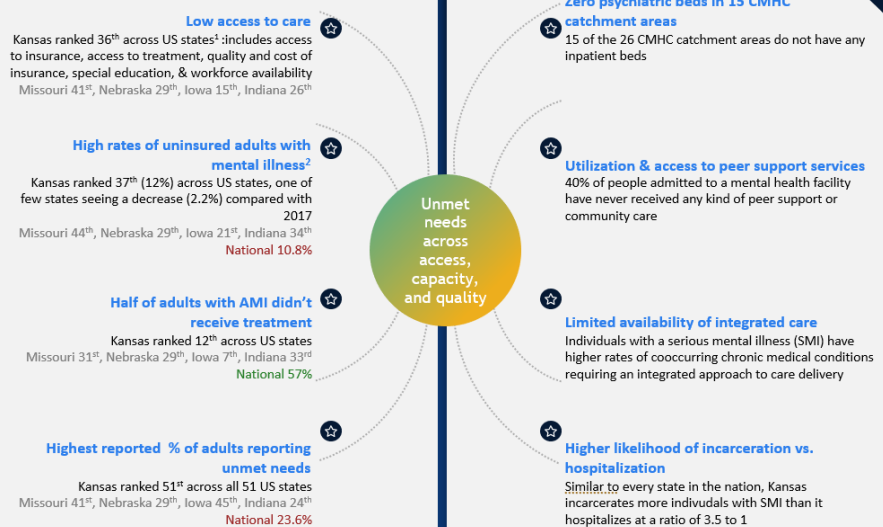
1. Normalized index score measuring education, income, poverty, unemployment, crowded housing and dependency measures
Sources: America's Health Rankings 2020 Report, all figures as of Dec 2020; Expert Interviews; CDC, WHO Social Determinants of Behavioral Health 2007

(2) Treatment

- a. High level of unmet needs across all Kansans driven by challenges in affordability, care availability, and integrated care (e.g., handoff between primary care systems and behavioral health systems)
 - i. Diverting crisis response from law enforcement
 - ii. Long wait times for hospitals & crisis response
- b. Increase capacity of care to accommodate further increase in in-patient care; expand/optimize existing in-patient network




Treatment | Examples of Kansas treatment needs span across access, capacity, and quality



(3) Rehab & Recovery

- a. High psychiatric readmission rates; inconsistent transition management, quality of care, and re-integration support for rehab & recovery patients
 - i. Long wait times for recovery services
 - ii. High cost of care
- b. Increase capacity of care

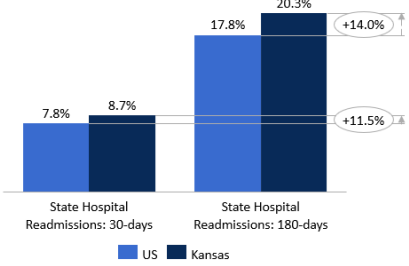
BCG presentation of KDADS Needs Assessment, March 2021, slide 31

Rehab & recovery 

Rehab & Recovery | Existing system of care need to be enhanced across transition, quality, and re-integration to reduce hospitals readmission and meet individual needs

Kansas has ~10-15% higher psychiatric hospital re-admission rates than the national rate

While Kansas' state and private psychiatric hospitals are exempt from readmission penalties, readmission increases cost of care



Readmission Period	US Rate	Kansas Rate	% Increase
State Hospital Readmissions: 30-days	7.8%	8.7%	+11.5%
State Hospital Readmissions: 180-days	17.8%	20.3%	+14.0%

1. Nursing Facilities for Mental Health Funded
Source: [KHN](#); SAMHSA URS FY19; DRC Kansas

31

Optimized rehab & recovery care are paramount to reduce hospital readmission and meet individual needs

- Transition management**
 - Limited staff responsible for discharge planning, compounded by lack of clear guidelines; only 9% of interviewed NFMH¹ residents had a discharge plan
- Quality of care**
 - Insufficient funding for community-based and peer support services; e.g., only 1 ACT team
- Re-integration**
 - Limited use of Recovery Oriented Systems of Care (ROSC) including, but not limited to, housing & employment support

In an effort to address the needs identified by BCG, Kansas is utilizing Block Grant additional funding for Prevention, Treatment, and Recovery activities including Social Determinants of Health.

Examples include Prevention activities, supplementing the CCBHC expansion recommended by the Kansas Legislative Special Committee on Mental Health Modernization and Reform, and targeted funding towards Assertive Community Treatment (ACT) teams, Assisted Outpatient Treatment (AOT) expansion, the 988 hotlines, and the Stepping Up Initiative.

The Stepping Up Initiative is a national partnership between The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation. The initiative aims to reduce the number of people in jail as a result of their mental illness. Kansas just launched (January 2021) the technical assistance project for the Stepping Up initiative to inspire counties to become Stepping Up communities. The goal of this project is to facilitate better solutions for linking people with mental illness to treatment and services while improving public safety.

Other examples include discharge planning and supplementing housing and employment programs like IPS, Oxford housing, Housing First and Employment First. Additional funding is also directed toward inpatient and outpatient treatment including medication-assisted treatment (MAT). Kansas will be implementing reimbursement codes for alcohol use disorder MAT.

State Data and Resources

To further identify unmet service needs and critical gaps within the current Behavioral Health system in Kansas, KDADS heavily relies upon resources such as the state mental health data system called AIMS, the state substance use treatment data collection system called KSURS, and the Governor’s Behavioral Health Services Planning Council and subcommittees.

Automated Information Management System (AIMS)

Community Mental Health Centers (CMHCs) provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. The Automated Information Management System (AIMS) is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Per the State Automated Information Management System (AIMS), CMHCs served over 144,000 consumers during the past two fiscal years as the table below indicates.

State Fiscal Years	Adults (over 18)	Children/Youth (under 18)	Total Consumers Served
2020	102,527	42,434	144,961
2021	103,538	41,020	144,558

KSURS

In October 2018, the Kansas Department for Aging and Disability Services (KDADS) determined that the antiquated substance use disorder treatment data collection system called Kansas Client Placement Criteria (KCPC) could no longer be supported by the state and ended the transmission of client records. In addition to assessment and authorization of services, a critical function of the KCPC was the collection of admission and discharge data for SAMHSA’s Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMs).

While the state continues to explore a range of options to replace the KCPC system, all Kansas substance use treatment providers who accept public funding are required to collect and submit TEDS data to the new Kansas Substance Use Reporting Solution (KSURS). Providers have two options to submit data to KSURS: 1) manually enter treatment information through an online application; or 2) submit a bulk load in a file format provided and validated by the state.

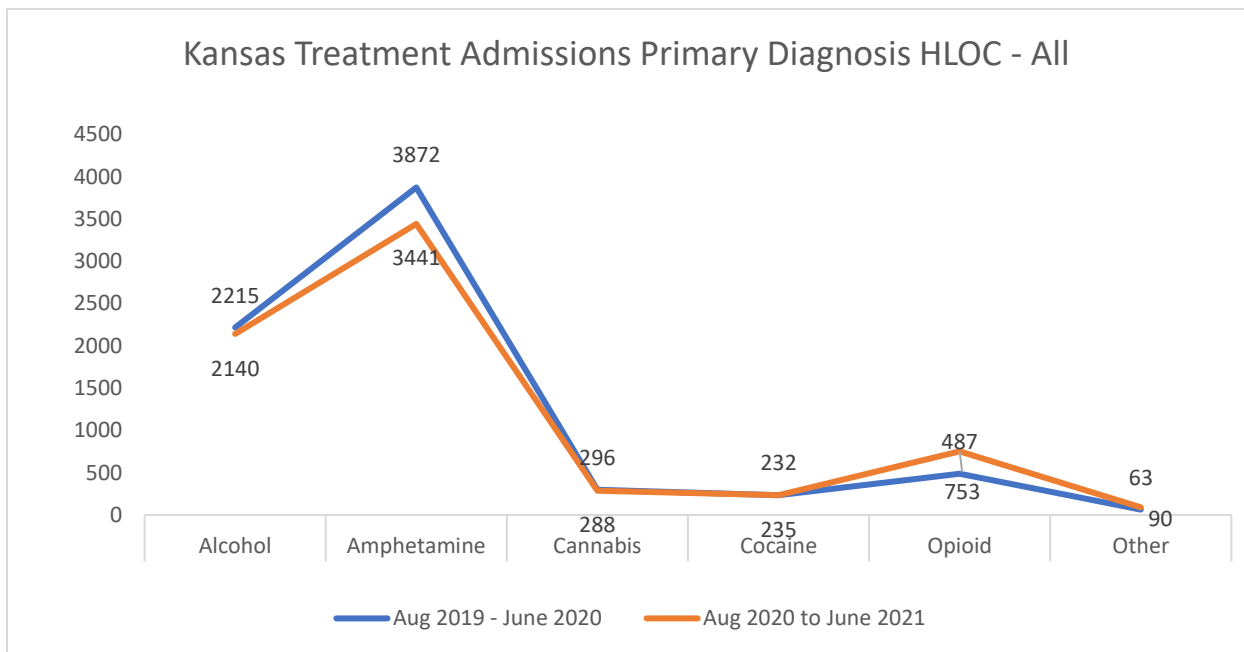
Through a Request for Proposal process, KDADS is working on a solution to modernize its substance use disorder data collection system. The RFP includes a comprehensive upgrade of IT systems at all four State hospitals both from the infrastructure and software perspective. The State is currently in the process of reviewing proposals and selecting a vendor.

Administrative Services Organization (ASO)

To identify unmet service needs and critical gaps within the current Block Grant substance use disorder treatment system, KDADS relies primarily upon data reported by the Administrative Service Organization (ASO) or Beacon HealthOptions with whom KDADS contracts to administer SAT Block Grant funds to providers. SAMHSA staff were onsite in May 2018 for a 10-year comprehensive review. The Center for Substance Abuse Treatment (CSAT) commented in the exit interview that a strength for the State is the strong relationships Kansas has formed between the State, the ASO, and SUD providers. CSAT reviewers were also impressed with the wealth of data the ASO provides the State.

Utilizing a combination of funding sources (SAT Block Grant, State general funds, and State fee funds), 13,418 people (unduplicated) received treatment services under the substance use disorder block grant in state fiscal year (SFY) 2020. For SFY 2021 (7/1/20 – 6/30/21), 9,145 people received treatment services. The reduction in people served can be contributed to COVID-19 impacts. Examples include court closures resulting in reduced number of no referrals, facility closures for cleaning due to staff or patient illness, residential centers reducing people to one per room versus two to accommodate social distancing, and workforce shortages. The primary reason people access Block Grant treatment services in Kansas (both inpatient and outpatient treatment levels of care) is for amphetamine dependency.

Upon request from the SEOW and using treatment data from the ASO, the following graph displays the primary diagnosis for residential levels of care admissions since August of 2019.



Governor’s Behavioral Health Services Planning Council (GBHSPC)

In Kansas, the Governor’s Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of behavioral health consumers, family members of behavioral health consumers, behavioral health service providers, state agency staff, and private citizens. The

Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' behavioral health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

The values of the GBHSPC is prevention, treatment, and recovery services:

- Allow people to direct their care and treatment;
- Are respectful and empowering;
- Are effective and influenced by evidence-based practices that lead to a personal process of recovery and resilience; and
- Are integrated, flexible, and accessible.

SAMHSA was onsite in May 2018 for a 10-year comprehensive onsite review. The SAMHSA Lead on the Review indicated onsite that Kansas has one of the best planning councils in the country.

There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Supportive Employment and Vocational Services 8) Service Members Veterans and Families 9) Evidence-Based Practices 10) Aging and 11) Problem Gambling.

Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees. The Subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as the Secretaries of relevant state agencies. The subcommittees reviewed draft sections of the FFY 2022-2023 Block Grant Applications and provided written feedback to the State.

Subcommittee Reports and Recommendations

The GBHSPC's annual subcommittee's charter, bylaws and reports can be found on the KDADS website at this link: <https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc>. For more information, please click on the embedded subcommittee links to expand.

- **Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC)**
The Kansas Citizen's Committee on Alcohol and Other Drugs has been in existence for many years and is statutorily required. K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A.'s 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas.

The Kansas Citizen's Committee also functions as the Quality Committee for KDADS substance use disorder treatment data submitted by the health plans to the State for Medicaid and the Block Grant.

➤ Children's subcommittee

The Children's subcommittee is dedicated to maintaining the community-based family driven values of the Kansas children's public mental health system of care. The subcommittee makes recommendations to improve the Kansas public mental health system and ensure the needs of children and families are met. In the subcommittee's 2020-2021 goals for work they considered many possible topics and areas of inquiry and research including workforce concerns, impact of COVID, gaps in services, data needs and gaps, child and caregiver engagement, and coordination of our work with other subcommittees and groups. Ultimately, three topics were selected for goal focus: Behavioral Health Telehealth, Behavioral Health Impact and Learning from COVID, and Racial Disparities in Behavioral Health. They have also committed to continuing the role as the advisory group for the KS Kids Map project. Using these topics as a guide, they developed the following goals for work during the 2020-2021 (state fiscal) year:

- 1) BEHAVIORAL HEALTH TELEHEALTH: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.
- 2) BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID: The impact of COVID has affected children and families differently. A closer look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.
- 3) RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas. a. Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.
b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.
- 4) KSKidsMAP Project: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

➤ Housing and Homelessness subcommittee (HHS)

The Housing and Homelessness Subcommittee (HHS) focuses on helping adults experiencing severe and persistent mental illness and children diagnosed with severe emotional disturbance and their families obtain and maintain safe, decent, affordable, and permanent housing. The HHS acts as the body in Kansas who offers guidance and recommendations to the Governor's Behavioral Health Services Planning Council and to KDADS, so they can effectively exercise leadership in this arena.

➤ Justice Involved Youth and Adult subcommittee

The Governor's Behavioral Health Services Planning Council's Justice Involved Youth and Adult Subcommittee is a group of stakeholders and forensic professionals charged with examining pertinent issues in Kansas as they pertain to the justice involved population. The Justice Involved

Youth and Adult Subcommittee prioritizes its goals and activities around transforming mental health policies, programs, and funding that address jail diversion, access to timely and appropriate services while incarcerated, and reentry.

➤ Supportive Employment and Vocational Services subcommittee

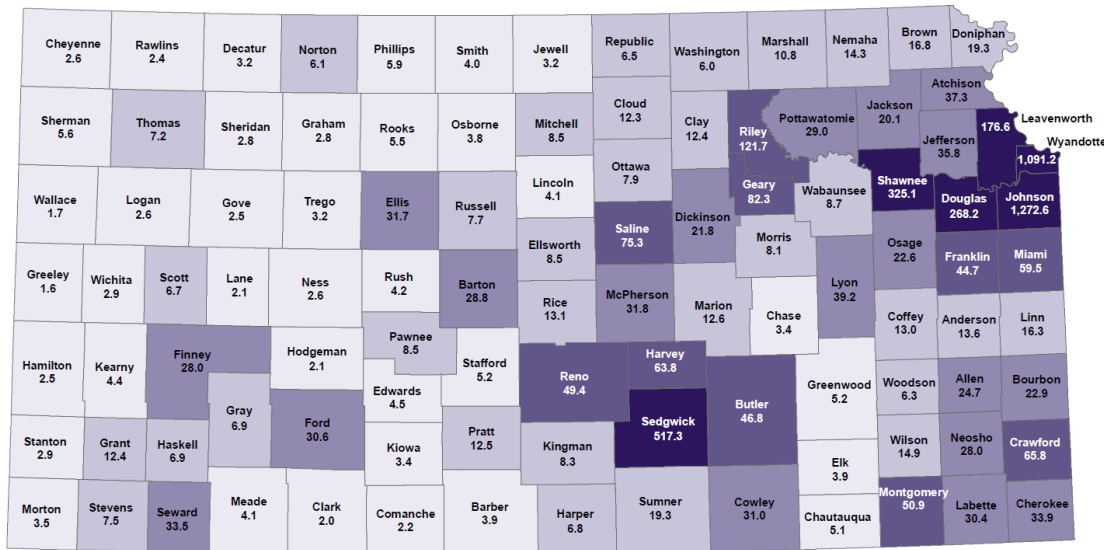
The Vocational Subcommittee evaluates outcomes to discover areas in which the system is doing well and where it can improve. It also makes recommendations on where to focus funding for vocational programs.

➤ Rural and Frontier Subcommittee

The Rural & Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, [the committee] assures accessibility/availability of mental health services in frontier/rural Kansas counties. The vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in mental health services. Rural issues are often misunderstood, minimized and not considered when forming mental health policy.

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

Population Density Classifications in Kansas by County, 2019



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2019.

Population Density by Classification* (persons per square mile)

State: 35.6

- Frontier (less than 6.0 ppsm)
- Rural (6.0 - 19.9 ppsm)
- Densely-settled Rural (20.0 - 39.9 ppsm)
- Semi-Urban (40.0 - 149.9 ppsm)
- Urban (150.0 ppsm or more)

* Kansas Department of Health and Environment classifications.

➤ Service Members Veterans and Families (SMVF) subcommittee

The SMVF subcommittee's mission is to ensure that veterans, service members and their families are involved in developing recommendations to improve access to behavioral health services which are relevant to military culture in collaboration with key provider organizations and other stakeholders.

According to the history section of the 2018 Veteran's subcommittee annual report, this subcommittee reactivated in June of 2017. The state was divided into five regions with a designated mental health facility as the lead in that region. The plan of the subcommittee was to identify members in those five regions to help accomplish their goals. Many of the subcommittee members received training from SAMSHA technical assistance program for strategic planning in September 2017. From that training the committee established goals to identify quality resources for veterans, their families and children across the state. this subcommittee was comprised of the chair, co-chair and 16 members from across the state.

SAMSHA technical assistance personnel came to Topeka for the Mayor's Challenge Site visit on August 30th and 31st [2018] to provide attendees training to identify other key players, set goals and objectives, implement strategies, identify other agencies to partner with etc. The training had representatives from the Topeka Police Department, Valeo, VA Eastern Kansas, State of Kansas, City of Topeka HR and Municipal Court and the Shawnee County Suicide Prevention Coalition. Once the Topeka Coalition was established, the goal was to expand this prevention/education effort to other cities in the state.

➤ Prevention subcommittee

The Prevention Subcommittee serves as a broad, representative voice for behavioral health as it relates to prevention of a range of health and behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder across the lifespan. The Prevention Subcommittee will serve as the Advisory Council for Kansas Behavioral Health Prevention Initiatives and will provide feedback and guidance to the Governor's Behavioral Health Services Planning Council. In FY2021, the Subcommittee has focused on increasing Youth Voice in its monthly meetings and has invited content specialists to increase Subcommittee awareness and education on Zero Suicide, SBIRT, and a health promotion campaign for men.

The Subcommittee is currently making updates to the Kansas Behavioral Health Prevention Plan. The Subcommittee uses the Strategic Prevention Framework (SFP) to guide the data-driven selection of behavioral health priorities for the State using the comprehensive Kansas Behavioral Health Profile.

A workgroup of the Prevention Subcommittee recently completed updates to the Kansas Suicide Prevention Plan (2021-2025). The Evidence-Based Strategies Workgroup has also developed an EBS Matrix of strategies to assist stakeholder in selecting appropriate prevention strategies.

FY2022 recommendations are to:

- 1) improve shared access to data resources among state agencies and planning council subcommittees,

- 2) provide better coordination of efforts and care transitions of behavioral health services, and
- 3) allocate resources to prioritized areas of need including:
 - a) additional prevention strategy implementation.
 - b) continue funding for the implementation of 988.
 - c) hiring a centralized epidemiologist to compile behavioral health needs assessment data gathered by all State Departments.

New GBHSPC Subcommittees

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

➤ Aging subcommittee

This subcommittee was identified and met for the very first time about a week prior to COVID-19 announcements. The participants looked at prior recommendations from the previous committee and determined most are still relevant. The main themes that were discussed at this meeting were about the following:

- The concern with the growth of the aging population in the next 15-20 years and the impact that will have on needs, services
- Rate of substance abuse is relatively high among this population
- May be difficult to place those in NFMH's and jails and particularly those with medical issues
- Rate of suicide is relatively high for this population
- Lack of workforce specialized in working with this population
- Mobility and accessibility to care issues
- Direct correlation between substance abuse, mental health and problem gambling

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

➤ Evidence-Based Practices subcommittee

The Evidence Based Practices (EBP) Subcommittee goal is to provide a framework

- for learning from other Council Subcommittee representatives, state stakeholders, providers, consumers, and family members for which EBPs or other measurement-based modes of care are creating positive outcomes for consumers
- for sustainable technical assistance to providers so they can deliver the best practices (evidence-based practices with fidelity) chosen by the consumer

- for providers to become efficient and effective in person-centered, value-based care provision
- for providers in measuring the value of care provision from the standpoint of structure, process, and impact of care provision
- Managed Care Organizations (MCO) support of training and fidelity review for their provider network as required by their contracts

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

➤ Problem Gambling

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

A brief description of other data sources available within the state and drug-related concerns are described below:

Kansas Annual Summary of Vital Statistics, 2019

The Kansas Annual Summary of Vital Statistics, 2019 report by the Kansas Department of Health and Environment is found at this link: https://www.kdheks.gov/phi/as/2019_Annual_Summary.pdf

According to the report, there were 27,312 Kansas resident deaths recorded in 2019, an increase of 0.4 percent from the 27,213 deaths recorded in 2018. The average age at death of Kansas residents in 2019 was 74.5 years, an increase of 0.3 percent from 74.3 in 2018. In the report, the ten leading causes of death in Kansas remained unchanged from 2018 to 2019, though their order changed in some cases.

Kansas recorded 521 resident suicide deaths in 2019, down 6.1 percent from 555 suicide deaths in 2018. The suicide age-adjusted death rate decreased from 19.2 deaths per 100,000 population in 2018 to 18.1 deaths per 100,000 population in 2019. Although the single-year change in rate was not statistically significant, the 2019 suicide rate was one of the three highest in the last twenty years.

Almost four-fifths (79.5%) of suicide victims were male. The three age groups with the largest number of suicides were 35-44 (106 deaths), 25-34 (104 deaths), and 15-24 (83 deaths). The three most common methods of suicide were firearms (290 deaths), suffocation (143 deaths), and poisoning (60 deaths).

Kansas Behavioral Health Indicators Dashboard

The Kansas Prevention Collaborative Behavioral Health Indicators Map presents summarized data for several Behavioral Health indicators prioritized by the Kansas Behavioral Health Services Planning

Council Prevention Subcommittee. The Kansas BH Indicators Dashboard was created and managed by a contractor, Greenbush or the Southeast Kansas Education Service Center.

The online dashboard is available at the following link: <http://kbhid.org/>.

The public can access Kansas data for a wealth of indicators on the following topics: Income/Poverty, Crime, Depression/Suicide, Problem Gambling, Family Functioning, Substance Use, Problem Gambling Treatment, Substance Use & Treatment, and Mental Health and Treatment. Substance Use & Kansas Substance Use and Treatment data that can be accessed on the site include needing but not receiving treatment for alcohol abuse, primary admissions by drug (alcohol, marijuana, opiates, tranquilizers, cocaine, methamphetamine, etc.), opioid prescribing rates, needing but not receiving treatment for illicit drug abuse). A screen shot of the dashboard is displayed below:



SABG Priority Populations

Beacon, the Administrative Services Organization, provides a vast array of reports for the SUD Block Grant including utilization reports, financial, adverse incident, appointment access, and diagnosis trends among others. Reports specific to priority populations include an Interim Services report and a Designated Women's Facility Report.

The Interim Services report provides quarterly and year-to-date data on modalities (crisis intervention, peer support/peer mentor, case management, and those admitting to a lower level of care than recommended) both number of people needing and number receiving services. The report breaks the information down into regional and priority populations (pregnant women, IV drug users, and all other SUD members).

Peer Mentors, as research has shown, increase the likelihood of people in treatment maintaining their recovery early in the process and are less prone to relapse. If relapse occurs when a Peer Mentor is providing support, the relapse is less severe and shorter. In addition, mentoring people also helps the Peer Mentor maintain their own recovery.

The Designated Women’s Facility report is also a quarterly report to the State. Women with children, Pregnant Women and total categories are reported. Women’s treatment is drilled down into data such as those not recommended for treatment and total that are recommended and then into modality of treatment. Total admitted to DWF by modality are also reported.

The Kansas Department for Aging and Disability Services (KDADS) continues to work towards ensuring priority populations including Pregnant and Parenting Women, Injecting Drug Users and Persons at risk for tuberculosis access timely treatment. Ideally, we need to be able to get patients assessed and in treatment when they present in order to best engage individuals (including priority populations) into treatment services. The ASO is contractually required to manage a waitlist to help ensure timely access to inpatient treatment for all individuals with substance use disorder. The priority populations are monitored and tracked separately. Beacon reports regularly to KDADS on any members waiting to include priority populations. Barriers to timely treatment for priority populations are similar to those of other individuals with substance use disorder such as behavioral health workforce shortage issues and the lack of some modalities of service especially in the rural and frontier areas.

Behavioral Health Workforce

Per the Behavioral Sciences Regulatory Board (BSRB) website (<https://ksbsrb.ks.gov/about-us/mission-hist>), the BSRB was established in 1980 to license and regulate psychologists and social workers in Kansas. It took over the responsibilities of the State Board of Examiners of Psychologists and the Board of Social Work Examiners. Those responsibilities have increased over the years to include the following licensed professionals: Addiction and other Professional Counselors, Marriage & Family Therapists, Psychologists, and Social Workers.

Consistent with national trends, Behavioral Health workforce shortages in Kansas impact the Behavioral Health system on many levels. KDADS will continue to work with external partners to recruit and train more Behavioral Health professionals to meet systemic needs.

2021 Midwest HIDTA Threat Assessment

Funded by the Office of National Drug Control Policy, the 2021 Midwest High Intensity Drug Trafficking Area (HIDTA) Threat Assessment report identifies current and emerging illicit drug trends within the region’s seven-state area. According to the report, “the Midwest HIDTA assesses methamphetamine as the region’s greatest drug threat when considering its nexus to violence and other criminal activity. This is evident in both of the Midwest HIDTA’s Law Enforcement (LES) and Public Health Surveys (PHS). Heroin/synthetic opioids and marijuana are the region’s second and third-greatest drug threats, respectively. A higher percentage of drug trafficking organizations (DTOs) were found to be gang-related, violent, and poly-drug trafficking in 2020 compared to the previous year. The Midwest HIDTA’s central location within the continental United States (U.S.) and extensive network of roadways make the region ideal for DTOs and criminal entrepreneurs intent on moving drugs into or through to other destinations.”

Further, the Executive Summary Overview states “a description of the drug and DTO threats facing the Midwest HIDTA region include, but are not limited to, the following:

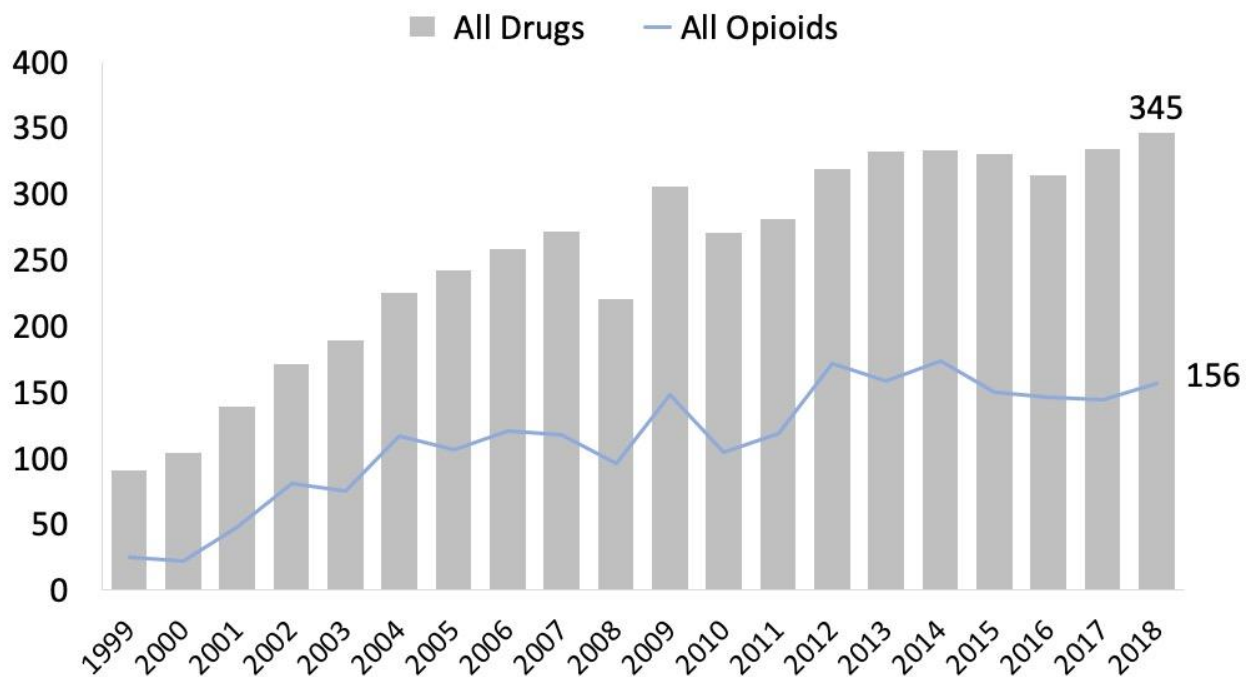
- Marijuana, methamphetamine, and heroin/synthetic opioids are the most widely available and widely used drugs in the Midwest region.
- Law enforcement and public health agencies report unprecedented levels of fentanyl and other synthetic opioids in the region’s illicit drug supply. Fatal and non-fatal drug overdoses have surged as a result.

- Privately owned vehicles, the United States Postal Service (USPS), and commercial parcel services (e.g. FedEx, UPS) are the most common methods used by DTOs to traffic drugs into and throughout the Midwest region. The number of seizures in which mailing services were used to traffic drugs into the Midwest HIDTA doubled from 2019 to 2020.
- Midwest HIDTA law enforcement initiatives documented 770 DTOs operating within the region in 2020, with 7,733 members and 1,178 leaders identified. This is a 21 percent increase from the 638 DTOs identified in 2019.
- Mexican DTOs continue to dominate virtually every aspect of the drug trade across the Midwestern U.S.
- DTOs in the Midwest HIDTA have adopted novel technologies to facilitate communication, obtain payment, and monitor courier location. These platforms include encrypted messaging applications, social media, portable GPS devices, and the dark web.
- Nearly 70 percent of Midwest HIDTA law enforcement initiatives reported that DTOs engaged in money laundering activities that were separate and distinct from independent money laundering organizations (MLOs).
- The Midwest HIDTA experienced a three percent increase in drug-related overdose fatalities from 2018 to 2019, the most recent year for which data is available.”

National Institute on Drug Abuse (NIDA)

In reviewing the Kansas Opioid Summary ([Link](#)) by the National Institute on Drug Abuse (NIDA), the most recent data available is currently from 2018 with 2019 data usually being released in early 2021. In 2018, Kansas providers wrote 64.3 opioid prescriptions for every 100 persons compared to the average U.S. rate of 58.7—a 20% decrease compared to 2011.

Also, according to NIDA and displayed in their graph below, in Kansas, about 45% of the 345 drug overdose deaths involved opioids in 2018—a total of 156 fatalities (a rate of 5.7) (Figure 1).



NIDA's National Drug Early Warning System (NDEWS), which tracks drug trends in sentinel sites across the country, found that treatment admissions for methamphetamine as the primary substance of use were less than one percent in sites east of the Mississippi River, but ranged from 12-29 percent in the sites west of the Mississippi ([Link](#)). Nationwide, overdose deaths from the category of drugs that includes methamphetamine increased by 7.5 times between 2007 and 2017. About 15 percent of all drug overdose deaths involved the methamphetamine category in 2017, and 50 percent of those deaths also involved an opioid.

State Opioid Response (SOR) grant

Kansas has received State Targeted Response (STR) or State Opioid Response (SOR) grants since 2017 to assist in addressing the opioid crisis. Illicit opioid use and related deaths continue to be a concern with 320 deaths from opioids reported in 2020. Kansas is using the SOR funding to invest in expanding access to treatment, particularly evidence-based treatment, and to reduce the number of opioid and stimulant related deaths across the state. KDADS' Behavioral Health Commission oversees and monitors grant activities. KDADS is using SOR award funding to provide medication-assisted treatment (MAT) services to uninsured patients in Kansas. Currently, there are around 40 grantees across the state providing treatment services for Kansans in all 105 state counties, including rural and frontier areas, as well as, urban areas. Treatment service providers are diverse and range from a university medical center to substance use disorder treatment providers, methadone clinics, regional alcohol and drug assessment centers, and community mental health centers. Areas of unmet service need and critical gaps include the location and number of medication-assisted treatment providers and/or methadone clinics primarily in the rural and frontier areas of the state.

As opioid addiction increases in Kansas, treatment providers available to offer medication-assisted treatment has also increased. KDADS conducted a gap analysis to determine not only how many MAT providers were practicing in Kansas, but how far patients were required to travel to receive services. Although there is still work to be done, we are headed in the right direction. In 2018, twenty (20) counties or 19% of Kansas had a local MAT provider. Currently in 2021 after conducting a gap analysis, forty-three (43) counties or 41% of counties have a local MAT provider within their county. The 22% increase over three years is due in part to the collaborative work of many partners and collaborations like the Kansas Prescription Drug and Opioid Advisory Committee, Governor's Behavioral Health Services Planning Council and subcommittees, State grantees of Federal grants, State agencies, providers, and other stakeholders.

When looking at the 2020 census population of the state as a whole and comparing it to the population in each county that has a local provider, we found that 80.3% of Kansas residents have a local MAT provider in their county.

Medication-Assisted Treatment (Alcohol)

Under the Block Grant, Kansas has not had the funding to implement medication-assisted treatment for alcohol use disorder. With the supplemental dollars Kansas is receiving through the Block Grant COVID Funding, Kansas is working on implementing reimbursement codes to providers for MAT for Alcohol. Alcohol is the second leading diagnosis people seek treatment for under the Substance Abuse Block Grant in Kansas after methamphetamine so the additional funding will positively impact many people we serve and hopefully save lives and reduce recidivism.

Tobacco Cessation treatment for people with Behavioral Health conditions

According to the Centers for Disease Control and Prevention ([Link](#)), despite significant progress, tobacco use remains the leading preventable cause of death and disease in the US. Further, nearly 25% of adults in the United States have a mental health or substance use disorder (i.e., behavioral health condition), and these adults consume almost 40% of all cigarettes smoked by adults in the United States. The CDC also states that people with behavioral health conditions die about five years earlier than people without such conditions, more than 50% from tobacco-attributable diseases.

According to the Kansas Annual Summary of Vital Statistics, 2019 report by the Kansas Department of Health and Environment ([Link](#)), tobacco use contributed to 4,793 deaths in Kansas in 2019 (25.1 percent of the deaths where the tobacco contribution was known and reported on the death certificate). Tobacco use was a contributing factor in 30.5 percent of male deaths, and in 20.0 percent of female deaths. The causes of death showing the largest tobacco contribution were cancer of the trachea, bronchus and lung (86.6%), chronic lower respiratory disease (83.7%), ischemic heart disease (35.2%), and diabetes mellitus (28.9%). (Table E21) Physicians and coroners can state on the death certificate whether tobacco contributed to the death. Because information may not be available at the time the death certificate is completed, tobacco's contribution may be subject to some under-reporting.

Until the recent infusion of additional Federal Block Grant dollars, Federal Block Grant funding for behavioral health treatment needs for the uninsured/underinsured remained at the same level for many years and exceeded the allotted Federal Block Grant funding. Kansas has supplemented the funding using a combination of funding sources including State General funds and State Fee funds from the Problem Gambling and other addictions funds. Kansas Behavioral Health providers have been very creative in their approach to address the physical health needs of those they serve, however, unmet service needs around tobacco cessation exist including: 1) Tobacco cessation is not covered by the Block Grant but is by Medicaid 2) Medicaid reimbursement for both medication and counseling reported as insufficient by behavioral health providers and 3) Expanding the trained tobacco cessation workforce.

Kansas State Opioid Response

Tobacco cessation opportunities are included in the SOR grant as an optional activity. KDADS has offered two Requests for Applications (RFA) to integrate tobacco cessation treatment into the treatment of those with opioid/stimulant use disorders. A person with a substance use disorder who can quit using tobacco products, may greatly increase the odds of long-term recovery from substance use disorder (SUD) and have physical health benefits that begin almost immediately for smokers and continue for years to come. Use of tobacco products may interfere with the metabolism of prescribed psychiatric medications. Eliminating tobacco allows people to reduce their symptoms by taking lower levels of medication. Tobacco cessation also increases a person's sense of mastery and helps them focus on a positive and healthy lifestyle. Treatment providers may use funds to implement a smoke-free facility to benefit both clients and staff.

KDHE Kansas Tobacco Use Prevention Program

The Kansas Tobacco Use Prevention Program (<https://www.kdheks.gov/tobacco/index.html>) provides resources and assistance to state and local partners for development, enhancement and evaluation of state and local initiatives to prevent death and disease from tobacco use and secondhand smoke exposure.

The program focuses on four priority areas: 1) Preventing the initiation of tobacco use among young people, 2) Promoting quitting among tobacco users of all ages, 3) Eliminating nonsmokers' exposure to secondhand smoke, and 4) Identifying and eliminating disparities related to tobacco use and its effects among different population groups. Strategies include The Kansas Tobacco Quitline - a special program for pregnant smokers and smokers with mental illness or addiction.

NAMI Kansas has provided several trainings throughout the state to providers and other stakeholders on smoking cessation resources including Tobacco Guidelines for Behavioral Health Care: <https://namikansas.org/resources/smoking-cessation-information/?nowprocket=1>

One major outcome of the work so far has been the creation of the Kansas Tobacco Guideline for Behavioral Health Care. The Guideline was created as a roadmap for behavioral health providers to support Kansans motivated to end their dependence on tobacco products.

Problem Gambling Strengths and Needs

The Kansas gambling industry is represented by four state-owned casinos, five tribal casinos, charitable gaming and the Kansas Lottery. The first gambling prevalence study of gambling behaviors and attitudes in Kansas was conducted in 2012. The main purpose of this survey was to estimate the scope of at-risk gambling statewide and within defined gaming zones. The results of this study provided information about problem gambling awareness, attitudes toward gambling and problem gambling services, and information about how problem gambling is impacting Kansans. Survey findings are useful to State agencies and other stakeholders in efforts to mitigate gambling related harm.

The survey found that 75% of survey respondents gambled in the past year including 35% who played casino machine games such as slot machines, suggesting the rate of casino visitation among survey respondents is at least 30% higher than the national average. Similar to most U.S. states, almost half of respondents (45%) played lottery games in the past year. When recent gamblers were asked if they thought they had a gambling problem, one percent said that “most of the time” they feel they “have a problem with gambling,” and six percent said “sometimes.” The consequences of problem gambling can be emotional, physical, and financial. These consequences can extend to the friends, families, co-workers and even the employers of those affected. About 26% of survey respondents said they have been personally affected by the gambling of others.

Forty four percent of respondents gambled in the past 30 days. A series of nine problem gambling screening questions were asked of this group. Approximately 19 % of this group responded yes to at least one of these nine questions. Positive endorsement of just one problem gambling screening question suggests the person is at heightened risk for developing a gambling problem. Several links were found between casino patronage and problem gambling risk. About one fifth (21%) of respondents who endorsed casino machine games (slots, video poker, etc.) as their favorite form of gambling also replied “yes” to at least one problem gambling screening question. About one-third (32% of respondents that patronized a casino in the past 30 days) endorsed one or more problem gambling screening questions suggesting a large portion of casino gamblers are at heightened risk of having a gambling disorder or developing one. Also, there is a strong correlation between endorsing problem gambling screening questions and membership in casino groups. More than one third of all respondents who were casino club/program members may be considered at heightened risk for manifesting or developing a gambling problem.

Many subgroups of the population have problem gambling prevalence above the adult average, including adolescents, African-Americans, individuals who are Hispanic, Asians, American Indians, lower socioeconomic groups, men, those with substance use and mental health co-morbid conditions, military, college students and casino workers. The impact of problem gambling on the elderly is also an area of attention. The African American community appears to be impacted more by problem gambling than other ethnic groups. One in five African American survey respondents reported being personally affected by the gambling behaviors of a family member, a rate 60 % greater than among Caucasian survey respondents.

While most people who gamble do so without experiencing or causing harm, it is clear that a sizeable portion of respondents have been negatively impacted by problem gambling, and respondents showed widespread support to address the problem. Most respondents said they believe it is either “very important” or “important” to use public funds to make problem gambling treatment available and affordable (98%) and to educate young people in school about the risks of gambling (81%).

Aside from the adult prevalence study, Kansas has included eleven gambling specific question on the Kansas Communities that Care Youth Survey since 2007 and most recently two questions on the Kansas Young Adult (18 to 25-year-old) Survey. Seven percent of Kansas youth indicate they have gambled for money or something of value in the last 30 days. Every day in the past year, one percent of youth felt they would like to stop gambling but did not think they could. Over twelve percent of young adults indicate they have gambled for money or something of value in the last 30 days. Every day in the past twelve months, five percent of young adults felt they would like to stop gambling but did not think they could.

Stigma continues to remain a major barrier to people seeking treatment thus the need for statewide prevention, awareness and education. In 2007 the Kansas Legislature enacted the Problem Gambling and Addictions Grant Fund. Two percent of the monthly net revenue from the four state-owned casinos is deposited into this fund. Resources to fund problem gambling specific services are limited however as the funding allocated for these services have remained at less than ten percent of the total dollars deposited into this fund. The dollars that are allocated for problem gambling services are used statewide to provide treatment for problem gamblers and their concerned others, prevention resources, education and awareness, and research and evaluation. Kansas currently has forty-three state certified gambling counselors, two gambling prevention specialists and one program administrator.

HIV-designated state

Kansas is not a FY 2022 HIV-designated state.

Performance Indicators

KDADS has used the data and information provided in this planning step 2 to determine needs and gaps which has resulted in the following annual performance indicators: reduce underage drinking; reduce adolescent marijuana use; reduce vaping in adolescents and young adults; increase the number of prevention training in rural Kansas communities; provide access to community-based services for children/youth with SED allowing them to remain in their homes and communities with services and supports; provide access to community-based services for adults with SMI allowing them to remain in their homes and communities with services and supports; Recovery Oriented System of Care (Peer

Mentors); and expand access to youth experiencing their first psychotic episode and offer treatment and support within two years of the episode.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Provide access to community-based services for children/youth with SED 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 able to remain in home by building a community-based system of care to meet their needs.

Strategies to attain the goal:

Kansas does not implement any one strategy statewide. Continue to identify culturally-competent, person-centered services to meet the child's/youth's needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of children/adolescents, age 17 or younger, that received crisis intervention services (30) calendar days prior to a screen resulting in inpatient psychiatric admission, excluding PRTF.

Baseline Measurement: SFY2021 Baseline: 6.26%

First-year target/outcome measurement: SFY2022: Increase percentage to 10%

Second-year target/outcome measurement: SFY2023: Increase percentage to 15%

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System) AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of children/adolescents that received crisis services (30) calendar days prior to crisis screen resulting in admission within the reporting period. The following codes will be utilized: H2011, H2011-HK and/or H2011-HO (code numbers are subject to change by CMS)

Denominator: Number children/adolescents with a screen resulting in admission to inpatient within the reporting period.

Data issues/caveats that affect outcome measures:

This measurement relies upon contractor data, so ensuring that contractor's data is complete and accurate. For outcome measures, the social security number of children/youth needs to be included in our data and the data we receive from our vendor to verify that we are not duplicating counts.

Indicator #: 2

Indicator: The percentage of children/adolescents that received therapeutic intervention services (includes more than initial assessment and diagnosis such as Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, Therapy and/or Intake) within thirty (30) calendar days prior to a screen resulting in an inpatient psychiatric admission, excluding PRTF.

Baseline Measurement: SFY2021 Baseline: 13.91%

First-year target/outcome measurement: SFY2022: Increase percentage to 20%

Second-year target/outcome measurement: SFY2023: Increase percentage to 25%

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System) AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of children/adolescents receiving a therapeutic intervention within 30 calendar days prior to a screen resulting in admission within the reporting period. Service codes are as follows: 90791, H0036-HA, H0036-HB, H0036-HH, H0036-HJ, H0036-HK, H2017, H2017-HQ, H2017-TJ, H0038, H0038-HG, 90832, 90834, 90837, 90839, 90840, 90847, 90847HK, 90853, 90832, 90834, 90837, 90839, and/or 90840. (code numbers are subject to change by CMS)

Denominator: Total number of children/adolescents with a screen resulting in an inpatient psychiatric admission, excluding PRTF, within the reporting period.

Data issues/caveats that affect outcome measures:

The measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate. For future outcome measures, the social security numbers of children/youth needs to be included in our data and the data we receive from our vendor to verify that we are not duplicating counts.

Priority #: 2

Priority Area: Provide access to community-based services for adults with SMI 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 SMI are able to maintain community living and build a support system of care to improve their quality of life.

Strategies to attain the goal:

Kansas does not implement any one strategy statewide. Continue to identify culturally-competent, person-centered services to meet the person's needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults, age 18 and older, that received crisis intervention services (30) calendar days prior to a screen resulting in admission to a State Mental Health Hospital (SMHH) or State Hospital Alternative (SHA) as utilized by the Osawatomie Temporary Census Diversion Funds (OTCDF).

Baseline Measurement: FY2021 Baseline: 4.04%

First-year target/outcome measurement: FY2022: Remain static due to COVID at 4.04%

Second-year target/outcome measurement: FY2023: Increase percentage to 5.5%

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System) AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Description of Data:

Numerator: Number of adults that received crisis services within (30) calendar days of a crisis screen resulting in admission within the reporting period. The following codes will be utilized: H2011, H2011-HK and/or H2011-HO (code numbers are subject to change by CMS)

Denominator: Screens resulting in admission to inpatient within the reporting period.

Data issues/caveats that affect outcome measures:

This measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate. For future outcomes, the social security numbers of adults needs to be included in our data and the data we receive from the vendor to verify that we are not duplicating counts.

Indicator #:

2

Indicator:

The percentage of adults that received therapeutic intervention services (includes more than initial assessment and diagnosis such as Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, Therapy, and/or Intake) within seven calendar days of discharge from a State Mental Health Hospital (SMHH) or State Hospital Alternative (SHA) as utilized by the Osawatomie Temporary Census Diversion Funds (OTCDF).

Baseline Measurement:

FY2021 Baseline: 3.47%

First-year target/outcome measurement:

FY2022: Increase percentage to 4%

Second-year target/outcome measurement:

FY2023: Increase percentage to 6%

Data Source:

Contractor of the Crisis Triage & Screening (CTS) contract and AIMS (Automated Information Management System) AIMS is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by CMHCs to Kansans.

Description of Data:

Numerator: Number of adults receiving CSS services who had a therapeutic intervention within seven business days of discharge from a SMHH within reporting period. Services codes are as follows: 90791, H0036-HA, H0036-HB, H0036-HH, H0036-HJ, H0036-HK, H2017, H2017-HQ, H2017-TJ, H0038, H0038-HG, 90832, 90834, 90837, 90839, 90840, 90847, 90847HK, 90853, 90832, 90834, 90837, 90839, and/or 90840 starting seven calendar days from the day after discharge. However, if a CMHC provides one of these services the same day as discharge then that will count toward the seven days. (code numbers are subject to change by CMS)

Denominator: Total number of adult discharges from SMHH or SHA within the reporting period.

Data issues/caveats that affect outcome measures:

Measurement relies upon contractor data, so ensuring the contractor's data is complete and accurate. For future outcomes, the social security numbers of adults needs to be included in our data and the data we receive from our vendor to verify that we are not duplicating counts.

Priority #:

3

Priority Area:

Reduce underage drinking in Kansas

Priority Type:

SAP

Population(s):

PP

Goal of the priority area:

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

Strategies to attain the goal:

Kansas does not implement any one strategy statewide, rather community coalitions complete the planning phase of the SPF and utilize their needs assessment to create a logic model and identify strategies that will impact their specific community needs and capacity. All strategies must be evidence based. Kansas utilizes SAMHSA's definition of evidence-based when reviewing strategic plans.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator: On how many occasions, if any, have you had beer, wine, or hard liquor in the past 30 days? (at least once)

Baseline Measurement: State = 15.9%

First-year target/outcome measurement: State = 14.8 %

Second-year target/outcome measurement: State = 13.7%

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:

The survey requires written parent consent for participation which can put an added burden on school districts. Funded communities have a goal to achieve a 60 percent participation rate to ensure high quality data; if at time they are not at 60 percent they must create specific action plans designed to increase participation. Data collection during the 2020-2021 school year was challenged due to COVID -19, however Kansas was able to implement online survey and maintained high rates of participation. Some changes, including use of skip logic were made to the survey during this time. It is not yet clear how COVID and changes to the survey, including allowing remote administration have impacted the data, thus baseline for this data will be based on prior year (2020).

Priority #: 4

Priority Area: Reduce adolescent marijuana use in Kansas

Priority Type: SAP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

Kansas does not implement any one strategy statewide, rather community coalitions complete the planning phase of the SPF and utilize their needs assessment to create a logic model and identify strategies that will impact their specific community needs and capacity. All strategies must be evidence based. Kansas utilizes SAMHSA's definition of evidence-based when reviewing strategic plans.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: On how many occasions, if any, have you used marijuana during the past 30 days? (at least once)

Baseline Measurement: State = 6.8%

First-year target/outcome measurement: State = 6.3%

Second-year target/outcome measurement: State = 5.8%

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:

The survey requires written parent consent for participation which can put an added burden on school districts. Funded communities have a goal to achieve a 60 percent participation rate to ensure high quality data; if at time they are not at 60 percent they must create specific action plans designed to increase participation. Data collection during the 2020-2021 school year was challenged due to COVID -19, however Kansas was able to implement online survey and maintained high rates of participation. Some changes, including use of skip logic were made to the survey during this time. It is not yet clear how COVID and changes to the survey, including allowing remote administration have impacted the data, thus baseline for this data will be based on prior year (2020).

Priority #: 5
Priority Area: Reduce vaping in adolescents and young adults.
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Reduce percentage of students in ages 6, 8, 10, and 12 that report there is “no risk” of harm from taking one or two drinks of an alcoholic beverage nearly every day.

Strategies to attain the goal:

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. Kansas utilizes SAMHSA’s definition when reviewing individual strategic plans.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: How frequently have you vaped in the past 30 days? (at least once)
Baseline Measurement: State = 9.8%
First-year target/outcome measurement: State = 8.3%
Second-year target/outcome measurement: State = 6.8%

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:

The survey requires written parent consent for participation which can put an added burden on school districts. Funded communities have a goal to achieve a 60 percent participation rate to ensure high quality data; if at time they are not at 60 percent they must create specific action plans designed to increase participation. Data collection during the 2020-2021 school year was challenged due to COVID -19, however Kansas was able to implement online survey and maintained high rates of participation. Some changes, including use of skip logic were made to the survey during this time. It is not yet clear how COVID and changes to the survey, including allowing remote administration have impacted the data, thus baseline for this data will be based on prior year (2020).
The question wording changed from “electronic cigarettes” to “vaped” in 2021.

Indicator #: 2
Indicator: During the past 30 days, how frequency have you used electronic cigarettes of Juul? (at

least once)

Baseline Measurement: State = 29.0%

First-year target/outcome measurement: State = 28.0%

Second-year target/outcome measurement: State = 27.0%

Data Source:

Kansas Young Adults Survey (KYAS)

Description of Data:

The Kansas Young Adults Survey (KYAS) is a statewide survey administered online to individuals aged 18-25. The survey asks questions about attitudes and behaviors among young adults on public health issues, including the usage of tobacco and consumption of alcohol, prescription and non-prescription drugs, as well as gambling. Demographic questions include age, education, and income level and sources, among others.

Data issues/caveats that affect outcome measures:

The survey has been administered every other year and will use data from 2019 for baseline. The data is only available at a state level and thus prevention coalitions will not be able to measure local progress toward the goal.

Priority #: 6

Priority Area: Increase the number of prevention trainings in rural Kansas communities

Priority Type: SAP

Population(s): PP

Goal of the priority area:

KDADS would like to infuse more prevention knowledge and efforts into rural Kansas communities to increase rural coalition capacity to develop and implement strategic prevention plans.

Strategies to attain the goal:

Trainings will be held in rural communities and will focus on behavioral/mental health and substance use prevention for youth, young adults, school staff, and families.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of prevention trainings in rural Kansas communities

Baseline Measurement: State = Establish Baseline in 2022

First-year target/outcome measurement: State = baseline + 20

Second-year target/outcome measurement: State = first-year target + 10

Data Source:

Community Check Box

Description of Data:

Training data will be documented in the Community Check Box. Documentation will include a description of the training, dates, attendance, location if in-person or participant location if virtual, demographic rosters which include profession, age, gender, race/ethnicity, county, city.

Data issues/caveats that affect outcome measures:

Training contractors have not yet been selected so baseline is not able to be established this time. Performance estimates are based on desired targets across two years. Data quality in the Community Check Box will be dependent on complete and regular documentation. Training opportunities will be provided, but level of participation may not reflect desired outcomes. cannot be Participation in prevention training

Priority #: 7
Priority Area: Recovery Oriented System of Care
Priority Type: SAT
Population(s): PWWDC, PWID, TB

Goal of the priority area:

Kansas Behavioral Health System supports a recovery-oriented system of care.

Strategies to attain the goal:

Increase the peer mentoring workforce capacity.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of Kansas Certified Peer Mentors increase.
Baseline Measurement: Baseline in FY20 of 9 Peer Mentors
First-year target/outcome measurement: Increase Kansas Certified Peer Mentors by 10% in FY22.
Second-year target/outcome measurement: Increase Kansas Certified Peer Mentors by 10% in FY23

Data Source:

Adult Consumer Affairs tracking spreadsheet of the number of people trained to be Kansas Certified Peer Mentors and in-training Peer Mentors

Description of Data:

Peer Mentors in training and Peer Mentors certified

Data issues/caveats that affect outcome measures:

Training contractor reporting accuracy and timelines

Priority #: 8
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.

Strategies to attain the goal:

Identify opportunities to increase access to services for ESMI
Examine adequacy of ESMI-related service rates
Establish care coordinator 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 SFY21

First-year target/outcome measurement: 5% increase in number of youth experiencing ESMI served with Block Grant funded intervention in SFY22

Second-year target/outcome measurement: 5% increase in number of youth experiencing ESMI served with Block Grant funded intervention in SFY23

Data Source:

Quarterly provider reports

Description of Data:

Proportion of total number of youth experiencing ESMI served with Block Grant funded intervention in a given State Fiscal Year (SFY)

Data issues/caveats that affect outcome measures:

Individuals not correctly identified as being ESMI

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SABG) ^a	J. ARP Funds (SABG) ^b
1. Substance Abuse Prevention ^c and Treatment	\$18,544,249.00		\$29,840,831.24	\$0.00	\$24,909,389.28	\$0.00	\$691,651.00		\$8,345,968.00	\$7,224,524.00
a. Pregnant Women and Women with Dependent Children ^c	\$4,100,622.00		\$1,624,715.54		\$5,705,430.00				\$0.00	\$0.00
b. All Other	\$14,443,627.00		\$28,216,115.70		\$19,203,959.28		\$691,651.00		\$8,345,968.00	\$7,224,524.00
2. Primary Prevention ^d	\$4,945,134.00		\$8,918.24	\$29,866,302.32	\$1,182,975.34	\$0.00	\$0.00		\$2,250,000.00	\$1,926,539.00
a. Substance Abuse Primary Prevention	\$4,945,134.00		\$8,918.24	\$29,866,302.32	\$1,182,975.34		\$0.00		\$2,250,000.00	\$1,926,539.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	\$0.00									
5. Early Intervention Services for HIV	\$0.00									
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	\$1,236,284.00		\$51,004.58		\$1,122,400.96				\$557,682.00	\$481,635.00
10. Crisis Services (5 percent set-aside)										
11. Total	\$24,725,667.00	\$0.00	\$29,900,754.06	\$29,866,302.32	\$27,214,765.58	\$0.00	\$691,651.00	\$0.00	\$11,153,650.00	\$9,632,698.00

^a The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

^b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

^c Prevention other than primary prevention

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

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

Footnotes:

• a The 24-month expenditure period for the COVID-19 Relief Supplemental funding is March 15, 2021 - March 14, 2023, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

• b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – September 30, 2025, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

Per the revision guidance tables 2, 4, 5a, and 6 have been revised in order to meet with the revised allotment for the SABG FFY 2022 award issued June 1st 2022.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,079	164
2. Women with Dependent Children	5,355	138
3. Individuals with a co-occurring M/SUD	40,786	4,148
4. Persons who inject drugs	8,814	2,572
5. Persons experiencing homelessness	2,209	1,389

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

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

Footnotes:

*Private insurance data is not currently collected by KDADS and, therefore, not included in the Aggregate Number in Treatment.

Aggregate Number in Treatment: Data Source: KSURS

It should be noted that COVID 19 impacted utilization during this time period. For example, court closures reduced referrals and residential admissions are likely lower. Several residential facilities limited or stopped admissions to accommodate for patient safety during the national emergency (one person per room; social distancing).

Kansas has a new substance use disorder treatment data collection system (KSURS). Providers continue to update back data into KSURS also impacting the data reported.

1. Aggregate Number Estimated in Need Resources: Pregnant Women - Calculated using data from the Kansas PRAMS 2019 Surveillance Report (May 2021) and the 2019 NSDUH report (September 2018);

2. Women with Dependent Children Aggregate Number in Need: US Census Report 2019 and The CBHSQ Report 8/24/17 Children Living with Parents Who Have a Substance Use Disorder report "In 2019, 20.4 million people aged 12 or older (or 7.4 percent of this population) had an SUD in the past year." 72,370 female householder with kids in Kansas * 7.4% =5,355.

3. Co-occurring M/SUD Estimated Aggregate Number in Need: 2019 U.S. Census Bureau estimates on Kansas households and NSDUH 2019 "Among adults aged 18 or older in 2019 ... 1.4 percent (or 3.6 million people) had both SMI and an SUD." 2,913,314 total Kansas population * 1.4% SMI/SUD = approx. 40,786 individuals with co-occurring SMI/SUD. Estimate does not account for difference in prevalence rates between adults and children.

4. Aggregate Number Estimated in Need and Aggregate Number in Treatment: Epidemiologist (KDHE) Research and Estimation (2020 data)

5. Aggregate Number Estimated in Need: HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations (Kansas) https://files.hudexchange.info/reports/published/CoC_PopSub_State_KS_2020.pdf. Number in need is based on Point in Time counts, not prevalence throughout the year as reported by treatment count. Aggregate Number in Treatment: State database; AIMS and KSURS. Persons experiencing homelessness aggregate number in treatment is based on the number of co-occurring M/SUD experiencing homelessness according to AIMS data. KSURS reports the number of SUD specific at 1,060 clients.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²	FFY 2023 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
1 . Substance Use Disorder Prevention and Treatment ³	\$9,078,710.25	\$8,345,968.00	\$7,224,524.00	\$9,078,711.00	\$8,345,968.00	\$7,224,524.00
2 . Primary Substance Use Disorder Prevention	\$2,420,989.40	\$1,373,936.00	\$895,527.00	\$2,420,989.00	\$2,250,000.00	\$1,926,539.00
3 . Early Intervention Services for HIV ⁴	\$0.00	\$0.00	\$0.00	\$0.00		
4 . Tuberculosis Services	\$0.00	\$0.00	\$0.00	\$0.00		
5 . Administration (SSA Level Only)	\$605,247.35	\$557,682.00	\$481,635.00	\$605,247.00	\$557,682.00	\$481,635.00
6. Total	\$12,104,947.00	\$10,277,586.00	\$8,601,686.00	\$12,104,947.00	\$11,153,650.00	\$9,632,698.00

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

³Prevention other than Primary Prevention

⁴For the purpose of determining which states and jurisdictions 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 (SABG); 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 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 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'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.

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

Footnotes:

Covid Relief and ARPA expenditures for now are expected to be budgeted by 09.30.2023. The Arpa funds may require further revisions closer to the end of 09.30.23.

Standard Planning Period 7/1/21 through 6/30/23; COVID-19 Relief Supplemental Funding March 15, 2021 - March 14, 2023 ; and American Rescue Plan Act of 2021 September 1, 2021 – September 30, 2025

Per the revision guidance tables 2, 4, 5a, and 6 have been revised in order to meet with the revised allotment for the SABG FFY 2022 award issued June 1st 2022.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Strategy	A	B			B		
	IOM Target	FFY 2022			FFY 2023		
		SA Block Grant Award	COVID-19 Award ¹	ARP Award ²	SA Block Grant Award	COVID-19 Award ⁴	ARP Award ⁵
1. Information Dissemination	Universal		\$100,203		\$448,872	\$698,169	\$213,000
	Selected						
	Indicated						
	Unspecified	\$350,000					
	Total	\$350,000	\$100,203	\$0	\$448,872	\$698,169	\$213,000
2. Education	Universal					\$507,650	
	Selected						
	Indicated						
	Unspecified	\$644,133	\$340,000				
	Total	\$644,133	\$340,000	\$0	\$0	\$507,650	\$0
3. Alternatives	Universal						
	Selected					\$258,767	
	Indicated						
	Unspecified						
	Total	\$0	\$0	\$0	\$0	\$258,767	\$0
4. Problem Identification and Referral	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	\$0	\$0	\$0	\$0	\$0	\$0
	Universal						

5. Community-Based Processes	Selected						
	Indicated						
	Unspecified						
	Total	\$0	\$0	\$0	\$0	\$0	\$0
6. Environmental	Universal						
	Selected						
	Indicated						
	Unspecified						
Total	\$0	\$0	\$0	\$0	\$0	\$0	
7. Section 1926 Tobacco	Universal						
	Selected						
	Indicated						
	Unspecified						
Total	\$0	\$0	\$0	\$0	\$0	\$0	
8. Other	Universal						
	Selected						
	Indicated						
	Unspecified	\$689,288					
Total	\$689,288	\$0	\$0	\$0	\$0	\$0	
Total Prevention Expenditures		\$1,683,421	\$440,203	\$0	\$448,872	\$1,464,586	\$213,000
Total SABG Award³		\$12,104,947	\$10,277,586	\$8,601,686	\$12,104,947	\$11,153,650	\$9,632,698
Planned Primary Prevention Percentage		13.91 %	4.28 %	0.00 %	3.71 %	13.13 %	2.21 %

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

³Total SABG Award is populated from Table 4 - SABG Planned Expenditures

⁴The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

⁵The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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

Footnotes:

Per the revision guidance tables 2, 4, 5a, and 6 have been revised in order to meet with the revised allotment for the SABG FFY 2022 award issued June 1st 2022.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	FFY 2022 COVID-19 Award ¹	FFY 2022 ARP Award ²	FFY 2023 SA Block Grant Award	FFY 2023 COVID-19 Award ³	FFY 2023 ARP Award ⁴
Universal Direct						
Universal Indirect						
Selected						
Indicated						
Column Total	\$0	\$0	\$0			
Total SABG Award⁵	\$12,104,947	\$10,277,586	\$8,601,686	\$12,104,947	\$11,153,650	\$9,632,698
Planned Primary Prevention Percentage	0.00 %	0.00 %	0.00 %	0.00 %	0.00 %	0.00 %

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President’s FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President’s FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

³The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President’s FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

⁴The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President’s FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

⁵Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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

Footnotes:
 Kansas is utilizing Form 5a so 5b not required per guidance.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award ¹	ARP Award ²
Targeted Substances			
Alcohol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prescription Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath salts, Spice, K2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Targeted Populations			
Students in College	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Military Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



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

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022					FFY 2023				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated ¹	D. COVID -19 ²	E. ARP ³	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated ¹	D. COVID -19 ²	E. ARP ³
1. Information Systems							\$160,000.00		\$0.00	
2. Infrastructure Support		\$0.00			\$173,881.00				\$0.00	
3. Partnerships, community outreach, and needs assessment		\$40,830.40		\$293,483.00			\$444,226.00		\$0.00	
4. Planning Council Activities (MHBG required, SABG optional)		\$0.00							\$0.00	
5. Quality Assurance and Improvement							\$266,914.50		\$0.00	
6. Research and Evaluation				\$100,000.00	\$100,000.00		\$321,914.00		\$0.00	

7. Training and Education				\$293,484.00	\$173,882.00		\$881,044.00		\$0.00	\$302,249.26
8. Total	\$0.00	\$40,830.40	\$0.00	\$686,967.00	\$447,763.00	\$0.00	\$2,074,098.50	\$0.00	\$0.00	\$302,249.26

¹Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

²The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

³The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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

Footnotes:

Per the revision guidance tables 2, 4, 5a, and 6 have been revised in order to meet with the revised allotment for the SABG FFY 2022 award issued June 1st 2022.

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²² 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.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

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.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ 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.²⁷

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ 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 M/SUD include: developing models for inclusion of M/SUD 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.³⁰ 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 M/SUD 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 homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD 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.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ 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.³⁶ 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.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.³⁹ 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 M/SUD 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.⁴⁰

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.⁴¹ 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.

²² 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

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/million-hearts-initiative>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ 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; <https://www.samhsa.gov/find-help/disorders>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <https://www.cchpca.org/topic/overview/>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>;

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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.
Behavioral Health Treatment Providers - Until the recent infusion of additional Federal Block Grant dollars, Federal Block Grant funding for behavioral health treatment needs for the uninsured/underinsured remained at the same level for many years and exceeded the allotted Federal Block Grant funding. Kansas has supplemented the funding using a combination of funding sources including State General funds and State Fee funds from the Problem Gambling and other addictions funds. Kansas Behavioral Health providers have been very creative in their approach to address the physical health needs of those they serve. Some Community Mental Health Centers (CMHCs) have offered primary care services but it has been limited due to lack of funding and not been consistent across the state with each CMHC.

Many substance use disorder providers are dually licensed as CMHCs enabling them to coordinate both mental health and substance use disorder care for those with co-occurring diagnoses. These dually licensed CMHCs are eligible to take advantage of the recent Kansas Legislative support to encourage development of Certified Community Behavioral Health Clinics (CCBHC) in Kansas. The Kansas Legislature set aside funding to develop the certification process and technical assistance to help CMHCs become CCBHCs creating integrated care (physical, mental and behavioral health) for their consumers. CCBHCs provide comprehensive, integrated mental health and SUD services. CCBHCs receive enhanced reimbursement and in return, cover nine types of services including 24/7 crisis care, evidence-based practices (EBPs), and coordinated care. An objectives for the CCBHCs include facilitating access, crisis stabilization, and treatment for individuals with SMI (serious mental illnesses) and SUDs. Another objective includes establishing innovative partnerships with law enforcement and hospitals to improve care, reduce recidivism, and readmissions. Currently, six CMHCs have received CCBHC expansion grants. Funding for CCBHC expansion was included in both the SABG and MHBG funding plan proposals.

Medicaid - The Kansas Department for Health and Environment (KDHE), a separate state agency, is the Medicaid Single State Authority for the State. KDHE and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state of Kansas. KanCare is the managed care program through which the State administers Medicaid and seven home and community-based 1915 (c) waivers. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as, operates the state hospitals and institutions. Kansas contracts with three health plans (MCOs): Aetna Better Health of Kansas, Sunflower Health Plan (Centene), and United Healthcare Community Plan for Medicaid managed care services. Mental health and substance use disorder services are carved into KanCare to coordinate physical and behavioral health care for all people enrolled in KanCare. The current KanCare 1115 waiver demonstration program took effect on January 1, 2019.

Many SUD providers are partnering with Federally Qualified Health Centers (FQHCs) and other primary medical providers to offer SBIRT (Screening, Brief Intervention and Referral to Treatment) services, integrated treatment, and facilitated access to ongoing medical care. Substance abuse treatment (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 upon clinical need/medical necessity through the contracted plans.

SBIRT - Screening, Brief Intervention and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other substances at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents and injuries. SBIRT is designed to identify an individual who has an alcohol and/or substance use disorder or is at risk for developing one by evaluating responses to questions about alcohol and/or other substance use. Approved provider service locations include primary medical care practices, acute medical care facilities, rural health clinics, critical access hospitals, federally qualified health centers, licensed substance use disorders treatment centers, Indian Health Centers, and community mental health centers.

To become approved to provide SBIRT services to Medicaid-eligible patients in Kansas, a health care professional shall be currently licensed in good standing as a physician, physician's assistant, nurse practitioner, psychiatrist, nurse, dentist, or certified health educator in the state of Kansas or currently licensed in good standing by the Kansas Behavioral Sciences Regulatory Board as a psychologist, social worker, professional counselor, marriage and family therapist or addiction counselor.

Health Homes – The Health Homes program for Kansas is called "OneCare Kansas". OneCare Kansas provide coordination of physical and behavioral health care with long-term services and supports for people in KanCare with chronic conditions. OneCare Kansas expands upon medical home models to include links to community and social supports. OneCare Kansas focuses on the whole person and all his or her needs to manage his or her conditions and be as healthy as possible. All the caregivers involved in a OneCare Kansas member's health communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. OneCare Kansas is intended for people with certain chronic conditions and can be members who also receive Medicare along with Medicaid. One Care is an opt-in program. The target population recently significantly expanded to include additional ICD-10 codes. Specifically, there are now more asthma, bipolar, and schizophrenia ICD-10 codes, and major depressive was added as a Severe Mental Illness qualifying diagnosis. This population expansion went into effect on 4/1/2021.

Crisis Centers

Stabilization services in Kansas are called Crisis Stabilization Units (CSU). With the support of Kansas legislation, 6 CSUs are fully operational and located in Hays, Kansas City, Salina, Manhattan, Topeka, and Wichita. The development and expansion of CSUs is ongoing with two programs under development in Lawrence and Leavenworth. All CSUs are under the management of the Community Mental Health Centers (CMHC) throughout the state and serve the catchment areas of the CMHCs. The graphic embedded in Planning Step 1 shows the connection between CSUs, Mobile Crisis Response, State Institutional Alternative (SIA) beds, and state hospital capacity expansion.

The size of the CSUs and services vary but the scope of work and outcomes reporting is uniform throughout the CSUs as established by the grant agreements with the CMHCs. The goal of CSU programs is to stabilize individuals, improve psychological symptoms of distress, and engage the individual earlier in the mental health or substance use crisis. Service delivery at CSUs is evidenced based practices of Recovery Oriented Systems of Care, Strengths Based Case Management principles, and Trauma Informed Care. Each of the CSUs have rapid drop-off and walk in availability, provide immediate triage, timely assessment, short term stabilization recliners or beds, (up to 23 hours). Participants are provided with therapeutic services meeting physical and mental health needs, medication assessment, discharge planning and referral. When needed participants may be provided with longer-term stabilization stays. Longer term placement is usually 3 to 5 days, but some stabilization centers may provide up to 14 days of stabilization services. The CSU programs also provide sobering Beds with peer supports for up to 23 hours and some provide availability of Social Detox or referral to Social detox placement.

Short Term Respite Care is available through the Serious Emotional Disturbance (SED) Waiver and provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. Short Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings including Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds.

MAT for Alcohol – Under the Block Grant, Kansas has not had the funding to implement medication-assisted treatment for alcohol use disorder. With the supplemental dollars Kansas is receiving through the Block Grant COVID Funding, Kansas is working on opening up reimbursement codes to providers for MAT for Alcohol.

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

Please see section above #1.

Designated Women's Facilities - There are five Designated Women's Facilities (DWFs) providers in Kansas located across the state in nine locations. Designated Women's Facilities receiving Block Grant funds give priority admission to pregnant women, women with dependent children and women using IV drugs. DWFs provide a full continuum of services:

- 1) Treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate

- 2) Provide or arrange for primary medical care for women, who are receiving substance abuse services, including prenatal care,
- 3) Provide or arrange for child care while the women are receiving services,
- 4) Provide or arrange for primary pediatric care for the women's children, including immunizations,
- 5) Provide or arrange for gender-specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting,
- 6) Provide or arrange for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect,
- 7) Provide or arrange for sufficient case management and transportation services to assure that the women and their children have access to the services provided by (2-6) above,

DWFs also provide pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of services to include: Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments, employment and training programs, education and special education programs, drug-free housing for women and their children, prenatal care and other health care services, therapeutic day care for children, Head Start and other early childhood programs.

State Opioid Response (SOR) grant - Kansas has received State Targeted Response (STR) or State Opioid Response (SOR) grants since 2017 to assist in addressing the opioid crisis. Illicit opioid use and related deaths continue to be a concern with 320 deaths from opioids reported in 2020. Kansas is using the SOR funding to invest in expanding access to treatment, particularly evidence-based treatment, and to reduce the number of opioid and stimulant related deaths across the state. KDADS' Behavioral Health Commission oversees and monitors grant activities. KDADS is using SOR award funding to provide medication-assisted treatment (MAT) services to uninsured patients in Kansas. Currently, there are around 40 grantees across the state providing treatment services for Kansans in all 105 state counties, including rural and frontier areas, as well as, urban areas. Treatment service providers are diverse and range from a university medical center to substance use disorder treatment providers, methadone clinics, regional alcohol and drug assessment centers, and community mental health centers.

Under the Block Grant, Kansas has not had the funding to implement medication-assisted treatment for alcohol use disorder. With the supplemental dollars Kansas is receiving through the Block Grant COVID Funding, Kansas is working on opening up reimbursement codes to providers for MAT for Alcohol. Alcohol is the second leading diagnosis people seek treatment for under the Substance Abuse Block Grant in Kansas after methamphetamine so the additional funding will positively impact many people we serve, provide continuity of care with insurance like Medicaid, and hopefully save lives and reduce recidivism.

Through a Request for Proposal process, KDADS is working on a solution to modernize its substance use disorder data collection system. The RFP includes a comprehensive Electronic Health Record upgrade of IT systems at all four State hospitals both from the infrastructure and software perspective. The State is currently in the process of reviewing proposals and selecting a vendor.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? Yes No
- b)** and Medicaid? Yes No
4. Who is responsible for monitoring access to M/SUD services provided 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 M/SUD providers screen and refer for:
 - a)** Prevention and wellness education Yes No
 - b)** Health risks such as
 - ii)** heart disease Yes No
 - iii)** hypertension Yes No
 - iv)** high cholesterol Yes No
 - v)** 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?
10. 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

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

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)⁴⁵.

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."⁴⁶

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 status⁴⁷. 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 populations⁴⁸. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

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, sexual orientation, gender identity, 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 M/SUD 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) Standards? Yes No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No
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

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

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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 General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² 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."⁵³ 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 M/SUD 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**)⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA 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**)⁵⁵ was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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.

⁴⁹ 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

⁵⁰ 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.

⁵¹ 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.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. 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.

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

Footnotes:

Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards? Yes No
3. 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

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

Footnotes:

Environmental Factors and Plan

7. 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](#)⁵⁶ 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.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. 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.

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

Footnotes:

Environmental Factors and Plan

8. 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:

1. **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;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **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;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **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
 - a) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) Intervening variables (including risk and protective factors)
 - d) Other (please list)
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)

The Kansas SEOW monitors the use of alcohol, tobacco, and other drugs and the consequences of such use in order to identify and prioritize the prevention and treatment needs of the state. To achieve this end, the Kansas SEOW oversees the collection, interpretation, and dissemination of statewide data that quantifies substance use and its consequences in the broader context of behavioral health for Kansas. KDADS utilizes this data to determine prevention and treatment priorities at the state, county, and local levels. The prioritization process primarily uses the Kansas Behavioral Health Profile indicators drawn from the Kansas Communities That Cares survey and other behavioral health data sources. Stakeholders review the indicators for trends and differences from national and other comparison data to select priority areas and allocate SABG resources.

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

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.

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

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

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

If yes, please describe mechanism used

The readiness and capacity of funded communities to implement the SPF was measured using several instruments and metrics. Two methods are used to assess community readiness and collaboration: The Tri-Ethnic Center Community Readiness Assessment utilizes key informant interviews that are scored to determine a community's degree of readiness across the following six dimensions: (1) Community Efforts, (2) Community Knowledge of the Efforts, (3) Leadership, (4) Community Climate, (5) Community Knowledge about the Issue, and (6) Resources Related to the Issue.

The Kansas SPF Collaboration and Capacity Survey is an online survey used to obtain information about how organizations in communities work together to reach common goals related to their goals. The survey assesses coalition capacity for sharing resources, building relationships, and communication. The survey is comprised of 23 items which supported three sections: demographics, collaboration, and capacity.

The levels of readiness, collaboration and capacity determined by these approaches are used to determine the type and amount of training and technical assistance needed and provided to promote the success of each grantee.

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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

The Kansas Evidence-Based Strategies Workgroup has adopted the Center for Substance Abuse Prevention's (CSAP's)/Substance Abuse Mental Health Services Administration's (SAMHSA's) three tiers of criteria for determining if a strategy is evidence-based (https://www.hcpmcme.org/pubadmin/health/SPEP/CSAP4p56_Guidance_Jan04_2007.pdf).

- Tier 1 – Strategy appears on a national registry of evidence-based strategies
- Tier 2 – Strategy appears in a peer reviewed publication with positive effects
- Tier 3 – Strategy includes documented effectiveness that is supported by other sources of information and the consensus judgment of informed experts

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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:
Multiple community coalitions across the state implement "It Matters" media campaign. The campaign originally focused on underage drinking prevention but has since been revised to include messaging on marijuana, opioids, binge drinking, and suicide prevention. Examples include Media campaigns, It Matters, Town hall meetings, Red Ribbon
 - 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. A KPC partner, "DCCCA", will continue to offer support, technical assistance, training, and other resources to community coalitions that enable them to engage in prevention education efforts tailored to local needs. Community capacity for the implementation of prevention education initiatives include, trainings, presentations, coaching, or other activities intended to affect life or social skills and will be cultivated among prevention staff. Examples include Active Parenting, Alcohol and Drug Fines, Alcohol EDU, Alcohol Literacy Challenge, Alcohol true Stories, All Stars, Conscious Discipline Keeping it Real, Lifeskills, More than SADD, Not in My HousePositive Action, SAFE, Smart Moves, Too Good for Drugs.
 - 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. Examples include Youth Leadership Summit, CADCA Youth Leadership, Drug Free Events

d) Problem Identification and Referral:

No statewide system for problem identification and referral will be funded. Each sub-state recipient has its own system for problem identification and referral to their own prevention education programs. However, it should be noted that Kansas does plan to utilize ARPA supplemental dollars to provide strategies to the community related to Problem Identification and Referral.

e) Community-Based Processes:

Kansas continues to fund community coalitions through a competitive request for proposal (RFA) process. We have provided awards for planning grantees (utilizing the SPF process), and implementation grantees. Communities will be supported by a statewide project team throughout this process enabling them to effectively implement prevention programming and achieve outcomes. Examples include Parent Network, Family day, Parent COnnect. It should be noted that Kansas also plans to fund newly established coalitions who have an interest in serving their community in the area of substance use prevention and require additional supports to be prepared to apply for planning stage. Emphasis on coalitions in areas that have been underserved, coalitions that may have been marginalized by the traditional grant application process in an effort to promote equity and diversity. This will be funded by ARPA Supplemental funds.

f) Environmental:

Community coalitions that receive SABG funding and have completed a strategic plan and identified appropriate evidence based strategies will be supported through an array of environmental strategies that include programs, practices, and policy changes. Examples include Compliance Checks, Guiding Good Choices, Sticker Shock, Alcohol and drug fines, environmental systems changes,

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

Funded community coalitions are required to complete a comprehensive needs assessment, capacity assessment, readiness assessment and assessment of existing community resources. This assessment is reviewed by multiple Kansas Prevention Collaborative partners for internal review as well as it is clearly stated within their grant agreement that SABG funds do not supplant prior sources of funding for prevention services and programming.

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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):

Evaluator assigned to each coalition to support building capacity for data collection and evaluation.

- 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):

Documentation of accomplishments, stories and activities (Qualitative data)

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):

Other risk and protective factors, Lifetime usage

Footnotes:

Environmental Factors and Plan

10. 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) Services for special populations:

- Targeted services for veterans? Yes No
- Adolescents? Yes No
- Other Adults? Yes No
- 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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? 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. Has your state identified a need for 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, and custody issues? 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.

The Kansas Department for Aging and Disability Services (KDADS) license behavioral health providers in Kansas. Licensing standards identify expectations and guidelines for the development and operation of substance use disorder (SUD) treatment programs licensed/certified by the State. When new providers apply for a license and during regular site visits, KDADS staff verify compliance with these standards. The standards are rigorous and cover a range of areas, including but not limited to, client rights, confidentiality, client record review, incident reports, member accessibility, program environment and safety, assessment, treatment planning, updates, and discharge planning/follow-up. In Kansas, there are five Designated Women's Facilities (DWFs) located across the state in nine locations. DWFs undergo the same rigorous licensing requirements as described above.

In October of 2018, the state of Kansas discontinued the use of the Kansas Client Placement Criteria (KCPC). The KCPC was an antiquated data source used to collect admission and discharge data for SAMHSA's Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMs). A new data collection tool, the Kansas Substance Use Reporting System (KSURS), was implemented in October of 2019. The current system collects a minimal data set, primarily TEDS data. Kansas released a RFP to replace the Electronic Health Records (EHR) system at the four State Hospitals and to modernize the KSURS system and expand the data collected. Expanding the data collected will help the State better monitor and track Block Grant services related to DWFs and other Block Grant facilities. Block Grant monitoring processes are being reviewed and enhanced electronic Block Grant data collection and monitoring elements is being considered for the new system. Responses to the RFP are currently under review.

Kansas contracts with three Managed Care Organizations for Medicaid and an Administrative Services Organization (ASO) for Block Grant substance use disorder treatment services. KDADS monitors the Medicaid plans and the ASO that oversee, authorize and reimburse for SUD treatment services. The ASO and the Medicaid plans contract with Substance Use Disorder providers, including the previously referenced Designated Women's Facilities, to provide a full continuum of services for pregnant women and women with dependent children.

The ASO for the Block Grant substance use disorder system also provides an expansive array of reports to the State on substance use disorder services utilization including Designated Women's specific-reporting for additional monitoring. Contract language with the plans and in the provider agreements include compliance related activities including corrective action up to and including provider suspension and termination from their network. The ASO maintains and manages the State's substance use disorder hotline and waitlist for residential treatment. Pregnant women are rarely on the waitlist, but if there is one waiting, the ASO ensures pregnant women and other priority populations are given priority in accessing care.

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, if applicable Yes No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Has your state identified a need for 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 (e.g., 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.

The Kansas Department for Aging and Disability Services (KDADS) license both behavioral health providers and methadone clinics in Kansas. Licensing standards identify expectations and guidelines for the development and operation of substance use disorder (SUD) treatment programs and methadone clinics licensed/certified by the State of Kansas. The standards are rigorous and cover a range of areas. There are a set of standards specific to methadone clinics which includes onsite reviews of policies, procedures, and client records.

A new data collection tool, the Kansas Substance Use Reporting System (KSURS), was implemented in October of 2019. The current system collects a minimal data set, primarily TEDS data. Kansas released a RFP to replace the Electronic Health Records (EHR) system at the four State Hospitals and to modernize the KSURS system and expand the data collected. Expanding the data collected will help the State better monitor and track Block Grant services related to methadone clinics and other Block Grant facilities. Block Grant monitoring processes are being reviewed and enhanced electronic Block Grant data collection and monitoring elements is being considered for the new system. Proposals in response to the RFP are currently being reviewed.

Kansas contracts with three Managed Care Organizations (Medicaid) and an Administrative Services Organization (ASO) for the Block Grant substance use disorder treatment services. KDADS monitors the the Medicaid plans and the ASO that oversee, authorize and reimburse for SUD treatment services for the providers in their network. The ASO and the Medicaid plans contract with Substance Use Disorder providers to provide a full continuum of services for those who inject drugs. The ASO maintains and manages the State's substance use disorder hotline and waitlist for residential treatment. The ASO ensures those who inject drugs and other priority populations are given priority in accessing care. Contract language with the plans and in provider agreements include compliance related activities including corrective action up to and including provider suspension and termination from their network.

There are nine methadone clinics in Kansas located primarily in urban areas. Half of the clinics (5) accept some form of insurance or are in the process of contracting to accept insurance. Medicaid plans are highly encouraged to contract with Methadone clinics. There is one methadone clinic in the ASO network under the Block Grant program.

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. Has your state identified a need for 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.

In Kansas, there is a Kansas Tuberculosis Control Program within the Kansas Department of Health and Environment. State laws and regulations require that cases of tuberculosis be reported to the local or state health department, The Kansas Tuberculosis Control Program provides, free-of-charge, anti-tuberculosis medications to local health departments for the treatment of TB disease. Additionally, preventative medications for individuals with TB infection are provided at no cost to local health departments or other medical providers. In order to receive medications for a person afflicted with TB infection, the health care provider or local health department must provide the state program information about the diagnostic screening of the patient (skin test and chest x-ray results). For individuals with active TB disease, the local health department must provide information about the diagnostic screening of the patient along with information about the patient's treatment, potential contacts to the patient, and other detailed information as requested on an ongoing basis.

For substance use disorder Block Grant treatment services, KDADS maintains a policy on our website specifically related to Tuberculosis to ensure compliance with the federal regulation to facilitate the provision of TB services and to create the necessary linkages between substance use disorder providers and local health care providers. Contractual agreements with the ASO and in the ASO's provider agreement with providers also include language about TB referrals. Contract language with the plans and in provider agreements include compliance related activities including corrective action up to and including provider suspension and termination from their network. In addition, the previous substance use disorder data system (KCPC) included a TB Risk assessment along with other TB related data elements for monitoring and tracking. This is under consideration for the new data system.

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

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No
2. Has your state identified a need for 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. Has your state identified a need for 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 services 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. Has your state identified a need for 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, such as 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. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) An organized referral system to identify alternative providers? Yes No
 - c) 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. Has your state identified a need for 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. Has your state identified a need for 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 including 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.

Independent Peer Review was one of the areas reviewed during Kansas's 10-year comprehensive site visit with CSAT in May 2018. It was noted in one of the communications from a SAMHSA MHBG reviewer that "States may satisfy the independent peer review requirement by demonstrating that at least 5 percent of their entities providing services obtained accreditation, during their fiscal year, from a private accreditation body such as the Joint Commission on the Accreditation of Healthcare Organizations, the Commission on the Accreditation of Rehabilitation Facilities, or a similar organization." Our Block Grant Coordinator position was vacant during the review. In follow-up, KDADS researched provider accreditation. It was found that the SABG provider network did meet the required 5% accreditation. During that time period, of the 44 SABG providers, there were nine providers with accreditation or 20.5% (Council on Accreditation (COA), Commission on the Accreditation of Rehabilitation Facilities (CARF), Joint Commission). KDADS notified SAMHSA of the follow-up and findings. Upon SAMHSA review of our response, it is our understanding that CSAT is requiring independent review. Kansas has been hindered by COVID-19 impacts but will work on a process to comply with this requirement.

3. Has your state identified a need for 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) Development of 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, such as the 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. Has your state identified a need for 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. Has your state identified a need for 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
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? Yes No
 - b) Mental Health TTC? Yes No
 - c) Addiction TTC? Yes No
 - d) State Targeted Response TTC? 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 that govern the Mental Health and Substance Use Disorder Programs.

Footnotes:

Criterion 1 b):

MAT for Alcohol – Under the Block Grant, Kansas has not had the funding to implement medication-assisted treatment for alcohol use disorder. With the supplemental dollars Kansas is receiving through the Block Grant COVID Funding, Kansas is working on opening up reimbursement codes to providers for MAT for Alcohol. Alcohol is the second leading diagnosis people seek treatment for under the Substance Abuse Block Grant in Kansas so the additional funding will positively impact many people we serve.

PWID 1.c: Media campaign and Billboards with the hotline number (SOR)

Service Coordination 2.: The Stepping Up initiative, a national partnership between the CSG Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation, aims to reduce the number of people with behavioral health issues in jail. Kansas became the fifth state in the nation to launch a statewide Stepping Up initiative. Kansas jails report up to 80% of their inmates have a mental health condition and approximately 50% of jail staff are not adequately trained to address mental health issues. A high prevalence of inmates with mental illness also have a substance use disorder. Kansas has set-up a Technical Assistance Center targeting 40 participating counties through FY22. Kansas currently has a total of eight participating counties in the Stepping Up initiative. COVID-19 halted case processing in the justice system and paused or substantially limited capacity for behavioral health providers to accept new admissions, especially in residential SUD treatment programs, resulting in significant increases in population and length of stay of individuals with complex behavioral health needs in local correctional facilities across the state. Funding to communities participating in the Stepping Up Initiative will help facilitate the referral and connection to care for those who are justice-involved and in need of MH or SUD treatment and recovery supports. In order to reduce the prevalence of people with behavioral health conditions in jails and shorten their length of stay through connection to treatment, Kansas received approval with the COVID-19 Supplemental Funding plan to expand the participating counties in the program.

Kansas is not a FY2022 HIV designated state.

Kansas does not have any syringe service programs.

Environmental Factors and Plan

11. 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 2020-FFY 2021? Yes No

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

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

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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 Trauma⁵⁸ paper.

⁵⁷ 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.*

⁵⁸ Ibid

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers? Yes No
3. Does the state have a plan to build the capacity of M/SUD 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.

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

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

Footnotes:

Environmental Factors and Plan

13. 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.⁵⁹

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.⁶⁰

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 the Health Insurance 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.

⁵⁹ 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 Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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?

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

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

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

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], 49 [4], and 63[5].

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.

TIP 40 - <https://www.ncbi.nlm.nih.gov/books/NBK64245/> [ncbi.nlm.nih.gov]

TIP 43 - <https://www.ncbi.nlm.nih.gov/books/NBK64164/> [ncbi.nlm.nih.gov]

TIP 45 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf> [store.samhsa.gov]

TIP 49 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf> [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

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?

**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.*

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

Footnotes:

Kansas Medicaid covers all FDA-approved medications for Opioid Use Disorder (OUD).

Kansas has received State Targeted Response (STR) or State Opioid Response (SOR) grants since 2017 to assist in addressing the opioid crisis. Kansas is using the SOR funding to invest in expanding access to treatment, particularly medication-assisted treatment (MAT) services to uninsured patients in Kansas to reduce the number of opioid and stimulant related deaths across the state. Currently, there are around 40 grantees across the state providing treatment services for Kansans in all 105 state counties, including rural and frontier areas, as well as, urban areas. Treatment service providers are diverse and range from a university medical center to substance use disorder treatment providers, methadone clinics, regional alcohol and drug assessment centers, and community mental health centers. Medications for OUD MAT reimbursed through SOR include buprenorphine, methadone, vivitrol and sublocade. In Kansas, SOR also funds a free statewide naloxone distribution and training program. Recovery services are also funded through the grant including for people transitioning from correctional and other rehabilitative programs back into the community with access to sober living group homes, MAT, peer support, employment helps, and other services that can move them towards a successful recovery.

MAT for Alcohol Use Disorder (AUD)

Under Kansas Medicaid, Antabuse and Vivitrol are both covered for AUD. Kansas Medicaid covers any FDA approved drug that meets CMS rules to require coverage.

Under the Block Grant, Kansas has not had the funding to implement medication-assisted treatment for alcohol use disorder. With the supplemental dollars Kansas is receiving through the Block Grant COVID Funding, Kansas is working on opening up reimbursement codes to providers for MAT for AUD. Alcohol is the second leading diagnosis people seek treatment for under the Substance Abuse Block Grant in Kansas after amphetamines so the additional funding will positively impact many people we serve for continuity of care as people transition in and out of funding streams/insurance and hopefully save lives and reduce recidivism.

Tobacco Cessation

Tobacco cessation opportunities are included in the SOR grant as an optional activity. KDADS has offered two Requests for Applications (RFA) to integrate tobacco cessation treatment into the treatment of those with opioid/stimulant use disorders. A person with a substance use disorder who can quit using tobacco products, may greatly increase the odds of long-term recovery from substance use disorder (SUD) and have physical health benefits that begin almost immediately for smokers and continue for years to come. Use of tobacco products may interfere with the metabolism of prescribed psychiatric medications. Eliminating tobacco allows people to reduce their symptoms by taking lower levels of medication. Tobacco cessation also increases a person's sense of mastery and helps them focus on a positive and healthy lifestyle. Treatment providers may use funds to implement a smoke-free facility to benefit both clients and staff.

KDHE Kansas Tobacco Use Prevention Program

The Kansas Tobacco Use Prevention Program (<https://www.kdheks.gov/tobacco/index.html>) provides resources and assistance to state and local partners for development, enhancement and evaluation of state and local initiatives to prevent death and disease from tobacco use and secondhand smoke exposure.

The program focuses on four priority areas: 1) Preventing the initiation of tobacco use among young people, 2) Promoting quitting among tobacco users of all ages, 3) Eliminating nonsmokers' exposure to secondhand smoke, and 4) Identifying and eliminating disparities related to tobacco use and its effects among different population groups. Strategies include The Kansas Tobacco Quitline - a special program for pregnant smokers and smokers with mental illness or addiction.

NAMI Kansas has provided several trainings throughout the state to providers and other stakeholders on smoking cessation resources including Tobacco Guidelines for Behavioral Health Care: <https://namikansas.org/resources/smoking-cessation-information/?nowprocket=1>

Evidence-Based Practices Subcommittee

Kansas has formed an Evidence Based Practices Subcommittee (EBP) of the Governor's Behavioral Health Services Planning Council. The goal of this Subcommittee is to develop a way to provide training and fidelity review for evidence based practices in Kansas including MAT. The Mental Health Technology Transfer Center (MHTTC) is providing Technical Assistance to this subcommittee.

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ 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 M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"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 M/SUD 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.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

- f) Recovery community coaches/peer recovery coaches
- g) Recovery community organization

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

Kansas is working to expand peer support beyond mental health and substance use disorder settings. Kansas urban areas have developed their own local mobile crisis response programs. Kansas Department on Aging and Disability Services (KDADS) is seeking funding through State General Funds to develop a statewide mobile crisis response program.

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

Kansas can benefit from technical assistance in two areas: Evidence Based Practices and Mobile Crisis Response.

Evidence Based Practices: KDADS developed an Evidence Based Practices (EBP) Subcommittee as part of the Governor's Behavioral Health Services Planning Council in the summer of 2019. The EBP Subcommittee originated from a need for tracking of evidence based practices and practice based evidence currently in use by Community Mental Health Centers (CMHCs), development of statewide training in those EBPs, and a process for fidelity review of the EBPs. This Subcommittee re-organized in March of 2021 and have been meeting weekly (EBP Leadership Team one week and the full Subcommittee the following week). The Subcommittee Leadership Team has reached out to the Mid-America Mental Health Technology Transfer Center to receive technical assistance on the development of an infrastructure for EBP training, support, and fidelity reviews in Kansas. Additional technical assistance would be beneficial to develop the infrastructure needed for EBP.

Mobile Crisis Response: KDADS has received funding to plan and implement 988. In addition, many of the urban communities in Kansas have a version of mobile crisis response. However, Kansas anticipates development of a statewide mobile response, if funding is secured, and would benefit from technical assistance.

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

Footnotes:

The Kansas Legislature provided some funding for developing the Certified Community Behavioral Health Clinic, 988 funding, and Housing First.

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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 No

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.

Consumer Run Organizations (CROs)

Kansas has built an infrastructure of Consumer Run Organizations (CROs) to promote recovery through peer support recovery supports to those who currently or in the past have accessed mental health services, especially those with severe and persistent mental illness. Nine CRO's were awarded funding from KDADS for FY2022. 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. Typically, a CRO provides an array of services to its members that include leadership, education, training and research opportunities, one-on-one peer support, peer support groups, 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 seek to provide a safe, healing and trauma-free environment which enhances wellness and promotes resiliency. Peer support is distinct from other social supports in that the persons providing support can draw from their own recovery journey to inspire hope in others who are facing similar situations. There are currently nine CROs that receive funding by KDADS across the state of Kansas.

Parent Peer Support Specialists

KDADS Behavioral Health Children's Division is in the process of developing curriculum for an online and in-person training to certify peer supports who will serve children and their families in the role of Parent Peer Support Specialist (PPSS). A PPSS will meet the qualifications of navigating their own journey of supporting an SED child through lived experience and recovery, and be certified to support other parents who are involved with multiple systems while raising a child with SED. The role of peers in supporting others through recovery has been well documented. A go-live date is expected to be January 2022.

Supportive Housing Recovery Supports

KDADS currently offers several programs to assist individuals who are homeless or at risk of homelessness and experiencing a serious mental illness (SMI). The Kansas Department for Aging and Disability Services (KDADS) is the Single State Authority for Behavioral Health Services in the State of Kansas. KDADS has recently merged our Housing, Employment and Benefits programming division within our Commission. KDADS has embraced the Housing First Model throughout our Behavioral Health Provider networks within the state.

Our Housing, Employment and Benefits division help provide technical assistance and training on the following Evidenced Based or Promising Practices: Social Security Outreach Access and Recovery (SOAR) and Housing First. The State hopes to kick off IPS Supported Employment again in late 2021 or early 2022. Our Commission contracts with local Community Mental Health Centers (CMHCs) and Substance Use Disorder provider agencies across the state. Each of the CMHC's contracts now require each center to have a certified SOAR staff to assist people with re-connecting and connecting homeless or at risk of homelessness consumers back to their federal SSA and Title 19 Medicaid benefits, if eligible. COMCARE, our largest Community Mental Health Center in the State, has a SOAR representative that participated in a National SOAR training event for Children/SOAR. This representative continues to work with the Behavioral Health Authority to create a statewide system to assist children and transitioned aged youth with benefit application and employment through Vocational Rehabilitation Services, IPS Supported Employment, or Federal Programs under the CHAFFEE Act. Our State Psychiatric Hospitals are following Center for Medicaid Services (CMS) recommendations for discharge planning and our Psychiatric State Hospital's discharge teams are also working daily to connect discharging consumers back to SSA and Medicaid. The State Behavioral Health Authority (KDADS) and State Medicaid Entity Kansas Department of Health and Environment (KDHE) are working together through a policy to ensure that eligible Medicaid consumers can have access to their Medicaid benefit and Managed Care Organizations on the day of discharge from the hospitals and/or institutions.

In 2016 KDADS the Behavioral Health Authority embraced the Housing First Model and have been receiving training and fidelity consultation from the team from Pathways to Housing and Sam Tsemberis. KDADS continues to explore our efforts in expanding the Housing First Model across the state. In July of 2019, KDADS and the State Medicaid Authority Kansas Department of Health and Environment (KDHE) opened a per diem Medicaid billing code for reimbursement. This code is specific to Housing Supportive Services using the Housing First Model. This billing code is identified in our State as Operation Community Integration, and the target population for this code are: consumers exiting institutions, consumers who can be diverted from inpatient psychiatric placement, consumers exiting residential treatment facilities, SED/transitioned aged youth who may or may not be exiting foster care or juvenile corrections custody and Medicaid high utilizers. Several of our provider agencies that provide behavioral health supportive services for the Youth/Transitioned Aged will be invited to participate in a Housing First training with Sam Tsemberis in late 2021 and we will be inviting the local Continuum of Care (COC) programs from those regions to also participate in that

training. We hope that our Housing First training will be funded through a technical assistance award from SAMHSA under the PATH grant. We currently have six Community Mental Health Center locations in the State where the SOAR staff work directly with the IPS Supported Employment specialist so disabled consumers who wish to return to employment can be referred directly to an IPS Supported Employment and Vocational Rehabilitation services, to assist them with access to employment and benefits planning through a Certified Work Incentive Specialist (C-WICK). Our Behavioral Health Authority KDADS works directly with a transition team from the Home and Community Based Services (HCBS) Waivers Commission to coordinate services within HUD's Continuum's of Care. KDADS Behavioral Health Commission has recently hired a new Veterans Program Manager who will be working with the VA and the HUD VASH programs in our State. The U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program is a collaborative program between HUD and VA that combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.

KDADS Behavioral Health Children's Division is working closely with the Department for Children and Family Services (DCF) and our Partners at Kansas Statewide Homeless Coalition. DCF and the Kansas Balance of State (KS BoS) team have recently entered a Memorandum of Understanding (MOU) to ensure consumers discharging from foster care within the Balance of State Catchment areas, are given the Vi-SPDAT and connected to their local COC's to assist with Housing Services. The VI-SPDAT stands for Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool. It helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention to who is eligible and in greatest need of that intervention.

In 2020 when the COVID pandemic hit our State, KDADS in partnership with the Kansas Statewide Homeless Coalition (KSHC) and KSBoS, decided we would have to pivot and pivot quickly to be able to accommodate all the demands that were hitting our systems for people in need of housing and supportive services. KSBoS created a private referral form that would lead to a remote phone VISPDAT assessment to ensure that individuals who are homeless/or at risk of homelessness had immediate access to the VISPDAT assessment tool. Individuals and families who were found to be eligible were referred to an appropriate coordinated entry list for housing supports. KDADS, in partnership with the KSHC set up a phone-in referral process to ensure that homeless/or at risk of homelessness consumers who were disabled had immediate access to the HUD required screenings. If the consumers were eligible, they were referred to their local COC's for follow-up recommendations based on the outcome of the HUD screen.

In late 2020, KDADS partnered with a local Domestic Violence Shelter in the Leavenworth, Kansas area and the Community Mental Health Center to ensure that persons and families escaping domestic violence and/or sex trafficking victims were connected to mental health and housing services in an expedited manner. The local domestic violence shelter in the Leavenworth, Kansas area sends the referral to KDADS. KDADS refers to the Community Mental Health Center who refers the cases over to the Kansas Statewide Homeless Coalition who does the HUD screening. This program began in late November and in less than three months we have been able to connect nine women and children to community-based services and, if needed, have them screened for Housing Support Services through the local COC. All this work is done shortly after the consumer admits to the shelter and before they are ready for discharge from the residential domestic violence shelters to prevent homeless discharges. KDADS currently has a variety of state/federally funded programs that have been designed to help consumers with a behavioral health diagnosis sustain and/or obtain housing and to avoid un-necessary psychiatric or correctional institutional placements. KDADS targeted Supportive Services Housing programs are briefly described below. These programs are targeted for consumers that are homeless or at risk of homelessness and have a behavioral health diagnosis including mental health and substance abuse disorders.

Projects for Assistance in Transitioning from Homelessness (PATH)

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 SMI secure safe and stable housing, improve their health, and live a self-directed, purposeful life. Kansas currently has a total of five PATH providers. Two of the providers are located within HUD's Balance of State region. The other three provider agencies are in Metropolitan/Urban regional areas where the State has a higher number of behavioral health homeless/at risk of homelessness consumers.

Supported Housing Fund (SHF) Program

The Kansas Department for Aging and Disability Services Behavioral Health Services Commission funds the Supported Housing Fund Program (SHF) with state general funds. The SHF is a one-time or emergent need benefit able to provide "tenant-based housing first" assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is accomplished by providing temporary flexible funds for their housing needs. In FY2019, funds from the Supported Housing Fund program assisted approximately 95 individuals per month in obtaining or maintaining housing.

Interim Housing Program

The Interim Housing Program is a Bridge Housing program that has been designed, to assist consumers with building the skills necessary to obtain/sustain long-term permanent housing using the Housing First Support Services Model. The Behavioral Health Services Commission funds the Interim Housing Program. As a response to policy to prevent discharging individuals into homelessness, Kansas' mental health system saw a need to create more "interim" housing options for individuals leaving Nursing Facilities for Mental Health or State Psychiatric Hospitals who are without permanent housing arrangements. In FY 2019, BHS funded six Interim Housing (IH) projects across the state. Interim Housing is defined as short-term housing that is used

until a more permanent housing arrangement can be made.

Unlike the Supported Housing Fund Grant, which provides tenant-based assistance, these funds provide “project-based rental assistance.” Project-based housing provides immediate assistance, without the need for the individual to undergo a housing search, traditional tenant screening process, and acquisition of the furniture and items necessary to establish a household while still in-patient in a hospital setting. Upon entering the IH project, the CMHCs Housing and Homeless Specialists and other case managers immediately begin providing the assistance necessary for the resident to obtain more permanent housing.

Collectively, the FY2019 IH grantees prevented homelessness for 85 individuals. Of those individuals who exited the program, 80% moved into a community-based living situation by the end of the grant term. Approximately 50% of the individuals assisted in the Interim Housing Units were chronically homeless.

Operation Community Integration

This Program is a Medicaid Supportive Housing Services Per Diem Code that has been designed to connect Behavioral Health Medicaid eligible consumers to Housing Supportive Services that will help them with symptom management along their recovery journey and as they work with HUD systems to obtain and sustain housing. This program utilizes the Housing First Supportive Services Model.

Community Support Medication Program

This program was designed to provide funds and/or a short-term payor sources to ensure that consumers who do not have insurance or the ability to pay/afford their medications have access to medically necessary mental health medication for un-insured and under-insured consumers.

SOAR Medicaid

Programs that work with the State Hospitals and the Social Security Administration to ensure that homeless consumers that are at risk of losing housing are working with the Social Security Administration to sustain SSA benefits if they are residing in the state hospitals for less than 90 days. Our state Medicaid Authority, KDHE is working with the county jails, state hospitals and state correctional facilities to ensure that eligible Medicaid consumers exiting institutions have immediate enrollment to Medicaid to ensure access to medications and MCO supportive services necessary to obtain and sustain housing and full community integration.

Kansas Statewide Homeless Coalition (Coordinated Entry HUD Access Points)

In partnership with Kansas Statewide Homeless Coalition (KSHC) on behalf of the Kansas Balance of State Continuum of Care (KSBoS) in 2020 we have begun 2 Pilot Projects in the HUD's 101 counties making up the Balance of State Region to ensure that homeless or at risk of homeless consumers are connected to HUD's VISPDAT assessment tool. The KDADS team and the Kansas Statwide Homeless Coalition work in partnership to ensure that consumers are connected to their Community Mental Health Centers, or local Substance Abuse Provider networks for Behavioral Health Supports. The CMHC pilot sites are now working directly with the KSBoS and KSHC to better coordinate supportive service care for homeless or at risk of homeless consumers. In 2021 KDADS and KSBoS will also be working a mainstream benefits training committee that will be looking at developing a statewide process for SOAR certification and training for the State's COC's and the Behavioral Health Provider networks who want to provide the Promising Practice of SOAR.

The Emergency COVID-19 grant award

The COVID 19 emergency grant was awarded by SAMHSA in Federal Fiscal Year 2020. This grant provides direct mental and behavioral health services to individuals impacted by the COVID-19 pandemic. This fund has been designed to assist in providing long-term stability for persons in the State of Kansas. The Grant allocated funds can be used to help fund Oxford Housing for individuals recovering from Substance Use Disorders. These funds are available to the CMHCs targeted by the Grant for disbursement to individuals impacted by COVID-19. Also, important to note about this grant is that the term impacted does not mean contracted. The grant allows for self-reporting from consumers as to their impact. CMHCs will ask if the need for treatment has been impacted by COVID. If the response is “yes”, then the person qualifies.

The SAMHSA State Opioid Response II (SOR) grant

This award includes funds to support community recovery housing for clients transitioning from Kansas correctional facilities or other rehabilitation programs. These clients shall participate in outpatient treatment services for opioid or stimulant use disorders under the supervision of a licensed Kansas provider. The program goal is to assist each client in remaining abstinent and capable of securing stable employment, as well as, community accountability.

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 Mental Health Services (MHS) and/or Substance Abuse Treatment (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.

Kansas has 141 Oxford Houses that operate under the "Oxford House Model", a community-based approach to addiction treatment, which provides an independent, supportive, and sober living environment.

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

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

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Footnotes:

Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

- 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
 - Does the state have a plan to transition individuals from hospital to community settings? Yes No
- Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD 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 community.⁶³ 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 24.⁶⁴ 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 death.⁶⁵

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 21.⁶⁶ 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 costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ 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 M/SUD 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).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, 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.

⁶⁵Centers 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.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department 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 <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? Yes No
 - 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.)

Community Mental Health Centers (CMHCs)

CMHCs are charged by statute with providing the community-based public mental health services safety net in Kansas. Under Kansas Statutes Annotated (KSA) 19-4001 et. Seq., and KSA 65-211 et. Seq., twenty-six licensed Community Mental Health Centers (CMHCs) currently operate in the state. One of the 26 CMHCs specializes in children’s services – Family Service and Guidance Center.

Another mechanism for ensuring that Kansas children receive integrated services for their multiple needs is with 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). To be eligible for a waiver, one must be determined: 1) Eligible for the specific waiver program 2) Functionally eligible via a functional assessment and 3) Financially eligible. The single “point of entry” that completes each functional assessment varies depends on which waiver is being applied for.

Serious Emotional Disturbance (SED) Waiver

The local community mental health center (CMHC) is the single point of entry for the SED Waiver. Services provided under the SED Waiver are for children 4 to 18 years of age who experience serious emotional disturbance 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.

Parents and children are actively involved in planning for all services. Local Community Mental Health Centers provide services covered by the program. Children who meet eligibility requirements will receive a medical card and are eligible for Medicaid physical and behavioral health services.

SED Waiver Services include:

- Wraparound Facilitator: A person who works with the family and their identified supports to set treatment goals and decide on services for the child and family.
- Parent Support and Training: Services designed to provide education, assistance, and other support to parents and families.
- Independent Living Skills Building: Staff supported development of the skills needed in order to live independently.
- Attendant Care: A staff person who helps the child with daily tasks.
- Professional Resource Family Care (Crisis Stabilization): Intensive support services provided to the child outside the home in a safe environment.
- Short Term Respite Care: provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. Short Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings including Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds.

Autism Waiver

The Autism Waiver provides support and training to parents of children with an Autism Spectrum Disorder (ASD) diagnosis to help ensure children with ASD can remain in their family home. Autism Waiver Services include:

- Family Adjustment Counseling: Family Adjustment Counseling offers guidance and assistance for family members of a child with Autism Spectrum Disorder (ASD). These services are provided by a Licensed Mental Health Provider (LMHP) and help the family in coping with the child's diagnosis and daily needs, by offering a safe and supportive environment to express emotions and ask questions.
- Parent Support and Training (Peer to Peer): Parent Support and Training assists family members to acquire the knowledge and skills needed to understand and address the specific needs of and treatment for the child in relation to ASD and develop the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom and behavior management.
- Respite Care: Respite Care offers temporary direct care and supervision of the child to provide relief to families and caregivers of a child with ASD. A respite care provider assists with normal activities of daily life in order to meet the needs of the primary caregiver as well as the child.

The following three services were previously part of the Autism Waiver and are now part of state plan services that a child can access with a medical card. The child does not need to be on a waiver to begin or to continue to receive these services:

- Consultative Clinical and Therapeutic Services (provided by an autism specialist): Consultative Clinical and Therapeutic Services focus on improving of behavioral challenges related to the diagnosis of autism spectrum disorder (ASD). They teach skills to help the family and paid support staff or other professionals with meeting the needs of the child with ASD. The autism specialist assesses the child and family's strengths and needs, develops the Individual Behavior Plan/Plan of Care (IBP/POC), coordinates services, provides training and technical assistance, and monitors the child's progress within the program.
- Intensive Individual Supports: Intensive Individual Supports services are provided to a child with autism spectrum disorder (ASD) to assist in acquiring, retaining, improving, and generalizing skills needed to successfully function in their home and community. This may include development of skills such as social skills, language and communication, motor skills, engagement, cognitive skills, and behavior skills.
- Interpersonal Communication Therapy (ICT): Interpersonal Communication Therapy (ICT) works to improve social communication symptoms related to the diagnosis of an autism spectrum disorder (ASD). ICT includes the development of skills such as conversation, unplanned communication, understanding of verbal and nonverbal communication.

To be eligible for the Autism Waiver, an individual must meet the following criteria: 1) Be 0-5 years old (at time of application; they can apply until their sixth birthday) 2) Be diagnosed with an Autism Spectrum Disorder, Asperger's Syndrome or a Pervasive Developmental Disorder – Not Otherwise Specified and 3) Be financially eligible for Medicaid. Autism Waiver services are typically limited to three years. An additional year of service is available in some cases based upon a review process. Requirements for this one-year extension of services beyond the three-year initial limit include the following: 1) The child must meet eligibility based on a Level of Care assessment at the annual review of the third year of services, and 2) Data collected by the KanCare managed care organization must demonstrate a need for continued Autism Waiver services.

Kansas Department for Children and Families (DCF) Mobile Crisis Response Service for Kansas Families

In February 2021, the Kansas Department for Children and Families (DCF) awarded a contract for statewide mobile family crisis response and support services. This mobile crisis response service allows DCF to better serve families and caregivers who have children experiencing emotional crisis or other behavioral health symptoms including substance use disorder.

Mobile crisis response service ensures Kansas children and young adults between 0-20, have access to a comprehensive crisis system that anticipates needs and provides recovery-focused interventions in all phases of the crisis continuum. The centralized

behavioral health crisis services include on-the-phone or in-person rapid community-based mobile crisis intervention services; hotline with 24 hour a day, seven day a week assessment and screening, and up to eight weeks of stabilization services and connection to community-based referrals and services.

Per Secretary Howard, "This crisis response model gives DCF the capability to provide any child or youth in Kansas who are experiencing a behavioral or psychiatric emergency with rapid community-based mobile crisis intervention services regardless of health care insurance or status."

Young adults between the ages of 18 to 21 who were formerly in the foster care system also are eligible for the services.

Youth Leaders in Kansas (YLINK)

YLINK stands for Youth Leaders in Kansas. Currently, there are fourteen local community-based groups working on a wide range of mental health topics and community service projects. Each local group determines their own unique area of focus while developing leadership skills and supporting their communities. Examples include suicide prevention, avoidance of substance usage by youth, stigma reduction, anti-bullying efforts, and LGBTQ+ issues. KDADS is currently exploring ways to expand the YLINK concept to other Kansas communities. A Youth Advisory Council is in development, comprised of Kansas youth from the YLINK groups, who will serve as youth advisors to the Governors Behavioral Health Services Planning Council (GBHSPC). The plan is for the Youth Advisory Council to become a sub-committee to the GBHSPC.

Disaster Relief Grant

The Disaster Relief Grant was awarded September 2020. Through this grant, we have provided many trainings that support children's mental health and the identification of disorders that need further services. We have made these trainings sustainable by training the trainers to provide these trainings after the grant ends. We have 10 new Youth Mental Health First Aid trainers, 8 Teen Mental Health First Aid trainers, 14 Question, Persuade and Refer (QPR) trainers. These trainings are being offered free of charge through the grant to the communities, schools and professional organizations that work with children. We have provided Attachment Based Family Therapy to many therapists throughout the state and will have this training offered and implemented in future classes offered through Emporia State University to counseling students. We have trained 3 faculty at Emporia State University in Youth Mental Health First Aid. They have agreed to implement a required training program that will be offered to all graduating teachers and counselors, allowing individuals entering the workforce to come into it trained in mental health first aid. We have also created trainings that are offered to teachers, faculty, parents and children on different aspects of mental health. These trainings are created, so that sustainability is possible. Mental Health America and the Mental Health Association of Southeast Kansas provide these trainings and will continue to do so after the grant ends.

System of Care

Kansas was awarded a System of Care grant 2016-2020. A no cost extension was applied for and received for the period of September 2020 – March 2021. KDADS has applied for a second grant award for the period of September 2021 – September 2025. This application is for further expansion state-wide of the system of care principles and will focus on providing wrap-around care and support crisis services.

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.

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

Footnotes:

Evidence-Based Practices Subcommittee

Kansas has formed an Evidence Based Practices Subcommittee (EBP) of the Governor's Behavioral Health Services Planning Council. The goal of this Subcommittee is to develop a way to provide training and fidelity review for evidence based practices in Kansas. The Mental Health Technology Transfer Center (MHTTC) is providing Technical Assistance to this subcommittee.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dr. Jane Adams	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3926 SW 6th St. Topeka KS, 66607 PH: 785-233-8732	jadams@keys.org
Charles Bartlett	State Employees	Kansas Department for Aging and Disability Services	503 S. Kansas Avenue Topeka KS, 66603 PH: 785-368-6391	charles.bartlett@ks.gov
Dr. Ethan Bickelhaupt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2702 Olde Creek Court Leavenworth KS, 66049 PH: 312-610-9636	ethan.bickelhaupt@ks.gov
Robbin Cole	Providers	Pawnee Mental Health Services	2500 Meade Circle Manhattan KS, 66502	robbin.cole@pawnee.org
Wes Cole	Others (Advocates who are not State employees or providers)		937 Walnut Osawatomie KS, 66064 PH: 913-755-3655	scole@micoks.net
Hope Cooper	State Employees	Kansas Department of Corrections	714 SW Jackson Topeka KS, 66603 PH: 785-296-4213	Hope.Cooper@ks.gov
Ric Dalke	Providers	Iroquois Center for Human Development, Inc.	901 Lyle Avenue Garden City KS, 67846	ricdalke@irqcenter.com
Daniel Decker	State Employees	Kansas Rehabilitation Services	555 S. Kansas Avenue Topeka KS, 66612 PH: 785-368-7143	daniel.decker@ks.gov
Al Dorsey	Others (Advocates who are not State employees or providers)		611 S. Jackson Ave. Topeka KS, 66603 PH: 785-296-2262	adorsey@kshousingcorp.org
Kristin Feedback	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Osawatomie State Hospital Osawatomie KS, 66064	kristin.feedback@ks.gov
Victor Fitz	Persons in recovery from or providing treatment for or		PH: 316-390-3406	victor@sackansas.org

	advocating for SUD services			
Ashley Grill	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		KS,	
Brenda Groves	Parents of children with SED/SUD			newhorizonsdementia@gmail.com
Chris Howell	Representatives from Federally Recognized Tribes			
Shane Hudson	Providers	Central Kansas Foundation	Central Kansas Foundation Salina KS, 67401-7126 PH: 785-825-6224	shudson@ckfaddictiontreatment.org
Savannah Hunsucker	Youth/adolescent representative (or member from an organization serving young people)			
Clara Kientz	Others (Advocates who are not State employees or providers)		40691 Hwy 99 Wamego KS, 66547 PH: 785-323-7110	cvkientz@gmail.com
Christina Mayer	Providers	DCCCA	101 Peach Street Eudora KS, 66025 PH: 785-766-1498	cmayer@dcca.org
Ericka Nickelson	Parents of children with SED/SUD		322 Grant Street Quinter KS, 67752	erika.jean.gillespie@gmail.com
Elijah Redington	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Stephani Salisbury	Family Members of Individuals in Recovery (to include family members of adults with SMI)		500 E. Maple Coldwater KS, 67029 PH: 785-580-8698	stephaniesalisbury@outlook.com
Fran Seymour-Hunter	State Employees	Kansas Dept of Health and Environment	900 SW Jackson, Ste. 900 Topeka KS, 66612 PH: 785-296-2212	Fran.Seymour-Hunter@ks.gov
Rodney Shepherd	Persons in recovery from or providing treatment for or advocating for SUD services		1 South Washington St. Emporia KS, 66801 PH: 620-344-1158	rodneys@cornerhouseinc.org
Brenda Soto	State Employees	KS Department for Children and Family Services	555 S. Kansas Ave. Topeka KS, 66612 PH: 785-250-2741	Brenda.Soto@ks.gov
Guy Steier	Others (Advocates who are not State employees or providers)	District Court Judge	636 Grand Avenue Clyde KS, 66938	judges@12d.org
Dr. Mark Thompson	State Employees	KS Department of Education	900 SW Jackson St. Topeka KS, 66612	
Dr. Sherrie Vaughn	Others (Advocates who are not State employees or providers)	NAMI Kansas	501 Jackson Street Number 400 Topeka KS, 66601 PH: 800-539-2660	info@namikansas.org

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

Footnotes:

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

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

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)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	5	
Others (Advocates who are not State employees or providers)	5	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	21	63.64%
State Employees	6	
Providers	4	
Vacancies	2	
Total State Employees & Providers	12	36.36%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Youth/adolescent representative (or member from an organization serving young people)	1	

* 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?

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of behavioral health consumers, family members of behavioral health consumers, behavioral health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' behavioral health services.

Each of the Council's Subcommittees includes at least one member of the council and various other interested stakeholders, including consumers and

family members. Behavioral Health Services staff serve as liaisons and support to the subcommittees. The Subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as the Secretaries of relevant state agencies. The Kansas Governor's Behavioral Health Services Council and subcommittees are very active in the review of the application. Subcommittees reviewed draft sections of the FFY 2022-2023 Block Grant Application as they were drafted and provided written feedback and content before public comment. Feedback and content from subcommittees and Council are incorporated into the draft.

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

Footnotes:

Environmental Factors and Plan

22. 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/substance-abuse-and-mental-health-services-administration-block-grant>
 - c) Other (e.g. public service announcements, print media) Yes No

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

Footnotes:

Posted for public comment on the KDADS website on 8/23/21
Public comment can be found in the attached binder.

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction^{1,2} on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018³.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers⁴. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs⁵: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>,

1. [Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016](https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf) from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf>,
2. [Centers for Disease Control and Prevention \(CDC\) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016](http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf) The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs](http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf) <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
 - Include proposed protocols, timeline for implementation, and overall budget
 - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

¹ Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

² Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

³ Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

⁴ Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

⁵ ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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

Footnotes:

Kansas does not have any needle exchange programs.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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

Footnotes:

Kansas does not have any needle exchange programs and is not planning to expend funds from the COVID-19 Block Grant award for syringe service programs.

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404



www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Ric Dalke, Vice Chairperson

GOVERNOR LAURA Kelly

August 24, 2021

To Whom It May Concern,

During the past year, the Kansas Governor's Behavioral Health Service Planning Council (GBHSPC) has continued to focus on ensuring that Behavioral Health Services are integrated and meet the needs of Kansas children, adults, and their families who are experiencing mental health, addictions, and co-occurring disorders. GBHSPC members continue to participate in subcommittees and task forces. Currently, the GBHSPC has ten active subcommittees. The subcommittees are: Housing and Homelessness, Justice Involved Youth and Adults, Supportive Employment and Vocational Services, Prevention, Children's, Rural and Frontier, Service Members Veterans and Families, Evidence Based Practice, Problem Gambling and Gaming 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.

As additional support for recommendations in mental health and substance use disorder programs and recovery services in Kansas with oversight reviews and recommendations for the Block Grant in Kansas, the GBHSPC will be adding two additional subcommittees this year. The new subcommittees are the Aging Populations, and the Peer Services Subcommittees.

Each of the Subcommittees provided their yearly reports and recommendation to the Secretary and Leadership team of the Kansas Department for Aging and Disability Services. The reports are now available on the Behavioral Health Commission Website.

The reports from 2020 from the subcommittees have served as a vital source of information and for the development of recommendations for several special government taskforces in the past year. The reports were utilized by the Kansas Legislature's Mental Health Modernization legislative committee for development of a ten-year planning recommendation to the legislature. The 2021 reports from the GBHSPC subcommittee will be submitted to the committee for further review and recommendations in this ongoing process as the Kansas Legislature plans to continue to convene this committee in the FY22 session.

This letter is confirmation that the Kansas FFY2022 and FFY2023 Substance Abuse Prevention and Treatment and Mental Health Block Grant Application have both been reviewed and approved by the Kansas Governor's Behavioral Health Service Planning Council (GBHSPC).

Sincerely,

A handwritten signature in black ink that reads "Sherman Wes Cole". The signature is written in a cursive style.

Sherman Wes Cole
Chair, Governor's Behavioral Health Services Planning Council



August 26, 2021

**Kansas Department on Aging and Disability Services
Public Comment Regarding:
APPLICATION FY 2022/2023 Substance Abuse Prevention and Treatment
Block Grant Application
SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT**

Secretary Howard,

The Behavioral Health Association of Kansas (BHAK) is the state's trade organization dedicated solely to substance use disorder treatment and prevention providers seeking integrated behavioral health care. BHAK believes that true integrated behavioral health means access and funding for mental illness and substance use disorder treatment without regard to where a consumer seeks services. We appreciate the growing awareness of how substance use disorder affects everyone, particularly as a result of the impact of the pandemic. Addictions issues impact health care, employment, public safety, child welfare, and we support your investment of energy and resources.

Our specific comments regarding the FY 2022/2023 Substance Abuse Prevention and Treatment Block Grant Application include the following:

- MAT for alcohol treatment (P. 34). We offer strong support for the use of Medication-Assisted Treatment for alcohol. Expansion of eligibility is needed greatly to address the high prevalence in Kansas.
- Block Grant Data (P. 84-85). Client treatment, provider operations, planning and funding all are improved when Block Grant recipients have access to data. Unmet need, gaps in services, and efficient operations are exacerbated by restricting access to de-identified data. *"SAMHSA staff were onsite in May 2018 for a 10-year comprehensive review. The Center for Substance Abuse Treatment (CSAT) commented in the exit interview that a strength for the State is the strong relationships Kansas has formed between the State, the ASO, and SUD providers. CSAT reviewers were also impressed with the wealth of data the ASO provides the State."* (P. 85). Providers in Kansas do not see that data unless specifically requested and not statewide or regional. The State and the ASO must increase provider access to data at the individual provider level at least on a quarterly basis. Additionally, system-wide data assists providers, systems, and policy-maker ability to understand and support the SUD treatment system. The data and reports exist and the State and the ASO should provide them regularly.
- Health Care System, Parity, and Integration. (P. 119). We strongly recognize the statement regarding *"Health care professionals and persons who access M/SUD*

treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community.” (P. 119). We agree with this statement and support access and integration but that comes through openness, cooperation, not through the consolidation and centralization of well-funded silos. The more providers and systems that remain engaged, the greater is the SUD system’ capacity, access to care, choice, and improved outcomes.

We appreciate your on-going support and skilled management of the Block Grant program.

Stuart J. Little, Ph.D., President
Behavioral Health Association of Kansas
<https://www.bhakansas.com>

From: [Stephanie Rhinehart \[KDADS\]](#)
To: [Diana Marsh \[KDADS\]](#)
Subject: FW: Kansas BG Application Planning Step 2 draft (SABG and MHBG)
Date: Monday, August 23, 2021 8:50:16 AM
Attachments: [08-16-21 FY2022 - FY2023 MH and SUD BG Application_Step 2_DRAFT.CAC Edits.docx](#)

From: Childs, Chad <Chad.Childs@wichita.edu>

Sent: Monday, August 16, 2021 7:25 PM

To: Lisa Chaney <lisa.chaney@greenbush.org>; Aonya Barnett <aonya@partnersforwichita.org>; Bailey Blair <Bailey.Blair@mhasck.org>; Chrissy Mayer <cmayer@dcca.org>; Dyer, Callie L <calliedyer@centura.org>; EllisS3 <EllisS3@aetna.com>; Fulton, David C. <david.fulton@va.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>; Holly Bowyer <hollyb@thecentergb.org>; jan <jan@partnersforwichita.org>; Liz Hamor <ksulizh@gmail.com>; Marissa Woodmansee <mwoodmansee@bartoncounty.org>; Mary McBride <mannmcb@gmail.com>; monica <monica@ksphq.org>; Stephanie Rhinehart [KDADS] <Stephanie.Rhinehart@ks.gov>; sroberts <sroberts@cyle.info>; Sue Cooper <scooper@bartoncounty.org>; Vicki M. Broz <vbroz@compassbh.org>

Subject: RE: Kansas BG Application Planning Step 2 draft (SABG and MHBG)

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Thanks Lisa and Stephanie.

I've made a few suggested edits but didn't look at it super closely yet. I've also made some suggestions for other data I consider to be important and relevant in the attached draft of the document, and I wonder if we can discuss including some of this (especially on pages 7 and 10-12).

And, I didn't want to mess up the document too much, and this is an editorial not a research paper, but I'm proposing we consider that if more people with severe and persistent mental illness are going to jails and prisons instead of hospitals, we may need to consider this a priority especially for the disproportionate percentage of BIPOC adults being imprisoned in Kansas:

<https://www.kansas.com/opinion/guest-commentary/article235180582.html>

Thanks,

Citizen and Subcommittee Member chad

From: Lisa Chaney <lisa.chaney@greenbush.org>

Sent: Monday, August 16, 2021 1:00 PM

To: Aonya Barnett <aonya@partnersforwichita.org>; Bailey Blair <Bailey.Blair@mhasck.org>; Childs, Chad <Chad.Childs@wichita.edu>; Chrissy Mayer <cmayer@dcca.org>; Dyer, Callie L <calliedyer@centura.org>; Ellis, Shereen <EllisS3@aetna.com>; Fulton, David C. <david.fulton@va.gov>; Gary Henault [KDADS] <gary.henault@ks.gov>; Holly Bowyer <hollyb@thecentergb.org>; Jan Chandler <jan@partnersforwichita.org>; Lisa Chaney

<lisa.chaney@greenbush.org>; Liz Hamor <ksulizh@gmail.com>; Marissa Woodmansee <mwoodmansee@bartoncounty.org>; Mary McBride <mannmcb@gmail.com>; Monica Kurz <monica@ksphq.org>; Stephanie Rhinehart [KDADS] <Stephanie.Rhinehart@ks.gov>; Stephenie Roberts <sroberts@cyle.info>; Sue Cooper <scooper@bartoncounty.org>; Vicki Broz <vbroz@compassbh.org>

Subject: Fwd: Kansas BG Application Planning Step 2 draft (SABG and MHBG)

CAUTION: This email originated from outside of Wichita State University. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Lisa, can you send this out to Prevention Subcommittee Members:

The attached draft (Planning Step 2) is ready to send to GBHSPC subcommittees. This section is a required section for the Mental Health Block Grant Application and the Substance Abuse Block Grant Application due to SAMHSA by 9/1 (internal deadline is the Friday before 8/27). If the subcommittee would like to provide feedback, please request they send it to me, Stephanie Rhinehart, in writing so we can incorporate and attach to the plan.

If the subcommittee would like to provide feedback prior to the Application being posted for public comment, we are still drafting but hope to get this all together sometime this week to post. If they aren't able to make it by that date, no worries, they can still provide feedback during the public comment period.

Thank you

Stephanie Rhinehart, LMSW
Prevention Program Manager
Kansas Department for Aging and Disability Services
503 S. Kansas Ave
Topeka, Kansas 66603
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FFY2022 - 2023 Mental Health and Substance Abuse Prevention and Treatment Block Grant
Application

Section II: Planning Steps

Step Two Narrative

DRAFT

➤ **SABG Instructions (Step Two Narrative)**

From the guidance:

“Step 2: Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet services needs and critical gaps in the state’s current systems, as well as the data sources used to identify the needs and gaps of the 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 these unmet service needs and gaps.” The state’s priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA’s National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Abuse Treatment Services (N-SSATS), the Behavioral Health Barometer, and state data.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Person Who Inject Drugs, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Use Prevention, and, for HIV-designated states, Persons at Risk for HIV. Moreover, a discussion of the unmet service needs and critical gaps in the current system regarding diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American person, Asian Americans, and Pacific Islanders), members of religious minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality must be included. In addition, this narrative must include a description of the composition of the State Epidemiological Outcomes Workgroup and its contribution to the state planning process.

➤ **MHBG Instructions (Step Two Narrative)**

From the guidance:

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

This step should identify the unmet service needs and critical gaps in the state’s current M/SUD 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 M/SUD 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.

A data-driven process must support the state's priorities and goals. 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, 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 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.

The Kansas Legislative Special Committee on Mental Health Modernization and Reform

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

The Kansas Step 2 response was compiled from several Federal and State resources including Federal Data resources such as SAMHSA's National Survey on Drug Use and Health (NSDUH) and the Behavioral Health Barometer for Kansas (Volume 6), Kansas Legislative Special Committee on Mental Health Modernization and Reform recommendations, Governor's Behavioral Health Services [Committee Planning Council](#) and Subcommittee recommendations, and Contractor reporting, research and analysis. A large contribution was from the Boston Consulting Group (BCG), the Kansas State Epidemiological Outcomes Workgroup (SEOW), and Greenbush Education Service Center.

KDADS has determined the identified needs and gaps will be supported through a combination of funding streams and strategies including the Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) standard and additional COVID and ARP funds, along with other State funding and grants. To address the needs and gaps in Kansas's mental health prevention, treatment, and recovery services systems in the context of COVID-19, Kansas applied for and received funding for two programs - the SAMHSA/FEMA Crisis Counseling Program and the Emergency COVID-19 Response grant.

Kansas State Epidemiological Outcomes Workgroup (SEOW)

State Epidemiological Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) was created to integrate state efforts toward data collection. The intended purpose of the SEOW is to bring together a diverse group of data experts responsible for data on substance use/misuse and related behavioral health problems to the forefront of the prevention planning process for the state. The SEOW strives to support the State's prevention infrastructure by enhancing the ability to acquire, integrate, disseminate, and utilize a diverse set of

behavioral health indicators and epidemiological data to inform and guide prevention efforts and build capacity to address substance abuse prevention, treatment, and mental health outcomes in a coordinated, data-driven fashion. To achieve its mission, the Kansas SEOW is charged with the following core tasks: Identifying, analyzing, profiling, and sharing data from existing state and local sources; Creating data-guided products that inform prevention planning and policies; Training communities in understanding, using, and presenting data in an effective manner; and Building state- and local-level monitoring and surveillance systems.

The Kansas SEOW meets quarterly. Current membership includes representatives from the following:

- The University of Kansas Center for Community Health and Development
- The Learning Tree Institute at Greenbush
- Kansas Depart for Aging and Disability Services Behavioral Health Services
- Kansas Department of Health and Environment
- Kansas Department of Transportation
- Kansas Board of Pharmacy
- The University of Kansas Poison Control Center
- Kansas Board of Emergency Medical Services
- Kansas Racing and Gaming Commission
- Kansas Bureau of Investigation
- The University of Kansas Center for Telemedicine and Telehealth
- Sedgwick County Health Department

The SEOW maintains and updates the *Kansas Behavioral Health Profile* which integrates a data set inclusive of a wide array of behavioral health indicators and serves as a *Statewide Needs Assessment*. The original Profile was developed in 2006 and focused solely on substance use indicators. The profile was updated every two years and with each update, significant enhancements were made to expand the scope of behavioral health and mental health assessment and surveillance data that aligns with the Strategic Prevention Framework (SPF) and the Substance Abuse and Mental Health Block Grant. This included problem gambling, mental health, and treatment indicators. When available, all indicators report data related to the prevalence, treatment, and consequences by age, gender, race, and ethnicity. This is helpful for prevention and treatment focuses across the lifespan.

The 2021 Kansas Behavioral Health Profile has expanded to include *concerning trends* in psychostimulants and pseudo-synthetics drugs and measures of Serious Mental Illness. The updated profile is designed to provide an in-depth, data-focused perspective on the extent of substance abuse health agencies, treatment agencies, and law enforcement and revenue agencies. The intent is to illustrate, as completely as possible, the current state of behavioral and mental health which supports a data-informed prioritization process as part of comprehensive state-level and community-level assessment. Utilizing a broad range of information from multiple sectors, organizations, and data sets allows for the depiction of a more thorough picture of substance abuse-related consequence and consumption patterns.

The SEOW is working toward expanding and existing *Data Inventory* for Kansas which will include information from all available sources across state and private agencies to provide information on data providers, data characteristics, and the availability of data, raw or analyzed. The guide will assist stakeholders in locating behavioral health data to assist in sharing findings and promoting evidence-based prevention and positive outcomes.

In FY2022, the SEOW will look at *two unique populations* through additional statewide data being collected. Data from the Kansas Communities That Care Student Survey will ask questions related to sexual orientation and gender identity. And, the 2021 Kansas Young Adult Survey will have new data for the hard-to-reach 18–25-year-old population. New data from both sources will prove valuable to prevention stakeholders. The SEOW Co-Chairs will be *connecting with regional SEOWs* to review regional patterns and learn about novel approaches. The SEOW is also *building a website* to house resources, planning documents, and data briefs.

Prevention System Needs

KDADS provides funding/grants for community coalitions to plan and implement strategic prevention plans. With the amount of funding available, currently two coalitions are in the strategic planning process and 10 coalitions receive funds to implement their strategic prevention plans. While these grantees have shown ~~positive-desired~~ outcomes reducing underage drinking and youth marijuana use, ~~the lack of saturation of prevention efforts across the state~~ makes it difficult to realize impact and report statewide performance levels.

The State Epidemiological Outcomes Workgroup reviews and updates data for the *Kansas Behavioral Health Profile* which is used for assessing and prioritizing areas of need. The profile compiles all available behavioral health data in the state to provide a comprehensive picture of the impact of behavioral health challenges in Kansas. Some of the identified needs include services in rural communities, prevention efforts for young adults, and lack of data on sexual and gender minorities.

KDADS recognizes the challenges and barriers in access to public and behavioral health *services in rural and frontier communities*. ~~The vast majority of~~Most Americans living in underserved, rural and remote rural areas experience disparities in substance use and mental health services. ~~These-Related potential barriers to equity~~ include distance, travel time, cost, and time away from the workplace, and ~~often~~ lack of reliable transportation. A shortage of healthcare professionals in rural areas can also limit access by limiting the supply of available services. Prevention data sources including the Kansas Communities That Care Student Survey and the Kansas Behavioral Health Indicators Dashboard and others can be disaggregated by population density to monitor disparities between rural and urban areas. KDADS would like to infuse more prevention knowledge and efforts into rural Kansas communities to increase rural coalition capacity to develop and implement strategic prevention plans. One way KDADS will do this is to increase the number of trainings in rural communities which will be documented and reported in the Community Check Box system to report performance progress toward targets. Training will focus on behavioral/mental health and substance use prevention for youth, young adults, school staff, and families.

In addition to funding current [Kansas Prevention Collaborative \(KPC\)](#) grantees, [American Rescue Plan Act \(ARPA\)](#) funding will allow KDADS to expand prevention efforts to ~~better~~-address rural, underserved racial and minority populations and young adults.

In FY 2021, grantees applied the data-driven Strategic Prevention Framework process to identify and address sub-populations to improve behavioral health outcomes by utilizing the at-risk population assessment and developing a *local Health Disparities Statement*. Data used for review included *census data*, county-level *Kansas Communities That Care Student Survey demographic data*, and county-~~level~~ data from the *Kansas Behavioral Health Indicators Dashboard (KBHID)*. Use of data from other sources

including local county health departments was encouraged. In FY 2022 grantees will be implementing strategies focused on these populations. Through the support of the prevention system, Kansas will offer additional assistance to communities that will allow them to identify which strategies will be the most effective and sustainable in their community.

Part of the challenge of this process is the lack of **coordinated** data for diverse subpopulations. One step KDADS will take in FY 2022 is to *expand data collection include gender identity and sexual orientation*. For the first time, Kansas school districts will be able to choose to participate in a new module of the Kansas Communities That Care Student Survey that asks students in 6th, 8th, 10th, and 12th grades about their gender identity and sexual orientation. Survey participation requires parent consent, student consent and is completely anonymous. However, new information gathered from the survey can inform prevention needs and identify supports for this youth population.

Commented [CC1]: What is "coordinated data"?

Another hard-to-reach population is young adults aged 18-25 **years**. KDADS is gathering information through the 2021 Kansas Young Adult Survey (KYAS) to understand the needs of this population and develop a plan to enhance prevention efforts for this population. There is a lack of prevention strategies to specifically implement, and impact young adults aged 18-25 ~~and some~~ **relative to prioritized priority substances** such as marijuana. KDADS and the Evidence-Based **Strategies** Workgroup will continue to research effective strategies to address these needs.

Behavioral Health Needs

Nursing Facilities for Mental Health (NFMH)

In Kansas, Nursing Facilities for Mental Health provide residential care and rehabilitation treatment for persons experiencing severe symptoms of mental illness. They provide round-the-clock supervision and care for persons with mental illness needing this level of service. Despite bed capacity of approximately 635 beds available in NFMHs and 261 additional beds available at state hospital facilities (totaling approx. 896 total), KDADS has been notified that more bed space is needed to meet immediate needs.

Mental Health indicators with references to sources prepared by the Kansas SEOW are shared narratively and graphically below including data sources.

Mental Health Indicators

(Included in 2021 Kansas Behavioral Health Profile)

Major Depressive Episodes: Percent of population reporting having at least one major depressive episode in the past year

Why is this indicator important?

The link between mental health and substance abuse is well established. Experiencing episodes of depression or anxiety in the past year is associated with higher rates of substance abuse.

Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 – 2019

Important findings

- Percent of adults reporting having had at least one depressive episode in the last year is higher for Kansas residents than the national average.
- Percent of population reporting depressive episodes has increased over the past 5 years.
- Depressive episodes are most prevalent in the ages 12-17 category.

Graphs of Five-Year Trends

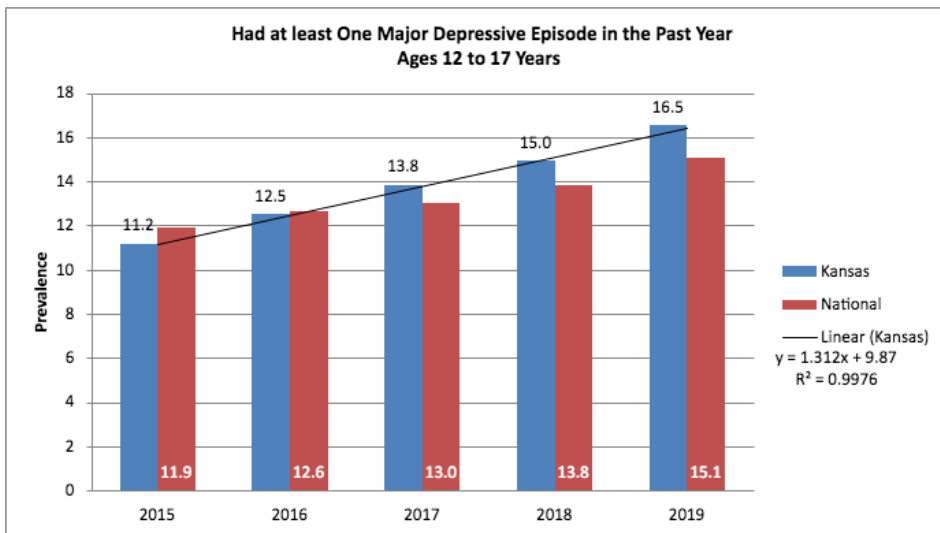
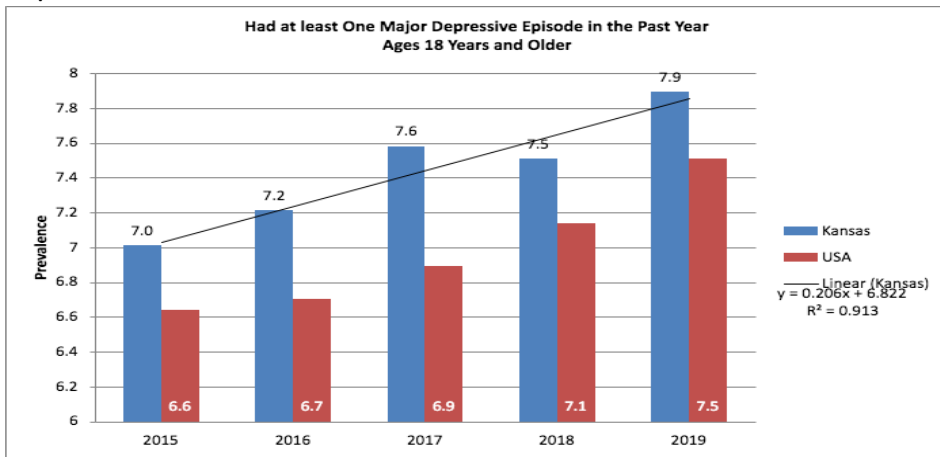


Table 17.1 Percent of population reporting having had at least one major depressive episode in the past year by age group, 2015-2019

Year	Ages 12-17	Ages 18-25	Age 26+	Age 18+
2015	11.2	9.8	6.5	7.0
2016	12.5	10.9	6.5	7.2
2017	13.8	11.9	6.8	7.6
2018	15.0	13.1	6.5	7.5
2019	16.5	14.6	6.7	7.9
5-Year Average	13.8	12.0	6.6	7.4

Depression: Percent of population responding, ‘yes’ to the question “Have you ever been told that you have a form of depression?”

Why is this indicator important?

The link between mental health and substance abuse is well established. Experiencing episodes of depression or anxiety is associated with higher rates of substance abuse.

Where did we get the data?

Centers for Disease Control and Prevention (CDC) Behavior Risk Factor Surveillance System (BRFSS) – 2015 – 2019

Important findings

- Percent of adults reporting having a form of depression has been generally higher for Kansas residents than the national average.
- Percent of population reporting depression has increased over the past 5 years.
- Depression is most often reported in females and those in the 18-25 age category.

Commented [CC2]: It is important that percentage of persons aged 18 and older reporting having been told they have depression is INCREDIBLY HIGH for people who are Native American and Multiple Race.

Graphs of Five-Year Trends

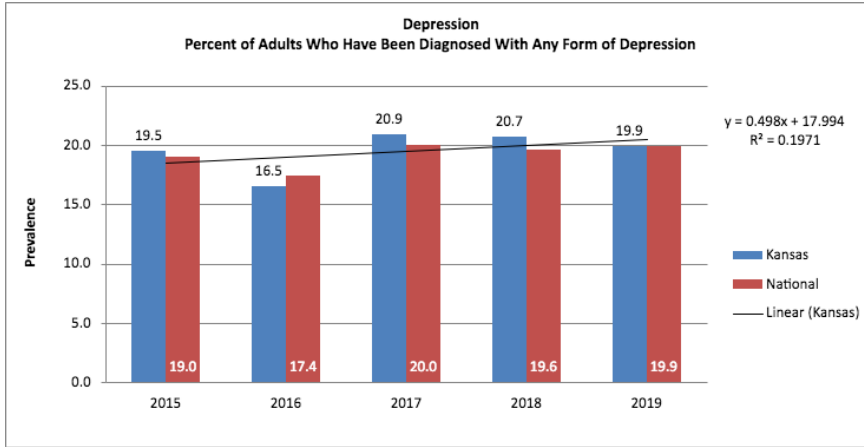


Table 17.2 Percentage of persons aged 18 and older reporting having been told they have depression by race and ethnicity, 2015-2019

Year	Overall	Race						Ethnicity	
		White	African American	Native American	Asian	Other	Multiple Race	Hispanic	Non-Hispanic
2015	19.5	20.0	19.9	36.2	4.5	0.0	31.5	13.9	20.0
2016	16.5	17.1	13.6	23.8	0.0	0.0	25.2	12.6	17.1
2017	20.9	21.3	18.8	31.8	6.6	0.0	37.3	21.1	21.3
2018	20.7	21.1	17.6	28.1	9.1	2.0	28.5	14.8	21.1
2019	19.9	19.9	15.4	24.4	9.2	0.0	28.0	21.6	19.9
5-Year Average	19.5	19.9	17.0	28.8	N/A	0.4	30.1	16.8	19.9

Table 17.3 Percentage of persons aged 18 and older reporting having been told they have depression for the State of Kansas by gender and age group, 2015-2019

Year	Overall	Gender		Age Group					
		Male	Female	18-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65+ years
2015	19.5	13.6	25.2	18.0	20.1	20.3	22.6	20.7	15.6
2016	16.5	11.8	21.0	17.1	17.8	17.8	16.3	18.2	12.7
2017	20.9	15.3	26.4	23.8	20.9	21.6	21.8	22.1	16.7
2018	20.7	14.6	26.6	24.1	23.2	21.1	20.1	22.2	15.3
2019	19.9	14.3	25.3	27.2	22.9	23.4	17.2	19.5	12.3

5-Year Average	19.5	13.9	24.9	22.0	21.0	20.8	19.6	20.5	14.5
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Table 17.4 Percentage of persons aged 18 and older reporting having been told they have depression for the State of Kansas by educational attainment and income, 2015-2019

Year	Overall	Education				Income			
		Less than High School	High School only	Some post-graduate	College Graduate	\$15,000 - \$24,999	\$25,000 - \$34,999	\$35,000 - \$49,999	\$50,000 and more
2015	19.5	21.6	19.1	22.2	15.6	27.1	20.9	18.4	14.9
2016	16.5	16.9	17.6	18.3	13.1	20.3	18.1	15.5	12.4
2017	20.9	30.1	20.9	21.8	16.5	30.1	21.3	21.5	15.3
2018	20.7	28.4	21.0	22.0	16.2	30.9	24.4	20.6	14.5
2019	19.9	28.3	18.5	21.1	17.0	27.9	22.8	21.2	15.0
5-Year Average	19.5	25.1	19.4	21.1	15.7	27.3	21.5	19.4	14.4

Suicidal Ideation: Percent of adult population surveyed reporting having had serious thoughts of suicide in the past year

Why is this indicator important?

Suicide is the most tragic consequences of major depressive disorders. Abuse of alcohol or other drugs may increase emotional problems leading to suicidal ideation or suicidal behavior.

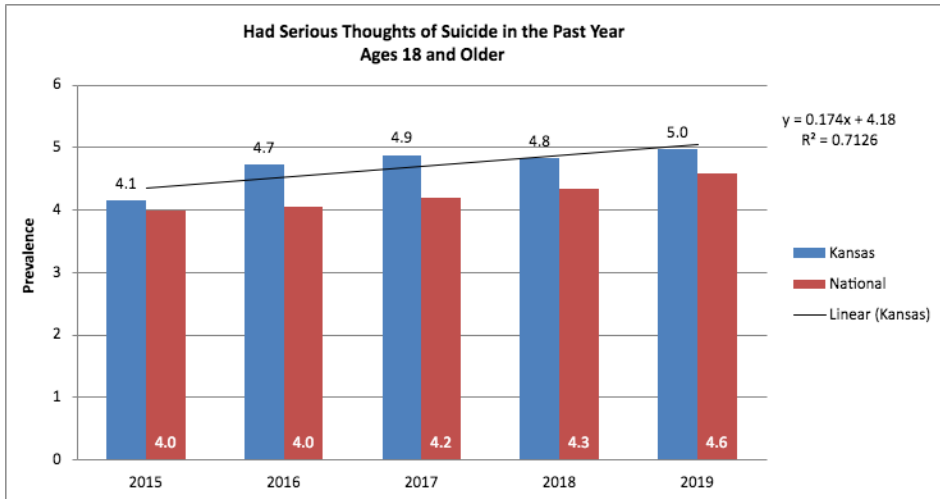
Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019

Important findings

- More adults in Kansas report having had suicidal thoughts in the past year than the national average.
- The percentage of those reporting having had serious thoughts of suicide during the twelve months preceding the survey has been increasing over the past 5 years.

Graph of Five-Year Trend



Persons Served in Community Mental Health Programs: Number and rate per 1,000 people served by Community Mental Health Treatment Centers, 2016-2020

Why is this indicator important?

The number of individuals receiving services is a useful indicator that helps illustrate both treatment capacity and treatment need, although not a standalone indicator of the total extent or pervasiveness of the behavioral health issue in terms of prevalence or incidence.

Where did we get the data?

Kansas Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, Output Tables 2016-2020

Important findings

- The number of individuals served in community mental health programs has remained relatively stable, although the rate per 1,000 in Kansas remains more than double the national average.
- Individuals aged 21-64 constituted 63% of admissions over a five-year timeframe.
- The rate of persons served by the State Mental Health Authority for Native American people was the highest rate of any racial group (NOMS CMHS, 2012-2016).
- Results of a nationwide survey show that 71% of LGBTQ+ Youth respondents reported symptoms of depression, 39% had considered suicide, and 18% had attempted suicide (The Trevor Project, 2019).

Commented [CC3]: Lots of important data to include in Kansas focus related to behavioral health disparities, with LGBTQ+ BIPOC

- Results of a national study showed female to male trans adolescents reported the highest rate of attempted suicide (50.8%), compared to 41.8% non-binary, 29.9% questioning, 17.6% female, 9.8% male (APA, 2021; <https://pediatrics.aappublications.org/content/pediatrics/142/4/e20174218.full.pdf>).
- This may hold true for Kansas (though data is limited).
- <https://www.kansashealthmatters.org/>:
 - 27.3% of people who are American Indian/Alaska Native reported having depression compared to 19.8% overall (all races)
- According to the KYAS:
 - Hispanic youth self-reported having driven under the influence of marijuana within the past year at a higher percentage (29.2%) than any youth who are not Hispanic (14.8%). (KYAS, 2017)
- According to KCTC Student Survey:
 - Native American/Alaska Native youth self-reported higher rates of depression than White/Non-Hispanic youth from 2016-2020 (37% vs. 27%; KCTC).
 - Multi-Racial youth self-reported higher rates of depression than White/Non-Hispanic youth from 2016-2020 (38% vs. 27%; KCTC).
 - American Indian/Alaska Native people (AI/AN) have the highest rates of suicide of any racial/ethnic group in the United States (21.5 per 100,000, more than 3.5 times higher than those among racial/ethnic groups with the lowest rates). The rates of suicide in this population have been increasing since 2003 (<https://www.cdc.gov/mmwr/volumes/67/wr/mm6708a1.htm>).
 - In 2017, Black youth and adults had higher percentages of the population who attempt and die by suicide than the overall U.S. population in the previous year (<https://www.sprc.org/scope/racial-ethnic-disparities/black-populations>).
 - Hispanic youth self-reported binge drinking at the highest rate among all racial and ethnic groups (KCTC,2013-2017).
 - Native American youth self-reported more risky alcohol use when compared to their peers of other races.
 - highest rate of initiating use of alcohol before age 13 of all racial and ethnic groups (KCTC, 2013-2017), at a rate almost 60% higher than White youth
 - lowest perception of “great risk of harm” of drinking alcohol regularly among all racial and ethnic groups (KCTC,2013-2017).
 - African American and Hispanic adults have higher percentages of current smokers 18 and older (CDC’s BRFSS, 2013-2016).
 - Native American youth self-reported a higher prevalence of recent cigarette, e-cigarette, and smokeless tobacco use than any other racial or ethnic group (Monitoring the Future, 2021-2016).
 - African American youth self-reported more past 30-days use of marijuana than any other racial or ethnic group (KCTC, 2013-2017).
 - According to self-report, Native American youth have taken prescription drugs not prescribed to them more in the past 30 days than any other racial or ethnic group (6.3%) (KCTC, 2013-2017).

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- o According to self-report, a higher rate of Native American youth have used any illicit drug (other than alcohol) in the past 30 days than any other race (24.2%) (KCTC, 2013-2017).

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Graph of Five-Year Trend

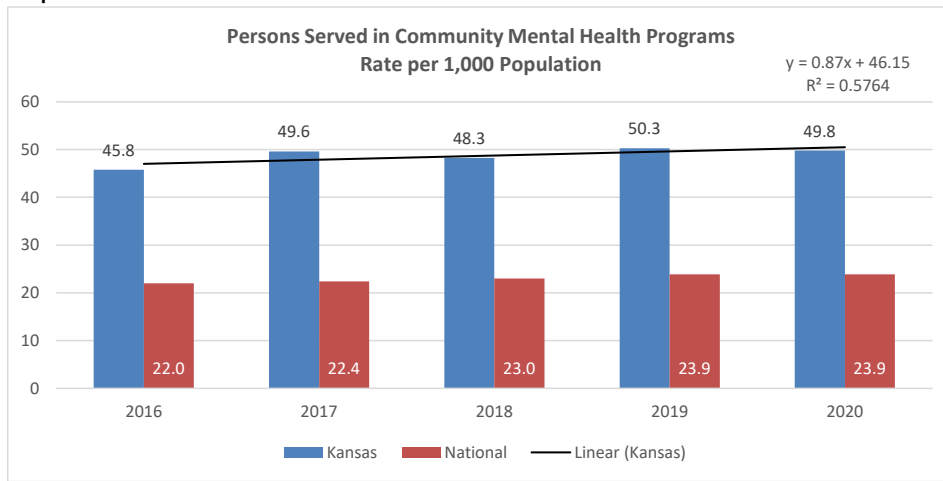


Table 18.1 Persons served in community mental health programs by gender and age, 2016-2020

Year	Female			Male			Age 0-17		
	Number	% of Total	Rate per 1,000	Number	% of Total	Rate per 1,000	Number	% of Total	Rate per 1,000
2016	69,524	51.90%	22.8	62,674	48.00%	21.8	8,254	27.50%	26.7
2017	76,095	52.10%	23.1	67,275	47.80%	21.9	9,134	28.00%	27.7
2018	74,368	52.20%	47.7	65,630	47.00%	43.1	8,881	26.80%	49.7
2019	77,019	52.70%	52.1	68,855	46.60%	46.5	9,397	26.50%	53.5
2020	77,003	52.90%	50.9	68,026	46.70%	45.2	9,385	26.60%	52.5
5-Year Average	72,810	52.00%	23	64,975	47.90%	21.9	8,694	27.70%	39.4

Table 18.2 Percentage of persons aged 18 and older reporting having been told they have depression for the State of Kansas by educational attainment and income, 2016-2020

Year	Age 18-20			Age 21-64			Age 65+		
	Number	% of Total	Rate per 1,000	Number	% of Total	Rate per 1,000	Number	% of Total	Rate per 1,000
2016	8,254	4.50%	24.7	81,189	63.50%	24.6	7,011	4.50%	6.5
2017	9,134	4.30%	24.3	88,065	62.80%	24.6	7,901	4.80%	6.9
2018	8,881	6.20%	65.4	85,466	60.90%	49.5	8,255	5.30%	16.4
2019	9,397	6.30%	73.3	88,676	61.00%	54	9,091	5.50%	18.1
2020	9,385	6.30%	71.4	88,762	60.80%	52.5	9,714	5.90%	18.4
5-Year Average	8,694	4.40%	24.5	84,627	63.10%	24.6	7,456	4.60%	6.7

Persons Served by State Mental Health Authority: Number and rate per 1,000 people (Adults with SMI and children with SED) served by Community Mental Health Treatment Centers, 2016-2020

Why is this indicator important?

Diagnoses of serious mental illness or serious emotional disorder among children and youth at admission to community mental health treatment services serves as an indicator of the number of individuals experiencing behavioral health difficulties, with implications for treatment need and capacity.

Where did we get the data?

Kansas Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, Output Tables 2016-2020

Important findings

- Over a five-year timeframe, individuals under age 18 represented the largest number of persons served by state mental health authority services.
- Males represented the largest number and highest rate of persons served by state mental health authority services over the five-year period as well as on an annual basis.

Graph of Five-Year Trend

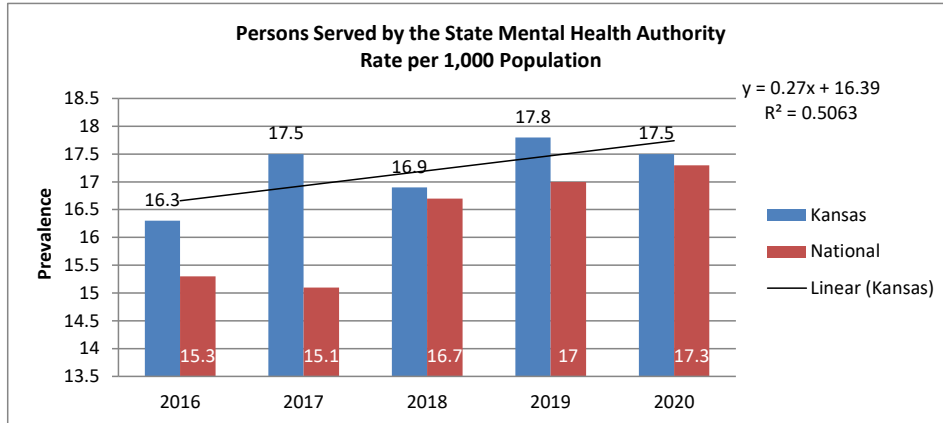


Table 18.2 Persons served by the State Mental Health Authority by age group, 2016-2020

Year	Age 0-17		Age 18-20		Age 21-24		Age 25-64		Age 65 and Over	
	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate
2016	22,711	38.8	3,964	31.4					1,386	3.1
2017	24,765	42.2	4,260	34.2					1,488	3.2
2018	24,343	41.5	3,784	30.4	2,409	16.2	16,941	12	1,512	3.2
2019	25,723	44.1	4,084	32.6	2,590	14	17,676	11.7	1,702	3.5
2020	24,870	43.2	4,163	33.1	2,635	15.3	9,652	12.2	36,841	8.2
5-Year Average	24,482	41.9	4,051	32.3	2,545	15.2	14,756	11.9	8,586	4.2

Table 18.3 Persons served by the State Mental Health Authority by race, 2016-2020

Year	White		African American		Multi-Racial		Native American, etc.		Native Hawaiian / Pacific Islander	
	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate
2016	34,855	13.8	5,225	31.5	1,494	18.0	1,601	46	102	30.9
2017	36,735	14.6	5,659	29.2	2,191	25.9	1,522	44	104	32.1
2018	34,906	13.9	5,235	31.1	2,860	33.1	1,375	39.7	252	73.5
2019	37,240	14.8	5,556	37.8	2,921	33.2	1,366	39.2	103	28.5
2020	5,407	30.3	1,326	0	4,016	0.0	608	6.5	3,113	34.9
5-Year Average	29,829	17.5	4,600	25.9	2,696	22.0	1,294	35.1	735	40.0

Table 18.4 Persons served by the State Mental Health Authority by gender and ethnicity, 2016-2020

Year	Female		Male		Hispanic		Not Hispanic	
	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000
2016	21,450	14.7	25,786	17.7	3,410	10.1	43,737	17
2017	23,195	15.9	27,573	19	3,958	11.7	46,597	18.1
2018	22,634	15.5	26,353	18.1	4,114	11.8	44,477	17.3
2019	23,829	16.3	27,945	19.3	4,495	12.8	46,884	18.3
2020	23,485	16.1	27,540	19	4,523	12.7	46,074	18
5-Year Average	22,919	15.7	27,039	18.6	4,100	11.8	45,554	17.7

Suicide: Number of deaths from suicide per 100,000 population

Why is this indicator important?

Suicide rates are highly correlated to alcohol and illicit drug abuse. Individuals suffering from chronic depression may begin to self-medicate, causing a higher-than-expected suicide rate.

Where did we get the data?

National and trend data from Centers for Disease Control and Prevention, National Center for Health Statistics - CDC WONDER online database, detailed mortality statistics 1999-2018 Multiple Cause of Death Files

Demographic data from Kansas Department of Health and Environment, Center for Health and Environmental Statistics, Office of Vital Statistics, Death Certificates 2015-2019

Important findings

- Rates of death by suicide are highest for white males.
- There is a higher rate of suicide in Kansas than the national average.
- The highest rates within the 25–44-year age range.
- The highest rate increase over the past five years is within the 15-24 age from 5.7 in 2015 to 11.4 in 2019.

Graph of Five-Year Trend

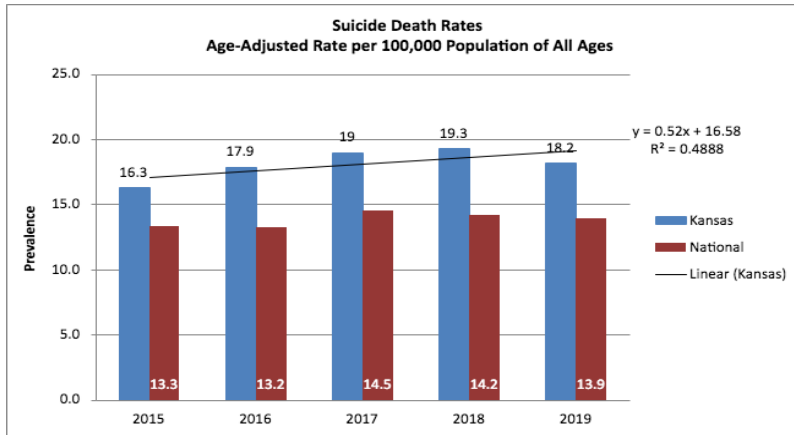


Table 19.1 Suicide death rates by gender, race, and ethnicity, 2015-2019

Year	Overall	Gender		Race			Ethnicity	
		Male	Female	White	African American	Otr	Hispanic	Non-Hispanic
2015	16.3	25.8	7.1	16.9	9.4		8.7	16.6
2016	17.9	28.2	7.9	18.5	12.7		9.9	18.7
2017	19.1	30.1	8.3	19.7	12.1		9.5	20.1
2018	19.3	30.4	8.2	19.9	13.4		9.8	20.2
2019	18.2	29	7.7	19.2	12		12.5	18.4
5-Year Average	18.2	28.7	7.8	18.8	11.9		10.1	18.8

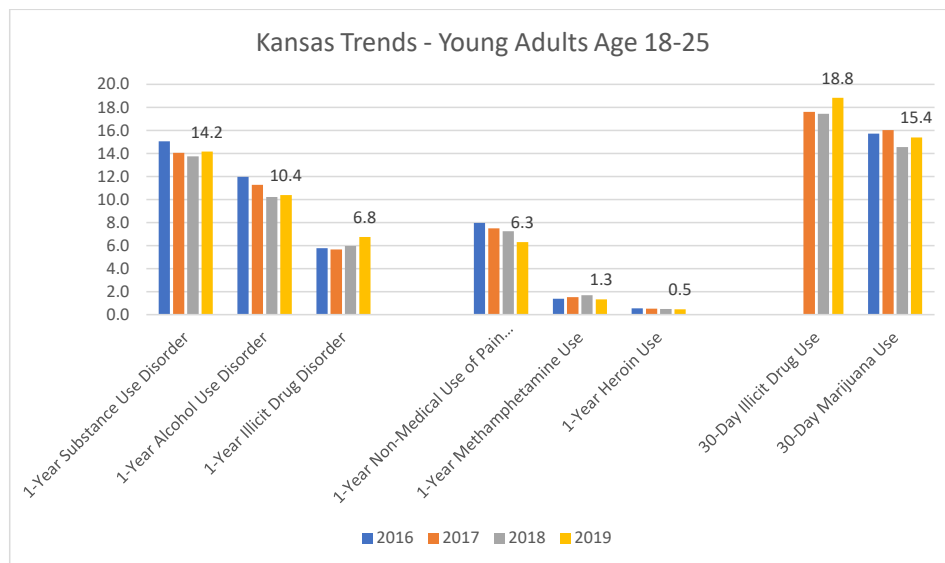
Table 19.2 Suicide death rates by age group, 2015-2019

Year	Overall Crude Rate	Age Group				
		Under 15 years	15-24 years	25-44 years Ave	45-64 years Ave	65+ years Ave
2015	16.4	0.0	5.7	9.7	9.2	6.8
2016	17.7	0.0	7.9	12.4	10.2	13.4
2017	19.0	0.0	11.8	13.3	13.9	7.7
2018	19.1	0.0	24.7	28.4	22.4	16.4
2019	18.0	0.0	11.4	13.6	10.0	6.6
5-Year Average	18.0	0.0	12.3	15.4	13.1	10.2

Substance Use: 1-year and 30-day Trends for Young Adults Ages 18 - 25

Where did we get the data?

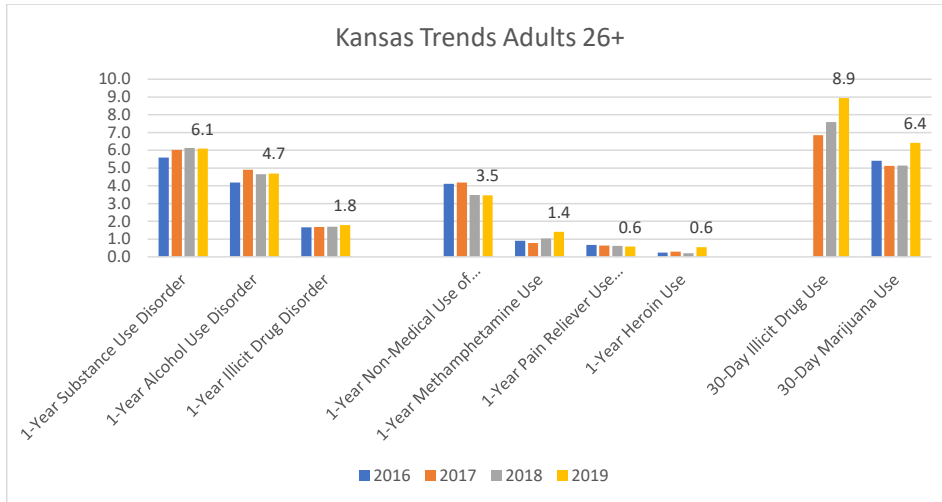
SAMHSA National Survey on Drug Use and Health (NSDUH) –
Summaries of National Findings and Detailed Tables 2015 - 2019



Substance Use: 1-year and 30-day Trends for Adults Ages 26+

Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and
Detailed Tables 2015 - 2019



Homicide: Number of deaths from homicide per 100,000 population

Why is this indicator important?

Homicide rates have been found to be correlated to alcohol and illicit drug abuse. Violence is a common side effect of both acute intoxication from alcohol as well as multiple illicit drugs.

Where did we get the data?

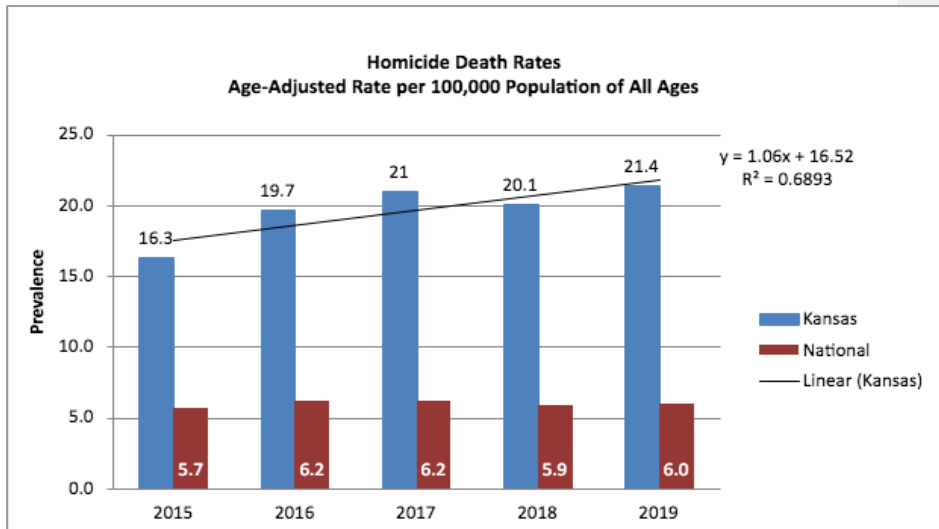
National and trend data from Centers for Disease Control and Prevention, National Center for Health Statistics - CDC WONDER online database, detailed mortality statistics 1999-2019 Multiple Cause of Death Files

Demographic data from Kansas Department of Health and Environment, Center for Health and Environmental Statistics, Office of Vital Statistics, Death Certificates 2015-2019

Important findings

- Rate of homicide in Kansas is substantially higher than reported nationwide. This may be due to difference in the way the data are tracked and reported and warrants further investigation.

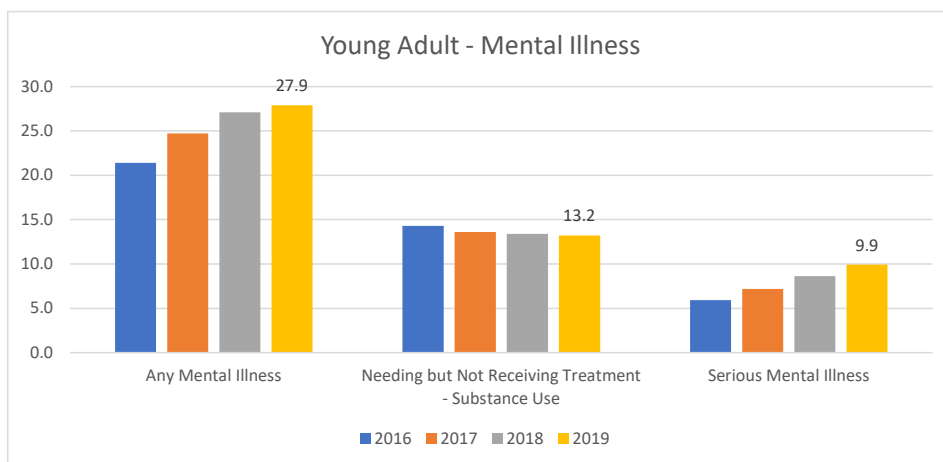
- **Graph of Five-Year Trend**



Mental Illness: Young Adult and Substance Use

Where did we get the data?

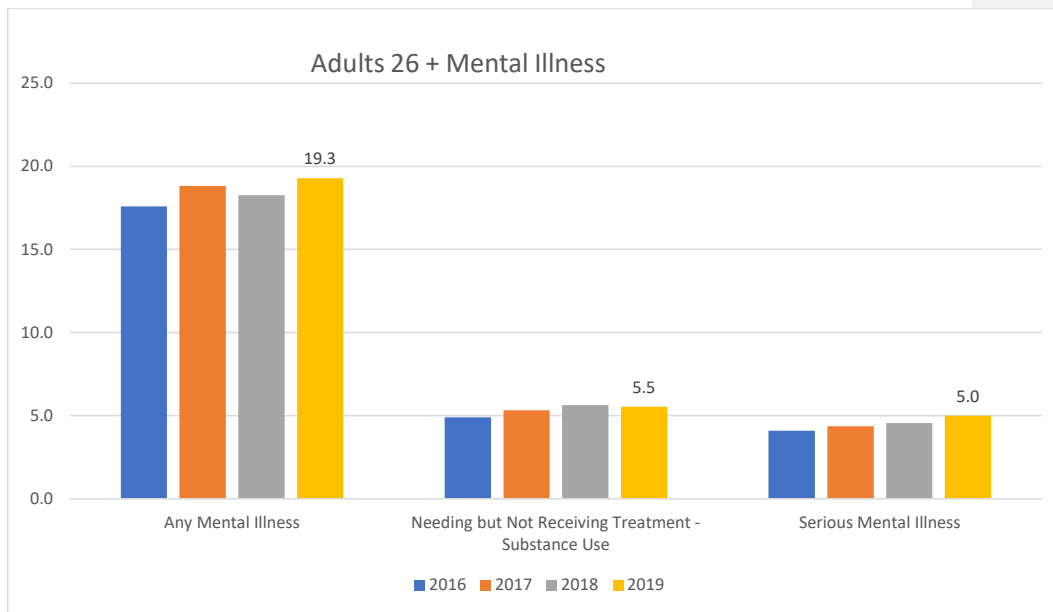
SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019



Mental Illness: Adult 26+ and Substance Use

Where did we get the data?

SAMHSA National Survey on Drug Use and Health (NSDUH) – Summaries of National Findings and Detailed Tables 2015 - 2019



The 2019 National Survey on Drug Use and Health (NSDUH) data for Kansas is shown in the table below:

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - Kansas		
Indicator	2017-2018	2018-2019
Kansans 18 or older reporting illicit drug use in the past month	9.1%	10.4%
NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - Kansas		
Indicator	2017 - 2018	2018-2019
18 or older marijuana use in the past month	6.5%	7.8%
Kansans 18 or older reporting illicit drug other than	9.1%	10.4%

marijuana use in the past month		
18 or older methamphetamine use in the past year	1.1%	1.4%
18 or older pain reliever misuse in the past year	4.1%	3.9%
18 or older illicit drug use disorder (per DSM-IV) in the past year	2.3%	2.5%
18 or older alcohol use disorder (per DSM-IV) in the past year	5.5%	5.5%
18 or older substance use disorder (per DSM-IV) in the past year	7.3%	7.3
18 or older needing but not receiving treatment at a specialty facility for substance use in the past year	6.8%	6.7%

Boston Consulting Group

Needs and gaps were further identified through efforts of the Boston Consulting Group (BCG) using prior reports such as The Kansas Legislative Special Committee on Mental Health Modernization and Reform Report, Governor’s Behavioral Health Services ~~Planning Committee~~ Planning Council Subcommittee Reports, and through interviews with Kansas Department on Aging and Disability Services staff. BCG defined key pillars of behavioral health services delivery as (1) prevention/promotion, (2) treatment, and (3) rehabilitation (rehab)/recovery.

In an effort to identify the needs and gaps in Kansas’s behavioral health services continuum including prevention, intervention, access to crisis services, treatment and recovery support services, BCG researched and provided the information detailed below.

(1) Prevention & Promotion

- a. Lower performance in both social and economic determinants of health create a higher risk profile for behavioral health challenges than the nation
 - i. Front-line healthcare workers
 - ii. Children out of school
- b. Increase prevention & promotion activities to mitigate COVID-19 impacts on behavioral health

BCG Presentation of KDADS Needs Assessment, March 2021, slide 15

Prevention

Prevention & promotion | Prevention of socioeconomic strains in Kansas can help improve correlated behavioral health outcomes

KS ranks 22nd nationally in Economic Hardship Index¹ which measures key socioeconomic measures

As of Dec. 2020: Indicates KS is less healthy; Indicates KS is healthier

- 14% Percent of households **unable to provide food** due to lack of resources vs. 11.4% NE; 9.2% IA; 11.7% nationally
- 3.9% Percent **unemployed** civilian population (ages 16-64) – down from 12% at beginning of pandemic vs. 3.4% NE; 3.9% IA; 4.6% nationally
- \$32.8k Per capita income (inflation adjusted) vs. \$33.3k NE; \$33.1k IA; \$35.7k nationally
- 16% Percent of children with **adverse childhood experiences** vs. 15.3% NE; 16.7% IA; 14.7% nationally

Socioeconomic factors are direct determinants of behavioral health outcomes

Prevalence of any mental illness (AMI) by household income % of general population

Additionally,

- Financial stress increases the risk of **family violence** by up to 50%
- Youth in low socioeconomic households are **2.5 times** more likely to have **depressed mood or anxiety**
- Children of mothers with mental ill-health are **5 times** more likely to have **mental disorders**

1. Normalized index score measuring education, income, poverty, unemployment, crowded housing and dependency measures. Sources: America's Health Rankings 2020 Report, all figures as of Dec. 2020, Expert Interviews, CDC, WHO Social Determinants of Behavioral Health 2007

(2) Treatment

- a. High level of unmet needs across all Kansans driven by challenges in affordability, care availability, and integrated care (e.g., handoff between primary care systems and behavioral health systems)
 - i. Diverting crisis response from law enforcement
 - ii. Long wait times for hospitals, & crisis response
- b. Increase capacity of care to accommodate further increase in in-patient care; expand/optimize existing in-patient network

BCG Presentation of KDADS Needs Assessment, March 2021, slide 22

Treatment

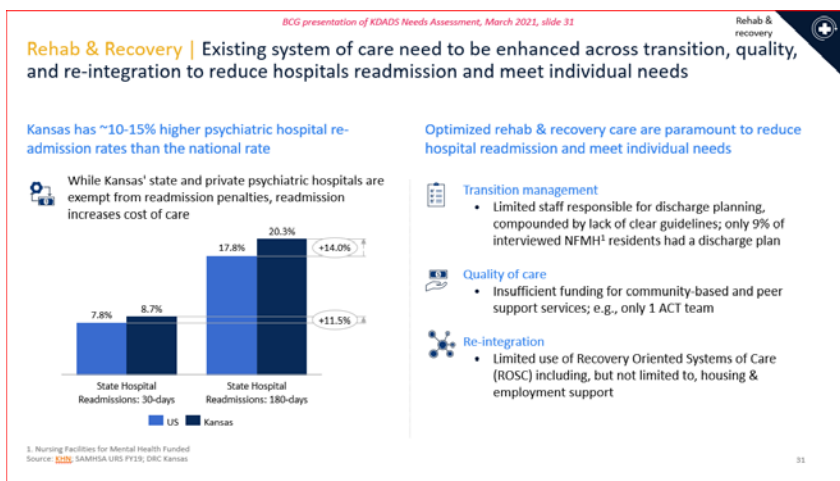
Treatment | Examples of Kansas treatment needs span across access, capacity, and quality

Unmet needs: access, capacity, and quality

- Low access to care**
Kansas ranked 36th across US states¹ includes access to insurance, access to treatment, quality and cost of insurance, special education, & workforce availability Missouri 41st, Nebraska 29th, Iowa 15th, Indiana 26th
- High rates of uninsured adults with mental illness²**
Kansas ranked 37th (12%) across US states, one of few states seeing a decrease (2.2%) compared with 2017 Missouri 44th, Nebraska 29th, Iowa 21st, Indiana 34th National 10.8%
- Half of adults with AMI didn't receive treatment**
Kansas ranked 12th across US states Missouri 31st, Nebraska 29th, Iowa 7th, Indiana 33rd National 57%
- Highest reported % of adults reporting unmet needs**
Kansas ranked 51st across all 51 US states Missouri 41st, Nebraska 29th, Iowa 45th, Indiana 24th National 23.6%
- Zero psychiatric beds in 15 CMHC catchment areas**
15 of the 26 CMHC catchment areas do not have any inpatient beds
- Utilization & access to peer support services**
40% of people admitted to a mental health facility have never received any kind of peer support or community care
- Limited availability of integrated care**
Individuals with a serious mental illness (SMI) have higher rates of cooccurring chronic medical conditions requiring an integrated approach to care delivery
- Higher likelihood of incarceration vs. hospitalization**
Similar to every state in the nation, Kansas incarcerates more individuals with SMI than it hospitalizes at a ratio of 3.5 to 1

(3) Rehab & Recovery

- a. High psychiatric readmission rates; inconsistent transition management, quality of care, and re-integration support for rehab & recovery patients
 - i. Long wait times for recovery services
 - ii. High cost of care
- b. Increase capacity of care



In an effort to address the needs identified by BCG, Kansas is utilizing Block Grant additional funding for Prevention, Treatment, and Recovery activities including Social Determinants of Health.

Examples include Prevention activities, supplementing the CCBHC expansion recommended by the Kansas Legislative Special Committee on Mental Health Modernization and Reform, and targeted funding towards Assertive Community Treatment (ACT) teams, Assisted Outpatient Treatment (AOT) expansion, the 988 hotlines, and the Stepping Up Initiative.

The Stepping Up initiative is a national partnership between The Council of State Governments Justice Center, the National Association of Counties, and the America Psychiatric Association Foundation. The initiative aims to reduce the number of people in jail as a result of their mental illness. Kansas just launched (January 2021) the technical assistance project for the Stepping Up initiative to inspire counties to become Stepping Up communities. The goal of this project is to facilitate better solutions for linking people with mental illness to treatment and services while improving public safety.

Other examples include discharge planning and supplementing housing and employment programs like IPS, Oxford housing, Housing First and Employment First. Additional funding is also directed toward inpatient and outpatient treatment including medication-assisted treatment (MAT). Kansas will be implementing reimbursement codes for alcohol use disorder MAT.

Commented [CC4]: I'm not sure what this means. I understand what Social Determinants of Health are, but I don't know if this is referencing funding like the Block Grant or what "activities" include SDOH.

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State Data and Resources

To further identify unmet service needs and critical gaps within the current Behavioral Health system in Kansas, KDADS heavily relies upon resources such as the state mental health data system called [Automated Information Management System \(AIMS\)](#), the state substance use treatment data collection system called [Kansas Substance Use Reporting Solution \(KSURS\)](#), and the Governor’s Behavioral Health Services Planning Council and [Subcommittees](#).

Automated Information Management System (AIMS)

Community Mental Health Centers (CMHCs) provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. ~~The Automated Information Management System (AIMS)~~ is a centralized database managed by KDADS and entered into by CMHC staff. AIMS tracks a comprehensive data set including consumer demographic information and mental health services provided by the CMHCs to Kansans.

Per ~~the State Automated Information Management System (AIMS) data~~, CMHCs served over 144,000 consumers during the past two fiscal years as the table below indicated.

State Fiscal Years	Adults (over 18)	Children/Youth (under 18)	Total Consumers Served
2020	102,527	42,434	144,961
2021	103,538	41,020	144,558

[Kansas Substance Use Reporting Solution \(KSURS\)](#)

In October 2018, the Kansas Department for Aging and Disability Services (KDADS) determined that the antiquated substance use disorder treatment data collection system called Kansas Client Placement Criteria (KCPC) could no longer be supported by the state and ended the transmission of client records. In addition to assessment and authorization of services, a critical function of the KCPC was the collection of admission and discharge data for SAMHSA’s Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMs).

While the state continues to explore a range of options to replace the KCPC system, all Kansas substance use treatment providers who accept public funding are required to collect and submit TEDS data to the new Kansas Substance Use Reporting Solution (KSURS). Providers have two options to submit data to KSURS: 1) manually enter treatment information through an online application; or 2) submit a bulk load in a file format provided and validated by the state.

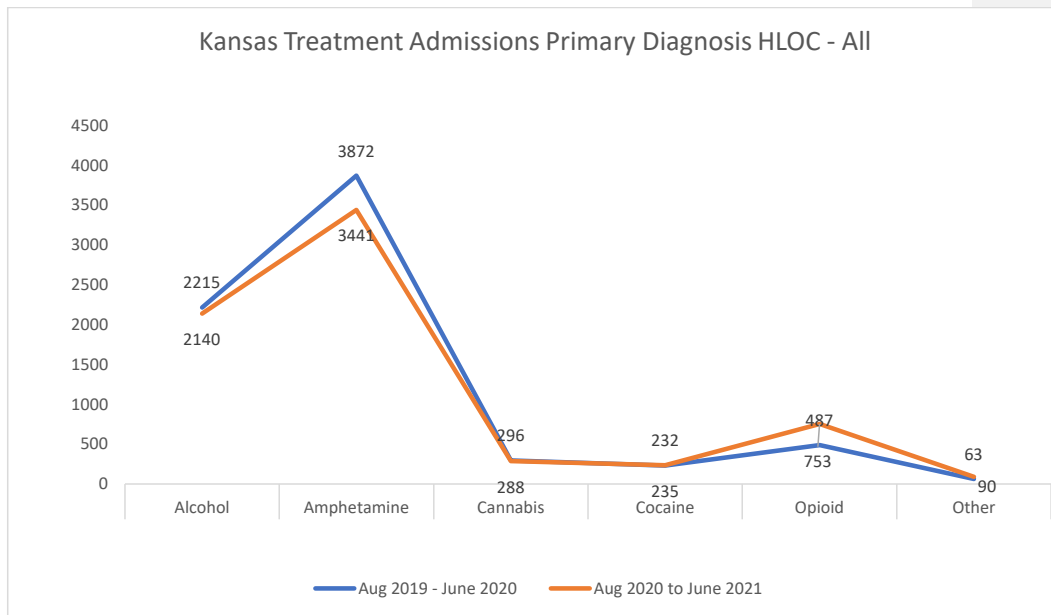
Through a Request for Proposal process, KDADS is working on a solution to modernize its substance use disorder data collection system. The RFP includes a comprehensive upgrade of IT systems at all four State hospitals both from the infrastructure and software perspective. The State is currently in the process of reviewing proposals and selecting a vendor.

Administrative Services Organization (ASO)

To identify unmet service needs and critical gaps within the current Block Grant substance use disorder treatment system, KDADS relies primarily upon data reported by the Administrative Service Organization (ASO) or Beacon HealthOptions with whom KDADS contracts to administer SAT Block Grant funds to providers. SAMHSA staff were onsite in May 2018 for a 10-year comprehensive review. The Center for Substance Abuse Treatment (CSAT) commented in the exit interview that a strength for the State is the strong relationships Kansas has formed between the State, the ASO, and SUD providers. CSAT reviewers were also impressed with the wealth of data the ASO provides the State.

Utilizing a combination of funding sources (SAT Block Grant, State general funds, and State fee funds), 13,418 people (unduplicated) received treatment services under the substance use disorder block grant in state fiscal year (SFY) 2020. For SFY 2021 (7/1/20 – 6/30/21), 9,145 people received treatment services. The reduction in people served can be contributed to COVID-19 impacts. Examples include court closures resulting in reduced number of no referrals, facility closures for cleaning due to staff or patient illness, residential centers reducing people to one per room versus two to accommodate social distancing, and workforce shortages. The primary reason people access Block Grant treatment services in Kansas (both inpatient and outpatient treatment levels of care) is for amphetamine dependency.

Upon request from the SEOW and using treatment data from the ASO, the following graph displays the primary diagnosis for Residential levels of care admissions since August of 2019.



Governor's Behavioral Health Services Planning Council (GBHSPC)

In Kansas, the Governor's Behavioral Health Services Planning Council (GBHSPC) fulfills the Mental Health Block Grant mandate that all states have a mental health services planning and advisory council. The Council is made up of a cross-section of behavioral health consumers, family members of behavioral health consumers, behavioral health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas' behavioral health services.

The mission of the Governor's Behavioral Health Services Planning Council is to partner to promote prevention, treatment, and recovery services to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities.

The values of the GBHSPC is prevention, treatment, and recovery services:

- Allow people to direct their care and treatment;
- Are respectful and empowering;
- Are effective and influenced by evidence-based practices that lead to a personal process of recovery and resilience; and
- Are integrated, flexible, and accessible.

SAMHSA was onsite in May 2018 for a 10-year comprehensive onsite review. The SAMHSA Lead on the Review indicated onsite that Kansas has one of the best Planning Councils in the country.

There are several subcommittees of the GBHSPC in Kansas: 1) Children's 2) Housing and Homelessness 3) Justice Involved Youth and Adult 4) Kansas Citizen's Committee on Alcohol and Other Drug Abuse 5) Prevention 6) Rural and Frontier 7) Supportive Employment and Vocational Services 8) Veterans 9) Evidence-Based Practices 10) Aging and 11) Problem Gambling.

Each of the Council's Subcommittees includes at least one member of the Planning Council and various other interested stakeholders, including consumers and family members. Behavioral Health Services staff serve as liaisons and support to the Subcommittees. The Subcommittees generate recommendations for the Council, the Secretary of KDADS, and the Governor regarding the Mental Health System of Kansas. Once a year, they report these recommendations to the Council body, as well as and the Secretaries of relevant state agencies. The Subcommittees reviewed draft sections of the FFY 2020-2021 Block Grant Application and provided written feedback to the State.

Subcommittee Reports and Recommendations

The GBHSPC's annual Subcommittees' charters, bylaws and reports can be found on the KDADS website at this link: <https://www.kdads.ks.gov/commissions/behavioral-health/gbhspc>. For more information, please click on the embedded subcommittee links to expand.

- Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC)

The Kansas Citizen's Committee on Alcohol and Other Drugs has been in existence for many years and is statutorily required. K.S.A. 75-5381 reads, "It shall be the duty of the Kansas Citizens' Committee on Alcohol and Other Drug Abuse to confer, advise, and consult with the Secretary of the Kansas Department for Aging and Disability Services Behavioral Health or their designee with respect to the powers, duties, and functions imposed upon the Secretary under K.S.A.'s 65-4006, 75-4007, and 75-5375." The purpose of this Committee is to be an advisory council for Substance Use Treatment, Prevention, Problem Gambling services, and Recovery Oriented Systems of Care in Kansas.

The Kansas Citizen's Committee also functions as the Quality Committee for KDADS substance use disorder treatment data submitted by the health plans to the State for Medicaid and the Block Grant.

➤ Children's Subcommittee

The Children's Subcommittee is dedicated to maintaining the community-based family driven values of the Kansas children's public mental health system of care. The subcommittee makes recommendations to improve the Kansas public mental health system and ensure the needs of children and families are met.

➤ Housing and Homelessness subcommittee (HHS)

The Housing and Homelessness Subcommittee (HHS) focuses on helping adults experiencing severe and persistent mental illness and children diagnosed with severe emotional disturbance and their families obtain and maintain safe, decent, affordable, and permanent housing. The HHS acts as the body in Kansas who offers guidance and recommendations to the Governor's Behavioral Health Services Planning Council and to KDADS, so they can effectively exercise leadership in this arena.

➤ Justice Involved Youth and Adult Subcommittee

The Governor's Behavioral Health Services Planning Council's Justice Involved Youth and Adult Subcommittee is a group of stakeholders and forensic professionals charged with examining pertinent issues in Kansas as they pertain to the justice involved population. The Justice Involved Youth and Adult Subcommittee prioritizes its goals and activities around transforming mental health policies, programs, and funding that address jail diversion, access to timely and appropriate services while incarcerated, and reentry.

➤ Supportive Employment and Vocational Services Subcommittee

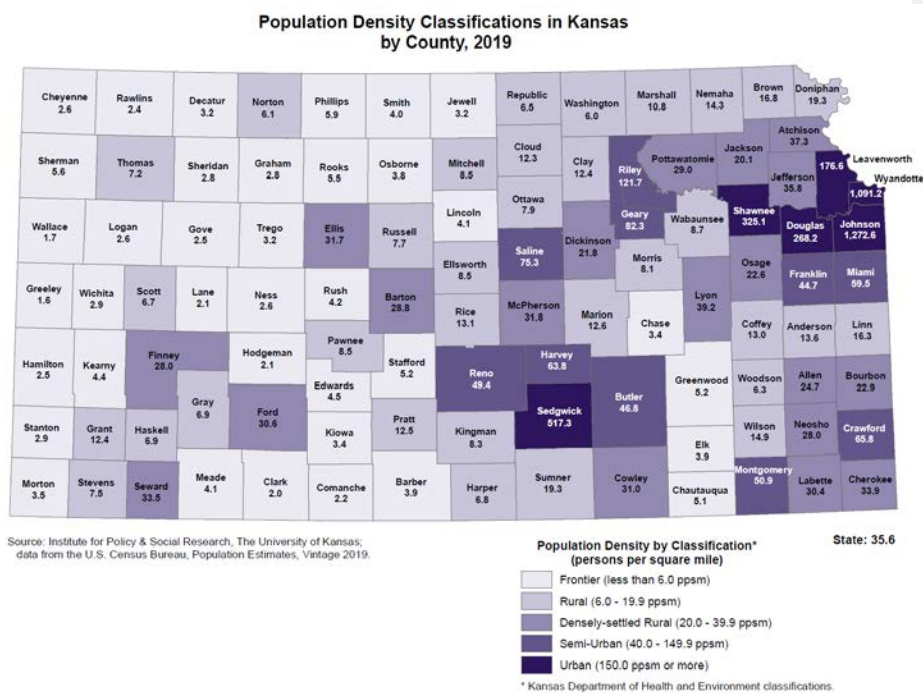
The Vocational Subcommittee evaluates outcomes to discover areas in which the system is doing well and where it can improve. It also makes recommendations on where to focus funding for vocational programs.

➤ Rural and Frontier Subcommittee

The Rural & Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental

health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, [the committee] assures accessibility/availability of mental health services in frontier/rural Kansas counties. The vast majority of all Americans living in underserved, rural and remote rural areas experience disparities in mental health services. Rural issues are often misunderstood, minimized and not considered when forming mental health policy.

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



➤ Veterans Subcommittee

The Veterans Subcommittee's mission is to ensure that veterans, service members and their families are involved in developing recommendations to improve access to behavioral health services which are relevant to military culture in collaboration with key provider organizations and other stakeholders.

According to the history section of the 2018 Veteran’s subcommittee annual report, this subcommittee reactivated in June of 2017. The state was divided into five regions with a designated mental health facility as the lead in that region. The plan of the subcommittee was to identify members in those five regions to help accomplish their goals. Many of the subcommittee members received training from SAMSHA technical assistance program for strategic planning in September 2017. From that training the committee established goals to identify quality resources for veterans, their families and children across the state. this subcommittee was comprised of the chair, co-chair and 16 members from across the state.

SAMSHA technical assistance personnel came to Topeka for the Mayor’s Challenge Site visit on August 30th and 31st [2018] to provide attendees training to identify other key players, set goals and objectives, implement strategies, identify other agencies to partner with etc. The training had representatives from the Topeka Police Department, Valeo, VA Eastern Kansas, State of Kansas, City of Topeka HR and Municipal Court and the Shawnee County Suicide Prevention Coalition. Once the Topeka Coalition was established, the goal was to expand this prevention/education effort to other cities in the state.

➤ Prevention Subcommittee

The Prevention Subcommittee serves as a broad, representative voice for behavioral health as it relates to prevention of a range of health and behavior issues, including but not limited to, suicide prevention, behavioral health promotion and substance use disorder across the lifespan. The Prevention Subcommittee will serve as the Advisory Council for Kansas Behavioral Health Prevention Initiatives and will provide feedback and guidance to the Governor’s Behavioral Health Services Planning Council. In FY2021, the Subcommittee has focused on increasing Youth Voice in its monthly meetings and has invited content specialists to increase Subcommittee awareness and education on Zero Suicide, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and a health promotion campaign for men.

The Subcommittee is currently making updates to the Kansas Behavioral Health Prevention Plan. The Subcommittee uses the Strategic Prevention Framework (SPF) to guide the data-driven selection of behavioral health priorities for the State using the comprehensive Kansas Behavioral Health Profile.

A workgroup of the Prevention Subcommittee recently completed updates to the Kansas Suicide Prevention Plan (2021-2025). The Subcommittee’s Evidence-Based Strategies (EBS) Workgroup has also developed a EBS Matrix of strategies to assist stakeholders in selecting the most appropriate prevention strategies.

FY2022 recommendations are to:

- 1) improve shared access to data resources among state agencies and Planning eCouncil sSubcommittees,
- 2) provide better coordination of efforts and care transitions of behavioral health services, and
- 3) allocate resources to prioritized areas of need including:
 - additional prevention strategy implementation to address data-driven, prioritized behavioral health indicators-
 - continued funding for the implementation of 988-

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- hiring a centralized epidemiologist to compile behavioral health needs assessment data gathered by all State Departments.

New GBHSPC Subcommittees

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

➤ Aging Subcommittee

This Subcommittee was identified and met for the very first time about a week prior to COVID-19 announcements. The participants looked at prior recommendations from the previous committee and determined most are still relevant. The main themes that were discussed at this meeting were about the following:

- The concern with the growth of the aging population in the next 15-20 years and the impact that will have on needs, services
- Rate of substance abuse is relatively high among this population
- May be difficult to place those in NFMH's and jails and particularly those with medical issues
- Rate of suicide is relatively high for this population
- Lack of workforce specialized in working with this population
- Mobility and accessibility to care issues
- Direct correlation between substance abuse, mental health and problem gambling

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

➤ Evidence-Based Practices Subcommittee

The Evidence Based Practices (EBP) Subcommittee goal is to provide a framework

- for learning from other Council Subcommittee representatives, state stakeholders, providers, consumers, and family members for which EBPs or other measurement-based modes of care are creating positive outcomes for consumers
- for sustainable technical assistance to providers so they can deliver the best practices (evidence-based practices with fidelity) chosen by the consumer
- for providers to become efficient and effective in person-centered, value-based care provision
- for providers in measuring the value of care provision from the standpoint of structure, process, and impact of care provision

- Managed Care Organizations (MCO) support of training and fidelity review for their provider network as required by their contracts

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

➤ Problem Gambling Subcommittee

This Subcommittee is in the process of being formed and a draft charter is being developed. A brief description of just some of the other data sources available within the state are described below.

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Kansas Annual Summary of Vital Statistics, 2019

The Kansas Annual Summary of Vital Statistics, 2019 report by the Kansas Department of Health and Environment is found at this link: https://www.kdheks.gov/phi/as/2019_Annual_Summary.pdf

According to the report, there were 27,312 Kansas resident deaths recorded in 2019, an increase of 0.4 percent from the 27,213 deaths recorded in 2018. The average age at death of Kansas residents in 2019 was 74.5 years, an increase of 0.3 percent from 74.3 in 2018. In the report, the ten leading causes of death in Kansas remained unchanged from 2018 to 2019, though their order changed in some cases.

Kansas recorded 521 resident suicide deaths in 2019, down 6.1 percent from 555 suicide deaths in 2018. The suicide age-adjusted death rate decreased from 19.2 deaths per 100,000 population in 2018 to 18.1 deaths per 100,000 population in 2019. Although the single-year change in rate was not statistically significant, the 2019 suicide rate was one of the three highest in the last twenty years.

Almost four-fifths (79.5%) of suicide victims were male. The three age groups with the largest number of suicides were 35-44 (106 deaths), 25-34 (104 deaths), and 15-24 (83 deaths). The three most common methods of suicide were firearms (290 deaths), suffocation (143 deaths), and poisoning (60 deaths).

Kansas Behavioral Health Indicators Dashboard

The Kansas Prevention Collaborative Behavioral Health Indicators Map presents summarized data for several Behavioral Health indicators prioritized by the Kansas Behavioral Health Services Planning Council Prevention Subcommittee. The Kansas BH Indicators Dashboard was created and managed by a contractor, Greenbush or the Southeast Kansas Education Service Center.

The online dashboard is available at the following link: <http://kbhid.org/>.

The public can access Kansas data for a wealth of indicators on the following topics: Income/Poverty, Crime, Depression/Suicide, Problem Gambling, Family Functioning, Substance Use, Problem Gambling Treatment, Substance Use & Treatment, and Mental Health and Treatment. Substance Use & Kansas Substance Use and Treatment data that can be accessed on the site include needing but not receiving treatment for alcohol abuse, primary admissions by drug (alcohol, marijuana, opiates, tranquilizers, cocaine, methamphetamine, etc.), opioid prescribing rates, needing but not receiving treatment for illicit drug abuse). A screen shot of the dashboard is displayed below:



SABG Priority Populations

Beacon, the Administrative Services Organization, provides a vast array of reports for the SUD Block Grant including utilization reports, financial, adverse incident, appointment access, and diagnosis trends among others. Reports specific to priority populations include an Interim Services report and a Designated Women’s Facility Report.

The Interim Services report provides quarterly and year-to-date data on modalities (crisis intervention, peer support, case management, and those admitting to a lower level of care than recommended) both number of people needing and number receiving services. The report breaks the information down into regional and priority populations (pregnant women, IV drug users, and all other SUD members).

The Designated Women’s Facility (DWF) report is also a quarterly report to the State. Women with children, Pregnant Women and total categories are reported. Women’s treatment is drilled down into data such as those not recommended for treatment and total that are recommended and then into modality of treatment. Total admitted to DWF by modality are also reported.

Commented [CC7]: Perhaps use person-first language?

Commented [CC8]: Confusing sentence with research jargon

The Kansas Department for Aging and Disability Services (KDADS) continues to work towards ensuring priority populations including Pregnant and Parenting Women, Injecting Drug Users and Persons at risk for tuberculosis access timely treatment. Ideally, we need to be able to get patients assessed and in treatment when they present in order to best engage individuals (including priority populations) into treatment services. The ASO is contractually required to manage a waitlist to help ensure timely access

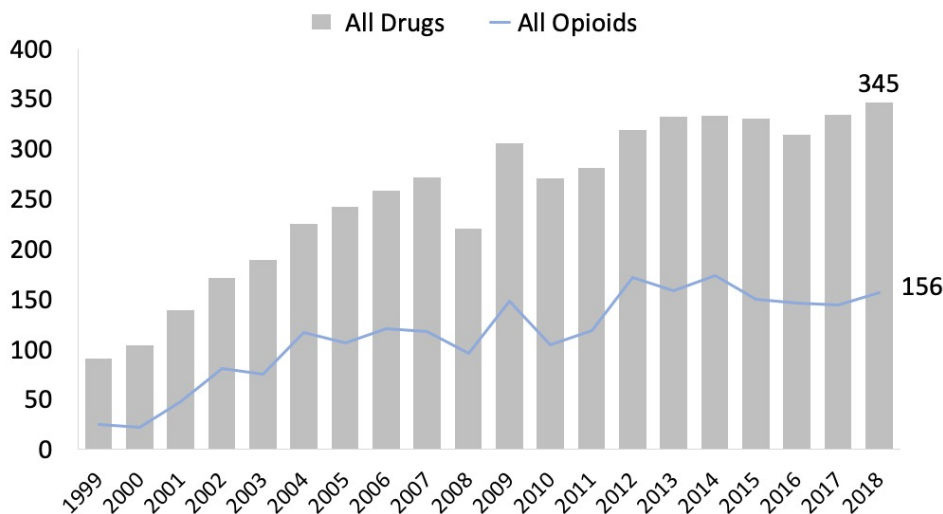
Commented [CC9]: Perhaps use person-first language?

to inpatient treatment for all individuals with substance use disorder. The priority populations are monitored and tracked separately. Beacon reports regularly to KDADS on any members waiting to include priority populations. Barriers to timely treatment for priority populations are similar to those of other individuals with substance use disorder such as workforce shortage issues and the lack of some modalities of service especially in the rural and frontier areas.

Opioid Summary – National Institute on Drug Abuse (NIDA)

In reviewing the Kansas Opioid Summary ([Link](#)) by the National Institute on Drug Abuse (NIDA), the most recent data available is currently from 2018 with 2019 data usually being released in early 2021. In 2018, Kansas providers wrote 64.3 opioid prescriptions for every 100 persons compared to the average U.S. rate of 58.7—a 20% decrease compared to 2011.

Also, according to NIDA and displayed in their graph below, in Kansas, about 45% of the 345 drug overdose deaths involved opioids in 2018—a total of 156 fatalities (a rate of 5.7) (Figure 1).



State Opioid Response (SOR) grant

Kansas has received State Targeted Response (STR) or State Opioid Response (SOR) grants since 2017 to assist in addressing the opioid crisis. Illicit opioid use and related deaths continue to be a concern with 320 deaths from opioids reported in 2020. Kansas is using the SOR funding to invest in expanding access to treatment, particularly evidence-based treatment, and to reduce the number of opioid and stimulant related deaths across the state. KDADS’ Behavioral Health Commission oversees and monitors grant activities. KDADS is using SOR award funding to provide medication-assisted treatment (MAT) services to uninsured patients in Kansas. Currently, there are around 40 grantees across the state providing treatment services for Kansans in all 105 state counties, including rural and frontier areas, as well as, urban areas. Treatment service providers are diverse and range from a university medical center to

substance use disorder treatment providers, methadone clinics, regional alcohol and drug assessment centers, and community mental health centers. Areas of unmet service need and critical gaps include the location and number of medication-assisted treatment providers and/or methadone clinics primarily in the rural and frontier areas of the state.

Medication-Assisted Treatment (Alcohol)

Under the Block Grant, Kansas has not had the funding to implement medication-assisted treatment for alcohol use disorder. With the supplemental dollars Kansas is receiving through the Block Grant COVID Funding, Kansas is working on implementing reimbursement codes to providers for MAT for Alcohol. Alcohol is the second leading diagnosis people seek treatment for under the Substance Abuse Block Grant in Kansas after methamphetamine so the additional funding will positively impact many people we serve and hopefully save lives and reduce recidivism.

Tobacco Cessation treatment for people with Behavioral Health conditions

According to the Centers for Disease Control and Prevention ([Link](#)), despite significant progress, tobacco use remains the leading preventable cause of death and disease in the US. Further, nearly 25% of adults in the United States have a mental health or substance use disorder (i.e., behavioral health condition), and these adults consume almost 40% of all cigarettes smoked by adults in the United States. The CDC also states that people with behavioral health conditions die about five years earlier than people without such conditions, more than 50% from tobacco-attributable diseases.

According to the Kansas Annual Summary of Vital Statistics, 2019 report by the Kansas Department of Health and Environment ([Link](#)), tobacco use contributed to 4,793 deaths in Kansas in 2019 (25.1 percent of the deaths where the tobacco contribution was known and reported on the death certificate). Tobacco use was a contributing factor in 30.5 percent of male deaths, and in 20.0 percent of female deaths. The causes of death showing the largest tobacco contribution were cancer of the trachea, bronchus and lung (86.6%), chronic lower respiratory disease (83.7%), ischemic heart disease (35.2%), and diabetes mellitus (28.9%). (Table E21) Physicians and coroners can state on the death certificate whether tobacco contributed to the death. Because information may not be available at the time the death certificate is completed, tobacco's contribution may be subject to some under-reporting.

Until the recent infusion of additional Federal Block Grant dollars, Federal Block Grant funding for behavioral health treatment needs for the uninsured/underinsured remained at the same level for many years and exceeded the allotted Federal Block Grant funding. Kansas has supplemented the funding using a combination of funding sources including State General funds and State Fee funds from the Problem Gambling and other addictions funds. Kansas Behavioral Health providers have been very creative in their approach to address the physical health needs of those they serve, however, unmet service needs around tobacco cessation exist including: 1) Tobacco cessation is not covered by the Block Grant but is by Medicaid 2) Medicaid reimbursement for both medication and counseling reported as insufficient by behavioral health providers and 3) Expanding the trained tobacco cessation workforce.

Kansas State Opioid Response

Tobacco cessation opportunities are included in the SOR grant as an optional activity. KDADS has offered two Requests for Applications (RFA) to integrate tobacco cessation treatment into the treatment of those with opioid/stimulant use disorders. A person with a substance use disorder who can quit using tobacco products, may greatly increase the odds of long-term recovery from substance use disorder

(SUD) and have physical health benefits that begin almost immediately for smokers and continue for years to come. Use of tobacco products may interfere with the metabolism of prescribed psychiatric medications. Eliminating tobacco allows people to reduce their symptoms by taking lower levels of medication. Tobacco cessation also increases a person's sense of mastery and helps them focus on a positive and healthy lifestyle. Treatment providers may use funds to implement a smoke-free facility to benefit both clients and staff.

KDHE Kansas Tobacco Use Prevention Program

The Kansas Tobacco Use Prevention Program (<https://www.kdheks.gov/tobacco/index.html>) provides resources and assistance to state and local partners for development, enhancement and evaluation of state and local initiatives to prevent death and disease from tobacco use and secondhand smoke exposure.

The program focuses on four priority areas: 1) Preventing the initiation of tobacco use among young people, 2) Promoting quitting among tobacco users of all ages, 3) Eliminating nonsmokers' exposure to secondhand smoke, and 4) Identifying and eliminating disparities related to tobacco use and its effects among different population groups. Strategies include The Kansas Tobacco Quitline - a special program for pregnant smokers and smokers with mental illness or addiction.

NAMI Kansas has provided several trainings throughout the state to providers and other stakeholders on smoking cessation resources including Tobacco Guidelines for Behavioral Health Care:

<https://namikansas.org/resources/smoking-cessation-information/?nowprocket=1>

One major outcome of the work so far has been the creation of the Kansas Tobacco Guideline for Behavioral Health Care. The Guideline was created as a roadmap for behavioral health providers to support Kansans motivated to end their dependence on tobacco products.

Problem Gambling Strengths and Needs

The Kansas gambling industry is represented by four state-owned casinos, five tribal casinos, charitable gaming and the Kansas Lottery. The first gambling prevalence study of gambling behaviors and attitudes in Kansas was conducted in 2012. The main purpose of this survey was to estimate the scope of at-risk gambling statewide and within defined gaming zones. The results of this study provided information about problem gambling awareness, attitudes toward gambling and problem gambling services, and information about how problem gambling is impacting Kansans. Survey findings are useful to State agencies and other stakeholders in efforts to mitigate gambling related harm.

The survey found that 75% of survey respondents gambled in the past year including 35% who played casino machine games such as slot machines, suggesting the rate of casino visitation among survey respondents is at least 30% higher than the national average. Similar to most U.S. states, almost half of respondents (45%) played lottery games in the past year. When recent gamblers were asked if they thought they had a gambling problem, one percent said that "most of the time" they feel they "have a problem with gambling," and six percent said "sometimes." The consequences of problem gambling can be emotional, physical, and financial. These consequences can extend to the friends, families, co-workers and even the employers of those affected. About 26% of survey respondents said they have been personally affected by the gambling of others.

Forty four percent of respondents gambled in the ~~past~~ 30 days prior to taking the survey. A series of nine problem gambling screening questions were asked of this group. Approximately 19% of this group responded “yes” to at least one of these nine questions. Positive endorsement of just one problem gambling screening question suggests the person is at heightened risk for developing a gambling problem. Several links were found between casino patronage and problem gambling risk. About one fifth (21%) of respondents who endorsed casino machine games (slots, video poker, etc.) as their favorite form of gambling also replied “yes” to at least one problem gambling screening question. About one-third (32% of respondents that patronized a casino in the past 30 days) endorsed one or more problem gambling screening questions suggesting a large portion of casino gamblers are at heightened risk of having a gambling disorder or developing one. Also, there is a strong correlation between endorsing problem gambling screening questions and membership in casino groups. More than one third of all respondents who were casino club/program members may be considered at heightened risk for manifesting or developing a gambling problem.

Many subgroups of the population have problem gambling prevalence above the adult average, including adolescents, African Americans, individuals who are Hispanic, Asians, American Indians, lower socioeconomic groups, men, those with substance use and mental health co-morbid conditions, military, college students and casino workers. The impact of problem gambling on the elderly is also an area of attention. The African American community appears to be impacted more by problem gambling than other ethnic groups. One in five African American survey respondents reported being personally affected by the gambling behaviors of a family member, a rate 60 % greater than among Caucasian survey respondents.

While most people who gamble do so without experiencing or causing harm, ~~it is clear that a~~ sizeable portion of respondents have been negatively impacted by problem gambling, and respondents showed widespread support to address the problem. Most respondents said they believe it is either “very important” or “important” to use public funds to make problem gambling treatment available and affordable (98%) and to educate young people in school about the risks of gambling (81%).

Aside from the adult prevalence study, Kansas has included eleven gambling specific question on the Kansas Communities that Care Youth Survey since 2007 and most recently two questions on the Kansas Young Adult (18 to 25-year-old) Survey. Seven percent of Kansas youth indicate they have gambled for money or something of value in the ~~last~~ 30 days prior to taking the survey. Every day in the past year, one percent of youth felt they would like to stop gambling but did not think ~~kg~~ they could. Over twelve percent of young adults indicate they have gambled for money or something of value in the ~~last~~ 30 days prior to taking the survey. Every day in the past twelve months, five percent of young adults felt they would like to stop gambling but did not think they could.

Stigma continues to remain a major barrier to people seeking treatment thus the need for statewide prevention, awareness and education. In 2007 the Kansas Legislature enacted the Problem Gambling and Addictions Grant Fund. Two percent of the monthly net revenue from the four state-owned casinos is deposited into this fund. Resources to fund problem gambling specific services are limited however as the funding allocated for these services have remained at less than ten percent of the total dollars deposited into this fund. The dollars that are allocated for problem gambling services are used statewide to provide treatment for problem gamblers and their concerned others, prevention resources,

education and awareness, and research and evaluation. Kansas currently has forty-three state certified gambling counselors, two gambling prevention specialists and one program administrator.

HIV-designated state

Kansas is not a FY 2022 HIV-designated state.

From: [Cissy McKinzie \[KDADS\]](#)
To: [Diana Marsh \[KDADS\]](#)
Subject: FW: Kansas BG Application Planning Step 2 draft (SABG and MHBG)
Date: Saturday, August 21, 2021 10:13:25 AM

For Plan feedback

From: Krista Machado <kmachado@dcca.org>
Sent: Wednesday, August 18, 2021 8:20 AM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Cc: Jamie Wallen [KDADS] <Jamie.Wallen@ks.gov>
Subject: RE: Kansas BG Application Planning Step 2 draft (SABG and MHBG)

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Looks good! All I noticed was the alignment of the bullet point arrows for the GBHSPC sub-committees had a couple out of alignment.

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Monday, August 16, 2021 12:33 PM
To: Daniel Warren <Daniel.Warren@ctcprograms.com>; Krista Machado <kmachado@dcca.org>; Kepple, Nancy Jo <njkepple@ku.edu>
Cc: Jamie Wallen [KDADS] <Jamie.Wallen@ks.gov>
Subject: [External] FW: Kansas BG Application Planning Step 2 draft (SABG and MHBG)

EXTERNAL:

Planning Step 2 for review. Please copy me and Jamie with any feedback.

Thank you!

Cissy

From: Cissy McKinzie [KDADS]
Sent: Monday, August 16, 2021 12:19 PM
To: Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>; 'Stephanie Rhinehart [KDADS] (Stephanie.Rhinehart@ks.gov)' <Stephanie.Rhinehart@ks.gov>; Melissa Bogart Starkey [KDADS] <Melissa.BogartStarkey@ks.gov>; Erin Olson [KDADS] <Erin.Olson2@ks.gov>; Gary Henault [KDADS] <Gary.Henault@ks.gov>; Debra Garcia [KDADS] <Debra.Garcia@ks.gov>; Jamie Wallen [KDADS] <Jamie.Wallen@ks.gov>; Carol Spiker [KDADS] <Carol.Spiker@ks.gov>; Sarah Hussain [KDADS] <Sarah.Hussain@ks.gov>
Cc: Diana Marsh [KDADS] <Diana.Marsh@ks.gov>; Andrew Brown [KDADS] <Andrew.Brown@ks.gov>

Subject: Kansas BG Application Planning Step 2 draft (SABG and MHBG)

Planning Step 2 draft

I believe I have all included all the GBHS Planning Council Liaisons here. Please feel free to forward if I missed anyone.

The attached draft (Planning Step 2) is ready to send to GBHSPC subcommittees. Consistent with previous submissions, could the subcommittees please review the attached draft? This section is a required section for the Mental Health Block Grant Application and the Substance Abuse Block Grant Application due to SAMHSA by 9/1 (internal deadline is the Friday before 8/27). If the subcommittee would like to provide feedback, please request they send it to their KDADS Liaison in writing so we can incorporate and attach to the plan.

If the subcommittee would like to provide feedback prior to the App being posted for public comment, we are still drafting but hope to get this all together sometime this week to post. If they aren't able to make it by that date, no worries, they can still provide feedback during the public comment period.

Thanks,

Cissy McKinzie

Block Grant/SUD Program Manager

SOTA

Behavioral Health Services Commission

Kansas Department for Aging and Disability Services (KDADS)

503 S. Kansas Ave.

Topeka, KS 66603

Phone: (785) 296-4079

Fax: (785) 296-0256

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Visit our web site: <http://www.kdads.ks.gov/>

From: [Cissy McKinzie \[KDADS\]](#)
To: [Diana Marsh \[KDADS\]](#)
Subject: FW: SABG Draft for KCC Review (Env Factors and Plan 10 SUD Treatment)
Date: Thursday, August 5, 2021 2:52:00 PM

From: Krista Machado <kmachado@dcca.org>
Sent: Thursday, August 5, 2021 2:28 PM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: RE: SABG Draft for KCC Review (Env Factors and Plan 10 SUD Treatment)

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Looks good to me!

From: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Sent: Thursday, August 5, 2021 12:01 PM
To: Daniel Warren <Daniel.Warren@ctcprograms.com>
Cc: Kepple, Nancy Jo <njkepple@ku.edu>; Krista Machado <kmachado@dcca.org>; Jamie Wallen [KDADS] <Jamie.Wallen@ks.gov>; Charles Bartlett [KDADS] <Charles.Bartlett@ks.gov>
Subject: [External] SABG Draft for KCC Review (Env Factors and Plan 10 SUD Treatment)

EXTERNAL:

Daniel, Nancy Jo and Krista,

Consistent with previous submissions, could the KCC please review the attached draft (Env Factors and Plan – 10 SUD Treatment)? This section is a required section for the Substance Abuse Block Grant Application due to SAMHSA by 9/1. If the subcommittee would like to provide feedback, please request they send it to me and Jamie in writing so we can attach to the plan.

If the subcommittee would like to provide feedback prior to the App being posted for public comment, our target date to incorporate feedback is around 8/16. If they aren't able to make it by that date, no worries, they can still provide feedback during the public comment period.

Thanks,

Cissy McKinzie

Block Grant/SUD Program Manager

SOTA

Behavioral Health Services Commission

Kansas Department for Aging and Disability Services (KDADS)

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Topeka, KS 66603

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Tamberly.McKinzie@ks.gov

Visit our web site: <http://www.kdads.ks.gov/>

From: [Cissy McKinzie \[KDADS\]](#)
To: [Diana Marsh \[KDADS\]](#)
Cc: [Carol Spiker \[KDADS\]](#)
Subject: FW: BG Edits
Date: Monday, August 23, 2021 2:00:29 PM
Attachments: [image002.png](#)

Diana,

Subcommittee feedback for the binder to attach to Application submission.

Thanks,
Cissy

From: Carol Spiker [KDADS] <Carol.Spiker@ks.gov>
Sent: Tuesday, August 17, 2021 7:35 AM
To: Cissy McKinzie [KDADS] <Tamberly.McKinzie@ks.gov>
Subject: BG Edits

Cissy,
The PG Subcommittee has reviewed the PG portion of the BG and found one typo. Other than that, it looks fine. The following paragraph is on page 35. "thing" should be "think"

Aside from the adult prevalence study, Kansas has included eleven gambling specific question on the Kansas Communities that Care Youth Survey since 2007 and most recently two questions on the Kansas Young Adult (18 to 25-year-old) Survey. Seven percent of Kansas youth indicate they have gambled for money or something of value in the last 30 days. Every day in the past year, one percent of youth felt they would like to stop gambling but did not thing they could. Over twelve percent of young adults indicate they have gambled for money or something of value in the last 30 days. Every day in the past twelve months, five percent of young adults felt they would like to stop gambling but did not think they could.

Please email, I am working remotely.

Thank you –

Carol

Carol Spiker LAC, KCGC
Problem Gambling Program Manager
Kansas Department for Aging and Disability Services
503 S Kansas Avenue
Topeka, KS 66603
carol.spiker@ks.gov
785-296-2269

Gambling problem?
Getting Help is your Best Bet.
800.522.4700 ksgamblinghelp.com

Visit Our Website: www.kdads.ks.gov

