Kansas Department for Aging and Disability Services
Request for Information
(RFI)

Table of Contents

RFI Summary

The Kansas Department for Aging and Disability Services (KDADS), Community Services and Program Commission (CSP), Behavioral Health Services (BHS) Division invites all interested parties (IP) to respond to this Request for Information (RFI) regarding the Behavioral Health Prevention Integration and Innovation Project.

As a state we recognize the opportunity to expand prevention efforts to be inclusive of substance use prevention, mental health promotion, suicide prevention, and problem gambling prevention to enhance the behavioral health of Kansas communities. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as a state of emotional/mental being and/or choices and actions that affect health and wellness. Individuals engage in behavior and make choices that affect their wellness, such as whether or not to use alcohol. Communities can also influence choices and actions that affect wellness, such as imposing and enforcing laws that restrict youth accessing alcohol. Behavioral health, then, can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of substance use, problem gambling, and mental health disorders, and the prevention of suicide.

Data at both the state and national level underscore that now is the time to comprehensively address prevention efforts across the spectrum of behavioral health.

- The annual total estimated societal cost of substance abuse in the U.S. is $510.8 billion, with an estimated 23.5 million Americans aged 12+ in need of treatment.
- Annually, approximately 5,000 youth under the age of 21 die as a result of underage drinking.
- More than 34,000 Americans die every year as a result of suicide (~1 every 15 minutes).
- In 2012, Kansas experienced 505 deaths by suicide. This was a 31.5% increase from 2011 deaths by suicide.
- In 2013, 426 Kansas residents died due to suicide, down 15.6 percent from 505 suicide deaths in 2012. Over four-fifths (81.2%) of suicide victims were male. The two age groups with the largest number of suicides were 45-54 (94 deaths) and 55-64 (76 deaths).
- High rates of suicide attempts have been found in studies of problem gamblers, about 15-20% of pathological gamblers report a significant suicide attempt.
- According to the World Health Organization, five percent of all suicides are related to compulsive gambling.
- Half of all lifetime cases of mental and substance abuse disorders begin by age 14, and 75% by age 24.
- In 2008, 9.8 million adults had a serious mental illness.
- In 2009, 1 in 5 individuals with a diagnosable mental health disorder also suffered from a substance abuse disorder.
- An estimated 2.2% of Kansas adults (46,951 citizens) are believed to manifest a gambling disorder.
- Per the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM5), those with a gambling disorder have high rates of substance use disorders, depressive disorders, anxiety disorders and personality disorders.

KDADS intends to integrate and innovate behavioral health prevention in an effort to eliminate disparate efforts and better leverage collective community resources toward shared outcomes.

In this RFI, our objective is to glean new perspectives and new approaches to designing a comprehensive prevention system that is inclusive of multiple behavioral health concerns.

KDADS/BHS is seeking system-level thinking for an integrated approach that emphasizes community-level strategic planning and implementation of strategies that utilize the core concepts of SAMHSA's Strategic Prevention Framework.

As a result of the information gathered from this request, KDADS, BHS will issue a request for proposal (RFP) to fund a comprehensive system that ensures adequate community level implementation of evidence based strategies, training and technical assistance, state and community level evaluation, and resource distribution.

Introduction

The Kansas Department of Aging and Disability Services (KDADS) holds the mission to foster an environment that promotes security, dignity and independence, while providing the right care at the right time in a place called home. KDADS is responsible by statute and holds the authority to coordinate and provide substance abuse and mental health services in Kansas.

The Behavioral Health Services (BHS) Division within KDADS envisions Kansas communities support a continuum of care throughout the lifespan. The mission of KDADS/BHS is partnering to promote prevention, treatment, and recovery in order to ensure Kansans with behavioral health needs live safe, healthy, successful, and self-determined lives in their communities. KDADS/BHS believes – and data supports – the notion that prevention works, people recover, and treatment is effective. KDADS/BHS is committed to creating a system of care that is customer/community focused, encourages thriving communities, and is driven by results that are supported by a highly competent and partnership-based workforce.

KDADS/BHS invites Interested Parties (IPs) to respond to this Request for Information (RFI) regarding the Behavioral Health Prevention Innovation and Integration Project. IPs shall respond to this RFI and submit it to the email address listed below no later than 5pm on March 10, 2015.

Responding IPs will not be bound by the written response or to any further obligations as a result of any response to this RFI; however, KDADS/BHS may utilize information provided by IPs when developing future Behavioral Health Prevention Services request for proposal(s).

With regard to each question set forth in Attachment 2, below, the responding IP is asked to answer each question as accurately and thoroughly as possible.

At this juncture, KDADS/BHS interest lies in your informed professional opinion on how to enhance the effectiveness of the prevention infrastructure to shape what changes will be made to the behavioral health system. This RFI should not be used to report information on your agency, personal credentials or capabilities.

Questions Concerning This RFI

KDADS/BHS will be hosting a webinar on February 10, 2015 at 10:00 a.m. regarding the contents of this RFI. Please use the link and conference call information below if you are interested in participating in the webinar.

Conference Call Information and Webinar Link
1-866-620-7326
Conference code: 2646419508
https://kdads-bhs.adobeconnect.com/eroom101/

Questions concerning this RFI shall be submitted electronically via email to prevprogramreports@kdads.ks.gov, no later than noon on February 13, 2015. Responses to questions will be posted on the KDADS/BHS website by February 18, 2015. All questions received electronically by noon on February 13, 2015, will be answered. No response will be given to oral questions.

Response Logistics

Response Packaging:

One (1) electronically transmitted set of forms emailed to prevprogramreports@kdads.ks.gov, no later than the submission deadline. Response files must be provided in Microsoft© Office 2007 or searchable Adobe© PDF files.

Response Deadline:

The submission deadline is 5pm, Central Standard Time, March 10, 2015.

Response Label

Responses shall bear the name of the individual, or entity submitting the information, and shall be labeled, **"Behavioral Health Prevention Innovation and Integration Project"** and shall contain the IP's contact information, phone number, mailing address, etc.

Response Template

To aid in the review and evaluation of responses, the agency asks that interested parties respond to the RFI using a standard response structure, as provided in the template in Attachment 2.

Response Follow-Up Communications and Presentations

Responding IPs may be invited to meet to further explain and clarify the IP's understanding and approach and/or to respond to questions from KDADS/BHS with regard to the information submitted.

Confidentiality

All information included in this RFI is confidential and only for the recipient knowledge. No information included in this document or in discussions connected to it may be disclosed to any other party.

Liabilities of Agency

This RFI is only a request for information about potential products /services and no contractual obligation on behalf of the KDADS whatsoever shall arise from the RFI process.

This RFI does not commit KDADS to pay any cost incurred in the preparation or submission of any response to the RFI.

Responses should be prepared simply and economically, providing a straightforward, concise description of the information being requested in this RFI. Emphasis should be on completeness and clarity of content.

Confidentiality & RFI Ownership

RFI Ownership: All responses to the RFI will become the property of the KDADS and will not be returned.

Open Records Act: Under the Kansas Open Records Act (reference K.S.A. 45-215) all materials received or created by KDADS are considered ***public records***. These records include but are not limited to bid or proposal submittals, agreement documents, contract work product, or other information submitted by a vendor to KDADS.

The State of Kansas Open Records Act requires that public records must be promptly disclosed by KDADS upon request unless those records are excluded in accordance with K.S.A. 45-221 (27)n (Specifications for competative bidding, until the speicifications are officially approved by the agency).

Marking Records Exempt From Disclosure (Protected, Confidential, or Proprietary)

If you believe any of the documents you are submitting to KDADS as part of your informational material are exempt from disclosure due to patent or proprietary issues, you can request they not be released. To do so, identify which areas are confidential and the reason why.

Only the specific records or portions of records properly identified will be protected and withheld for notice. All other records will be considered fully disclosable upon request.

By submitting a response to this RFI, Respondent acknowledges this obligation; and also acknowledges KDADS will have no obligation or liability to the proposer if the records are disclosed.

Scope of Request

In this RFI, our objective is to glean new perspectives and new approaches to designing a comprehensive prevention system that is inclusive of multiple behavioral health concerns. KDADS/BHS is seeking system-level thinking for an integrated approach that emphasizes community-level strategic planning and implementation of strategies that utilize the core concepts of SAMHSA's Strategic Prevention Framework (SPF).

Key focus areas and priorities include:

1. Alignment with the SPF

The SPF is a five-step approach built on identifying community-based risk and protective factors and using gathered data to select, implement, and evaluate appropriate evidence-based and sustainable prevention programs, practices, and policies intended to lead to population-level outcomes. Please see Attachment 3 for more information on the SPF.

2. Strategic Integration across Behavioral Health

KDADS/BHS vision is for an integrated, behavioral health system with a focus on outcomes. The model of risk-focused prevention allows for the assessment and identification of shared risk and protective factors common to substance abuse, problem gambling, suicide, and mental health disorders. It is possible to assess and identify shared risk factors, such as Adverse Childhood Experiences (ACEs), for an array of problem behaviors and reduce and respond to these risks with aligned evidence-based interventions funded through braided sources. At a minimum, integration is sought across all behavioral health system prevention programs including substance abuse prevention, problem gambling prevention and awareness, mental health promotion, and suicide prevention.

3. Innovative Approaches and Leverage

To be more in line with SAMHSA funding allocation ratios (85% towards community level processes that lead to the implementation of evidence based strategies and 15% towards administrative costs) and comprehensively address more communities' needs around the totality of behavioral health prevention, KDADS/BHS is compelled to find new and innovative approaches and practices that leverage resources, capture more community-level investment, and achieve intended outcomes.

4. Facilitation of Community Change through Training and Technical Assistance (T/TA)

Training and TA must demonstrate effectiveness in facilitating actionable community level strategic planning and implementation of innovative solutions that are sustainable at the community level.

The provision of training and technical assistance should be offered in a manner that builds community capacity, supports, guidance, coaching, and feedback necessary for communities to be able to autonomously engage in effective prevention processes associated with all five steps of the SPF, including cultural competency and sustainability.

5. Community Ownership

Community ownership is crucial to future prevention initiatives, and communities need to autonomously create broad-scope and multi-sector collaborations that are locally-driven and sustainable through:

- Effective technical assistance that consists of comprehensive facilitation of processes versus work on behalf of community groups
- Shifting emphasis and focus to community plans that are broad-based and inclusive of multiple core strategies
- Broader and more diverse public involvement
- Focus on both behavioral and policy/environmental changes
- Enabling shared resources to promote coordination and collaboration, and reduce duplication.

Desired RFI Outcomes and Strategy

KDADS/BHS would like the responding IP to address each of these questions regarding the Behavioral Health Prevention Integration and Innovation Project.

Considering all the focus areas and priorities outlined above, this RFI seeks your point of view and perspective on shifting from a behavioral health system that is divided in its efforts, to an integrated behavioral health system that collaborates and leverages resources for community-driven approaches to cohesively prevent substance abuse, suicide, and problem gambling and promote mental health. Please be mindful of the focus areas and priorities when responding to the following questions. Please use Attachment 2 when submitting your responses.

System Design Visioning

1. Describe a system that is community-based and incorporates the priorities listed in the Scope of Request section.

2. Describe a community infrastructure that would enable increasing the number of evidence-based strategies being implemented in more communities.

3. What best practices or strategic concepts from other fields align with the priorities?

4. How should KDADS/BHS structure and allocate funding to achieve a system that is more integrated and that addresses the shared risk and protective factors, inclusive of substance use prevention, problem gambling awareness and prevention, suicide prevention, and mental health promotion?

5. How might the system be organized differently to address substance abuse prevention, suicide prevention, problem gambling prevention and awareness and mental health promotion in a coordinated, cohesive fashion?

6. What challenges, needs or barriers may need to be addressed in regards to the geographic area and diversity of the state?

Opportunities and Barriers to System Integration

7. What inhibits implementation of integrated, community level, community-led strategic plans?

8. What new opportunities will arise if KDADS/BHS integrates behavioral health prevention?

9. What are the challenges in integrating all of KDADS/BHS behavioral health prevention areas?

Integration Support

10. What mechanisms and/or innovations in training, technology, and process would strengthen the systematic achievement of behavioral health prevention integration?

11. What technology platforms are being used and are found to be effective in distributing training and resources, increasing collaboration, managing project implementation, capturing process level data or what other details should be considered in a prevention system redesign?

12. What certifications or minimum qualifications are needed for technical assistance providers?

13. What experiences and capabilities are needed to achieve the priorities?

14. What other competencies do you feel are relevant to enhance the system?

System Background

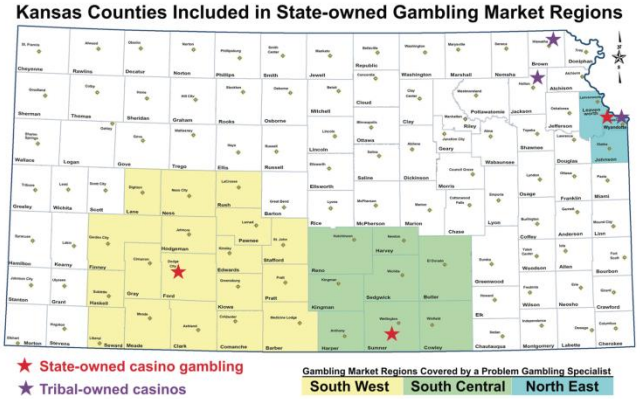
Mental Health Promotion and Suicide Prevention

Past agency efforts to address mental health promotion and suicide prevention have been limited and have lacked strategic coordination. KDADS is responsible the implementation of the State Suicide Prevention Plan, which is a requirement of the Mental Health Block Grant. The plan is updated and monitored by the Suicide Prevention Subcommittee of the Governor's Behavioral Health Planning Council. In the past year, KDADS staff has been working closely with the Garret Lee Smith Youth Suicide Prevention Grant to strengthen, enhance and sustain those efforts.

This integrated approach seeks to improve and enhance programming that promotes positive mental health and well-being while reducing the number of Kansans dying by suicide by focusing more comprehensively on risk and protective factors that impact behavioral health.

Problem Gambling Prevention, Education, and Awareness

The passing of Senate Bill 66 expanded gambling in Kansas and concerns were raised about the negative impact the expansion may have on the incidence of problem gambling and other addictive disorders. Due to these concerns, a provision was included in the act to create the Problem Gambling and Other Addictions Fund (PGOAF). The PGOAF is funded from 2% of net revenues created by State-owned casino gaming and is directed toward services to address problem gambling and the treatment of alcohol and other drug addictions. Some of these funds are allocated for the prevention, education and awareness of problem gambling.



Before the state-owned casinos were opened, task forces to provide problem gambling awareness and education were established in each of the three market regions. Task forces currently utilize core prevention strategies to increase awareness, build capacity, and implement strategies to educate local

communities about problem gambling and related harms.

Substance Abuse Prevention

Kansas has a 35-year history of pioneering new prevention initiatives and providing national leadership. In the mid-1970's, the Kansas Department of Social and Rehabilitation Services (SRS) oversaw two separate commissions, one on alcohol abuse and alcoholism, and another on drug abuse. In 1979, these commissions were merged into a single unit, the commission on Alcohol and Drug Abuse Services (ADAS).

During the late 1970's and early 1980's, SRS developed a prevention unit and appointed a State Prevention Coordinator. This was accomplished through National Institute on Drug Abuse (NIDA) funding. SRS supported the implementation of substance abuse prevention projects, such as the Model Community Prevention programs, Project STAR, Kansas School Team Training, a DCCCA (Douglas County Citizens Committee on Alcoholism) youth survey, and the Larned Sunrise Prevention Program.

In the mid-1980's, ADAS leadership challenged the prevention unit to study the national research and develop a state-of-the-art prevention service delivery system. The result was a regional prevention system that focused on developing services in a geographical region geared towards children and youth, providing training and T/TA services for youth and those who impact them (parents, teachers, etc.). Utilizing data from a student survey for youth in grades 7-12, T/TA efforts focused on increasing regional capacity to employ the Center for Substance Abuse Prevention (CSAP) six core strategies: information dissemination, alternative activities, social policy implementation, life skills education, community development, and a process for intervention.

In 1987, the "War on Drugs" brought an influx of new resources to Kansas and more than 20 State agencies became involved in funding substance abuse services. A major accomplishment in 1987 was the development of a plan to phase out the 13 existing, isolated grants and to begin working towards a true system approach. The result was a Regional Prevention Center (RPC) concept, which had been implemented in other states. The Centers provided services dedicated toward improving outcomes for youth by focusing on six core strategies: information, drug-free alternatives, community mobilization, social policy, intervention, and skill building. This Regional Prevention Center system was designed to blanket the state and coordinate all prevention activities in the communities and counties served within specific regions. Requests for proposals were issued and five Regional Prevention Centers (RPCs) were funded under the Toward a Drug-Free Kansas Program and the five RPCs began operation in July 1987. ADAS leadership developed a strategic plan for prevention and treatment. The goal was to complete the Regional Prevention Center Network within 10 years so that a comprehensive continuum of care of both prevention and treatment services could be delivered. The RPC system comprised of the five core Centers was completed in July 1990. Subsequently 13 full service Regional Prevention Centers were developed.

The Center for Substance Abuse Prevention (CSAP) funded regional parent workshops and provided set-aside funds for each state. Also during this time, Drs. Hawkins and Catalano, developers of the Communities That Care (CTC) Risk and Protective Factor Model and ADAS established a collaborative relationship in the service of integrating community-based, data-driven processes, and research-based prevention principles into the State prevention system.

A statewide substance abuse prevention strategy known as the Kansas Family Initiative (KFI) was drafted by ADAS and the Kansas Department of Education (KSDE) to submittal the proposal to the Governor's Office. The two agencies were asked to develop an implementation plan. Risk and

protective factors served as the theoretical framework for KFI. In December of 1991, Dr. Catalano and Dr. Alvera Stern presented the framework for the KFI during four regional meetings in Kansas. The framework included utilizing three research-based parenting programs: Preparing for the Drug-Free Years, Los Ninõs Bien Educados, and Effective Black Parenting. RPC staff and local volunteers were trained to deliver these programs. Several funding sources combined to implement the nine-point plan under the coordination of Mainstream, Inc. ADAS funded a three-day risk and protective factor data training in January of 1992 for RPC staff and other key stakeholders. The Centers were expected to use this information in shaping their FY 1993 grants: a direction not totally supported by RPCs. Many providers experienced difficulty altering their services from a program-driven approach to a system approach for prevention, and being expected to work with communities rather than schools.

An ADAS evaluation contractor – Research Services of Greenbush – assisted the prevention centers in gathering local archival data. In February of 1992, Greenbush began gathering data at a state level, and provided regional/county risk profiles. ADAS was asked to take the lead in applying for the Six State Consortium Needs Assessment Grant. The State Development Research Group (SDRG) submitted a technical proposal and funding was approved in October of 1993. This initiative was a watershed for prevention research and science across the states, and Kansas has since continued to serve on national data committees. Research Services of Greenbush was awarded the Kansas prevention needs assessment grant and was charged with the task of collecting relevant data. The Six-State Consortium was instrumental in developing the Kansas Communities That Care student survey (KCTC) with Drs. Hawkins and Catalano.

Since this time, Greenbush has continued to have responsibility for administering, compiling, and disseminating the results of the KCTC, and serves as a vital part of the current prevention infrastructure.

In 1995, KFI became a 501C (private non-profit organization) and later changed its name to the Kansas Family Partnership (KFP). KFP supported the cadre of Kansas Baseline facilitators from 1995 - 1999 and assumed the role as the RADAR (Regional Alcohol and Drug Awareness Resource) Distribution Center in 1998. RADAR or the Kansas Resource Clearinghouse as it was called in the early 1980's, serves as a resource library for materials related to substance abuse prevention. KFP also continues to contribute to the current infrastructure through advocacy, coordination of training and resources, and support for specific statewide initiatives, including workforce development, KS Students Against Destructive Decisions (SADD) Program, the Red Ribbon Campaign, and annual community events like Family Day.

ADAS received the federal State/Regional Partnership Grant, Kansas Communities That Care, to study the role that coalitions play in reducing risk and protective factors. Four regions (Colby, Hays, Topeka, and Wyandotte County) were targeted for this study. The University of Kansas Work Group on Health Promotion and Community Development (KUWG) was chosen by ADAS to implement an Online Documentation and Support System (ODSS). The ODSS allows coalitions to report and track progress being made in their communities. KUWG continues to provide documentation and support services to all RPCs, substance abuse prevention coalitions and most recently the Problem Gambling taskforces, and is a key part of the current infrastructure.

The Community Youth Development Study also led by SDRG, was initiated in 2002 as a five-year research project designed to determine the effectiveness of the CTC system in promoting healthy youth development, reducing the prevalence of health and behavior problems among children and youth (including substance abuse, violence, delinquency, teenage pregnancy, and school drop-out).

The study focused on how communities used local data on levels of local risk and protective factors to guide their selection and implementation of science-based prevention programs. Seven states (Colorado, Illinois, Kansas, Maine, Oregon, Utah, and Washington) were selected to participate in the study, and 24 communities in these states were randomly assigned to participate in either the control or experimental condition. In Kansas, four communities took part in the study. To determine long-term efficacy of the CTC process, a longitudinal panel survey on an annual basis was conducted until the students graduated in 2011 in order to obtain information regarding changes in risk factors, protective factors, and youth behaviors.

In 1995, ADAS began planning for a new administrative entity that was based on managed care principles. In the spring of 1995, a pilot was implemented in one region for substance abuse treatment. In August, Kansas Foundation for Managed Care was funded to take the model to scale for both prevention and treatment for substance abuse. The prevention contracts, administered by the management organization, were based on risk and protective factor prevention and the Communities That Care system. In July 1997, the management organization discontinued management of the Regional Prevention Centers and ADAS returned to the provision of oversight and grant monitoring. Kansas Foundation for Managed Care had provided frequent site inspections and audits, but the cost of the monitoring system was found to be prohibitive.

In October of 1997, ADAS received the State Incentive Cooperative Agreement: Kansas Communities That Care grant and the Governor appointed a seven-member Executive Advisory Committee to provide grant oversight. The allocations of sub-recipient funds (85% of the $9.1 million award) were to be based on community-level risk and protective factor data. Kansas, through ADAS, also became the lead state for a new federal contract, the Four State Consortium, with the SDRG acting as the technical coordinator.

Reorganized in May 1999, the SRS/ADAS Commission transferred treatment to the Commission on Mental Health and created a new Office of the Secretary for the Advancement of Prevention (later referred to as the Office of Prevention). This office served as the point of contact for substance abuse prevention within SRS, and provided leadership with other public and private agencies. The Office of Prevention also took on the responsibility of developing and implementing the Connect Kansas: Supporting Communities That Care initiative. This direction was institutionalized in September of 1999 when SRS reorganized further. Substance abuse prevention funds transferred to the new office.

The Connect Kansas initiative was designed around nine developmental outcomes for children and youth and three primary goals: research and evaluation, outcome-based planning in communities, and community capacity building. The following nine developmental outcomes – that is, characteristics of healthy communities - were based on work done in Vermont: (1) families, youth, and citizens are part of their community's planning, decision-making and evaluation; (2) families and individuals will live in safe and supportive communities; (3) pregnant women and newborns thrive; (4) infants and children thrive; (5) children live in stable and supported families; (6) children enter school ready to learn; (7) children succeed in school; (8) youth choose healthy behaviors; and (9) youth successfully transition to adulthood.

Research Services of Greenbush developed data for the 105 County Data and Planning Guides that incorporated 115 social indicators organized around these nine outcomes. The role of the RPCs was expanded to support communities in implementing Connect Kansas and the CTC process.

The Kansas Planning Framework, published by the Governor's Substance Abuse Council in September 1999, outlined an interagency approach toward youth substance abuse prevention. Three major goals were formulated by the council in the Framework, with FY 2000 strategies and short-term action plans for each. They included the following: Provide leadership in achieving outcomes to reduce the risks for problem behaviors through strengthening protective factors in important areas in the lives of children and youth: community, family, peers, schools, and workplaces; use a risk and protective factor framework to plan, coordinate, and leverage state and federal resources that are directed toward reducing alcohol, tobacco, and other drug abuse and related problems for children and youth; and promote environments that support children and youth in becoming healthy and contributing members of Kansas communities. The Framework targeted three major outcomes: 1) Reduce alcohol, tobacco, and other drug use by children and youth; 2) Delay the first use of alcohol, tobacco, and other drug use by children and youth; and 3) Increase attitudes opposed to alcohol, tobacco, and other drug use by children and youth.

Oversight of Substance Abuse Prevention services in Kansas was transferred within SRS. In January of 2002, SRS began addressing substance abuse prevention initiatives at the state level. As prevention services were integrated, the division's name also reflected the change. The new division name became Substance Abuse Prevention, Treatment, and Recovery Services (SAPTR). Regional Prevention Centers were under this division's direction effective July 1, 2002.

In November of 2002, SAPTR hosted a strategic planning meeting involving nearly 200 stakeholders and providers from across the state. At this time, the agency's mission and vision were shared along with outcomes for both the prevention and treatment infrastructures. At the same meeting, SAPTR announced a name change to Addiction and Prevention Services (AAPS). This name change provided more flexibility for the agency to include topics such as gambling and other addictive behaviors added to their responsibilities by the legislature.

The AAPS mission became "Ensuring a comprehensive system of quality addiction services for Kansas". Its vision statement also reflected this broad-based, comprehensive, flexible, and proactive approach to prevention and included: to adopt a consumer and community centered philosophy utilizing a strengths-based perspective; to encourage collaboration of stakeholders including dissemination of information and integrating technology and resources to the benefit of the client; to promote fiscal responsibility by leveraging resources and diversifying funding; to ensure availability and accessibility to the continuum of care in every region; and to promote continuous quality improvement based on data, research and outcomes.

In January of 2004, while ongoing workforce development efforts were in progress, an abrupt shift in focus occurred. Kansas was notified by CSAP of its failure to maintain an adequately low rate of retailer sales of tobacco to minors. The Synar Amendment is an element of the Substance Abuse Prevention and Treatment Block Grant and the implications of the State's noncompliance was a $2.3 million penalty. During the next two years, AAPS led a comprehensive effort to invest additional resources to address the systemic issues related the sale of tobacco to people under 18 years of age.

Partnership with state and local stakeholders led to the creation of the Synar Advisory Group and the first state-sponsored tobacco retailer education program. Intensified monitoring of retailers, media messages, and increased fines resulted in lowered sales. This work initiated key partnerships and agreements with KFP, RPCs, local coalitions, Alcoholic Beverage Control, and SRS that successfully returned Kansas to a rate of compliance within federal requirements.

Among other notable prevention accomplishments was a vision and mission for the Kansas Prevention infrastructure supported by the SAPT Block Grant. In May of 2005, representatives from the RPCs, KFP, YouthFriends, KUWG, Greenbush, and the CAPT articulated a vision to ensure *effective prevention in every community*. With a clear vision, the Kansas prevention infrastructure will continue to partner to build capacity to ensure implementation of effective programs, policies, and practices to reduce alcohol, tobacco, and other drug abuse. Workforce development efforts continued to ensure an effective professional development process to recruit, train, and retain a knowledgeable and skillful prevention workforce. Communities That Care process facilitators training was provided in FY 2005 to maintain the solid foundational understanding of how risk and protective factors impact substance abuse. A cadre of eight trainers completed certification to deliver CTC training in Kansas in January 2005.

At the national level, the SPF was created by SAMHSA that includes five steps: assessment, capacity building, planning, implementation, and evaluation. At the core of each step is an emphasis on cultural competency and sustainability. Kansas examined the similarities in these five steps and the phased approach of the CTC process and began to consider how this framework fit into the state's prevention infrastructure.

In March of 2006, Kansas was awarded funding through CSAP to conduct an epidemiological study of substance abuse across the state, which led to publishing the Kansas Substance Abuse Epidemiological Indicators Profile in September of 2006. The profile was developed by the State Epidemiological Outcomes Workgroup (SEOW) (also referred to as the Kansas Substance Abuse Profile Team), an interagency team that included the state's first full-time epidemiologist dedicated to substance abuse. In a collaborative arrangement with the Kansas Department of Health and Environment, an epidemiologist working in that agency on tobacco prevention was contracted to support the development of a profile of the statewide substance use consequence and consumption patterns. Data collected for the epidemiological profile was also critical in the assessment and prioritization of a single outcome by the SPF Advisory Council, which would become the focus of the Strategic Prevention Framework State Incentive Grant (SPF-SIG) awarded to Kansas in October of 2006. This five-year, $10.5 million grant supported 14 high prevalence Kansas communities using the SPF with training and technical assistance from a project team working statewide to reduce and prevent underage drinking.

A project team approach was developed to support the 2006 SPF-SIG funded communities to ensure that T/TA expertise would be available for assessment, planning, implementation, and evaluation at the local level. This team, consisting of RPC and state-level trainers, evaluators, and the epidemiologist, worked in tandem to assist communities during a nine-month planning phase. A project team comprised of two T/TA providers, a grant monitor, and the evaluators continued to provide support during the implementation phase of the SPF-SIG through annual site visits, quarterly group TA conference calls, and monthly individual supportive contacts with sub-recipients. This individualized approach to TA aimed to enhance sub-recipients' abilities to implement prevention strategies with a high degree of effectiveness, fidelity, and scope, as well as allow for formative and summative

evaluation. The SPF-SIG Project Team piloted the use of technology in virtual training, distance learning, web-based conferencing, performance feedback, and technical assistance in support of SPF-SIG grantees.

In addition to the collaborative work of the geographically dispersed SPF-SIG project team, enhanced technological resources and social media resources including blogs and Facebook were used to expand information dissemination and connect community members to local prevention efforts. Sector representatives from each community were asked to participate in sharing best practices and lessons learned, not only as it relates to their communities of place, but also in ways that will impact processes and procedures within their own sector or community of practice

Final outcome data for the SPF-SIG initiative showed a 9.7 percentage point reduction in reported 30-day alcohol use, which corresponded to a 29.8 percent decrease across the 14 communities. This reduction in alcohol use for SPF-SIG communities was statistically more substantial than in non SPF-SIG communities. At the end of the grant in 2011, the 14 SPF-SIG communities had lower prevalence rates than comparison communities.

In 2007, workforce development efforts to support the Kansas prevention system included sessions regarding using the five-step SPF: cultural competency, sustainability, systems thinking, technology transfer, and collaborative consulting. These sessions aimed to introduce a number of system-change tools that could help RPCs in their work with communities. Further development of the infrastructure occurred through involvement with various workgroups. These workgroups focused attention on the following: a) developing benchmarks and milestones associated with the steps of the SPF and aligned with the Communities that Care model; b)establishing basic workforce development requirements; c) assessing the use of technology to support prevention efforts; d)revising the Online Documentation and Support System; e) developing a logic model for prevention grantees; f) contributing to the SPF-SIG underage drinking media campaign materials; and g) establishing a definition and criteria for evidence-based strategies utilized across SRS.

Internal improvements associated with outcomes and accountability within AAPS prevention was based upon the contribution of workgroups in 2008. These include the establishment of a direct link between community capacity assessments, service/consulting agreements with communities, work plans and online documentation entries. Building upon processes piloted as part of the Kansas SPF-SIG, utilization of technology increased with the establishment of Technology Stewards to increase the capacity of communities, and the AAPS Prevention Network to utilize technology and social media to enhance outreach, improve access to resources, decrease travel time, and enhance efficiencies associated with capacity development activities. The enthusiasm and enhanced skills associated with expanded technology use in Kansas resulted in virtual workforce development opportunities, feedback, guidance, and other technical assistance to grantees, and community and youth meetings and trainings.

In 2009, efforts to improve the system were expanded by the establishment of the “System Development Think Tank,” a group of individuals representing peers, state partners and community partners nominated by AAPS Prevention Network members. This group was tasked to assure the future infrastructure supporting prevention efforts in Kansas maximized efficiencies and was contemporary with demographic needs, prevention strategies and technological advancements. The team was asked to assess the current state of prevention in Kansas, identify community support needs and make recommendations regarding needed actions to ensure a contemporary system to meet both the current and future needs. Members were asked to keep in mind these tactical resource considerations during the process:

- A local citizen coordinator in every Kansas community.
- No geographic boundaries should prevent communities from receiving needed support and/or specialized prevention expertise.
- Enhanced expertise across all steps of the SPF that is utilized well.
- Broader concept of the prevention workforce and capacity building among those partners.

The group utilized surveys completed by a variety of stakeholders including contractors, grantees, RPC consultants and directors, community members and state agencies; and conducted a content analysis of this data to inform their process for making recommendations regarding the future direction for prevention in Kansas. Think Tank efforts concluded in December of 2009, and after approval the resulting recommendations were then referred to four work teams for action plan development. The recommendations included: increased use of technology to support statewide prevention efforts; community-specific definition of quality of life and recognition of successful communities; establishment of a rate of reimbursement for prevention services; development of a structure for community capacity building and enhanced workforce development for prevention providers.

A Site Review from CSAP in 2009 reinforced the work of the AAPS Prevention Network and suggested possible improvements for the future. The site visit findings and suggested enhancements can be summarized by these six key points:

- AAPS's prevention system has experienced very few changes since its inception in 1987.
- Historical reliance on coalitions to determine prevention efforts – i.e., local coalitions, identify and target outcomes and priorities instead of established state-level goals.
- The current data system, ODSS, does not accommodate the actual expenditures for each of the six CSAP Core Strategies.
- The State uses historical funding of sub-contractors rather than using data to determine funding decisions and needs.
- The State does not have a formalized grassroots advocacy network for prevention.
- Cultural competency is not currently integrated in the Kansas prevention system.

Two shifts in practice occurred as a result of CSAP's emphasis on population level change; 1) a focus on community level implementation of the SPF model and 2) the adoption of underage drinking as the targeted statewide outcome, based upon the Kansas SEOW findings and the recommendations of the SPF Advisory Council. This aligned with the selection of underage drinking as a prevention priority for the Kansas SPF-SIG, and allowed for a synergistic impact of state and community-level prevention efforts in addressing underage drinking in an intentional and an optimally-leveraged fashion.

Additionally, shifts in processes also occurred as the result of system enhancement efforts. Feedback and learning loops (in the form of quarterly TA calls with grantees and contractors); linkages between diagnosing community needs, prevention outcomes, and deliverables, utilization of tools to enhance and improve communication, problem-solving, scenario planning, and meeting efficiencies, shared resources and improved accessibility of information in real-time via SharePoint (hosted on the Kansas Prevention Workstation and linked to the ODSS).

In 2009, AAPS involved stakeholders in providing input and feedback toward the establishment of a five year plan that incorporated treatment and prevention efforts, including communities as a critical element and embracing the concept of recovery as a hallmark of future efforts. The mission of AAPS efforts became "*Partnering to promote prevention and recovery in Kansas communities"* to support a vision that *"Kansas communities thrive and support recovery."*

An AAPS Strategic Plan was developed that emphasizes involvement of customers and communities and quality of care and services. “Addiction and Prevention Services is committed to creating a system of care that is customer/community centered focused, outcome driven, and consisting of a highly competent workforce that is focused on best practices. The mission will be accomplished and the vision realized through strategic partnerships, the development of a new information technology system, targeted workforce development initiatives, and being responsive to the needs of our partners and those we serve.”

Results of the work of the Work Groups, the Think Tank and Work Teams that followed, as well as input from the 2009 CSAP Site Review Team were easily incorporated into the Strategic Plan. Elements of previous planning were integrated into the following concepts found within the strategic plan:

- Increase the use of technology to expand the reach of prevention and to reach a broader spectrum of the workforce and provide real-time, on-time training
- Adopt a training framework that incorporates the elements of content, application and reinforcement
- Establish incentives for certification of and a career path for the Prevention Workforce
- Expand the Kansas Prevention Network to include the existing AAPS Prevention Workforce, Community Networks and local community coordinators, recipients of federal substance abuse prevention grants and grant coordinators, and specialized teams to address community-based processes and emerging trends.
- Develop a repository of expertise from among various community sectors, making resources readily accessible and available statewide
- Collaborate with institutions of higher education and training organizations to insure that the field’s workforce is skilled in evidenced based policies, practices, and programs; environmental approaches to prevention and emerging topics such as Recovery Oriented Systems of Care and Screening, Brief Intervention, Referral and Treatment SBIRT.

Consistent with the Strategic Plan, FY 2011 grants and contracts awarded by SRS marked an increase in accountability with the establishment of performance measures and annual targets for all contractors and grantees. In FY 2012 the RPC Infrastructure moved from 13 to 10 centers and work has continued to provide T/TA to communities.

In July of 2012, with the Executive Order issued by Governor Brownback to streamline state agencies, SRS programs and services moved to three different agencies, the Department for Children and Families, Department of Health and Environment and KDADS. Prevention services including mental health promotion, substance abuse prevention, and suicide prevention were merged into BHS Prevention within the Community Services and Programs Commission for KDADS.

In September of 2012, Kansas received the Strategic Prevention Framework Partnership for Success (SPF-PFS) II grant; this grant builds upon the lessons learned and successes achieved during the SPF-SIG grant (2007-2012). The five year, $2.6 million grant supports six (6) Kansas communities in their efforts to reduce and prevent underage drinking through a focus on strategic, data driven assessments that result in the implementation of evidence-based strategies designed to reduce targeted community level outcomes. SPF-PFS II communities are supported by a project team that is modeled after the SPF-SIG Project Team.

In July of 2013, the Kansas Strategic Prevention Framework (K-SPF) initiative was implemented within the RPC system. This effort was designed to move the SAPT-BG funded system forward in hopes of

aligning our state system more closely with the direction of SAMHSA' s CSAP. It also provided an opportunity to infuse lessons learned from the SPF SIG more directly into our broad prevention efforts. RPCs were asked to dedicate $20,000 (FY 2013 and FY 2014) and $27,500 (2015) of their grant award toward community implementation.

This initiative tasked each RPC with the identification of communities within their region that demonstrate a high need and high capacity to engage in the SPF process. Communities participating in the process would be eligible for funding after completing an assessment and developing a local level strategic plan that identifies targeted outcomes and evidence-based strategies that align with said outcomes. This effort was designed to infuse lessons learned from the SPF-SIG. It also moved the block grant funded system forward in aligning more closely with the direction of CSAP discretionary grant funding requirements: 85% of each grant award dedicated toward community level processes, that lead to the implementation for evidence-based strategies and limits the amount of funding for administrative costs at 15%.

In March of 2014, CSAP returned to Kansas to complete the 2014 Site Visit. CSAP suggested possible improvements and enhancements for the future. The 2014 site visit findings and suggested enhancements can be summarized by these three key points:

- Resources for communities (financial, manpower, time) for the implementation of a comprehensive array of evidence-based strategies at a level that goes beyond current K-SPF mini grants
- Education and training for communities for capacity development as well as for sustainable and effective broad based behavioral health initiatives
- Supportive coaching and assistance/TA provided to communities to reinforce training and assist them in navigating the steps of comprehensive assessment, planning, implementation, and evaluation

In FY 2015, 25 full time employees in ten regions, from Directors to Support Staff, were supported through RPC funding to provide T/TA to communities within their respective region. KFP funding supports 4.35 full time employees to provide support for Kansas SADD, the Kansas Red Ribbon Campaign, Family Day, the Kansas RADAR system, and Workforce Development Activities for the prevention infrastructure. The funding for the University of Kansas supports the ODSS, including training of new prevention staff, reliability scoring, and interpretation of data for federal reporting. The Center for Learning Tree Institute supports 5 full time employees to complete the following deliverables of their agreement: KCTC including the administration, dissemination of county level data via the website and analysis of data, creation of community and state level data summaries as requested, data collection and analysis for Synar compliance, and completion of the Annual Synar Report, SAPT-BG reporting, and the submission of National Outcomes Measures. This funding also supports the evaluation of all block grant funded programing. See the table below for FY2015 funding allocations.

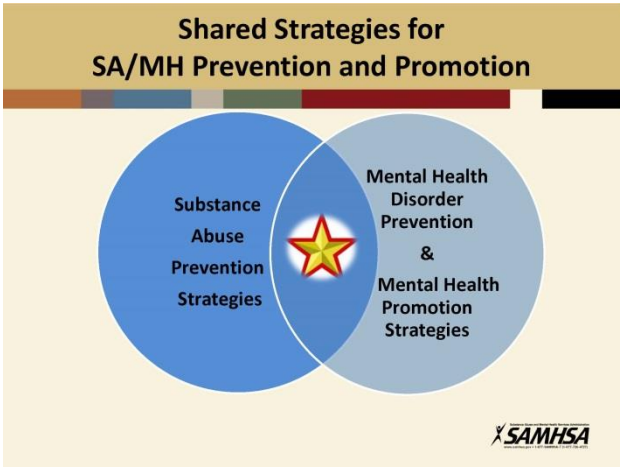
	SAPT-BG	State Fee Funds
Regional Prevention Centers	$2,189,000.00	0
Kansas Family Partnership	$148,660.00	$176,340.00
University of Kansas	$81,477.00	0
Center for Learning Tree	$292,110.00	$222,810.00

The vast majority of KDADS/BHS Prevention funding comes from the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG) issued through SAMHSA. Approximately 24% of the block grant funding is set aside for substance abuse primary prevention strategies. Primary prevention is defined as prevention activities designed to prevent substance abuse before any signs of a problem appear.

Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018

The Center for Substance Abuse Prevention within SAMHSA issues Strategic Initiatives and the top initiative is Prevention of Substance Abuse and Mental Illness. The goals within this initiative are: promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues; prevent and reduce underage drinking and young adult problem drinking; prevent and reduce attempted suicides and deaths by suicide among populations at high risk; and prevent and reduce prescription drug and illicit opioid misuse and abuse.

SAMHSA's model for implementing system change focuses on capacity building, infrastructure development, policy change, workforce development, and systems improvement. KDADS/BHS believes these principles must apply to the allocation of Kansas prevention resources and should be key focus areas for this RFI.



Research shows that substance abuse and mental illness share risk and protective factors and by focusing on risk and protective factors this will maximize opportunities to create environments where individuals, families, communities, and systems are motived and empowered to manage their overall emotional, behavioral, and physical health.

Attachment 1: Acronym Glossary

AAPS	The Division of Addiction And Prevention Services; changed from SAPTR in late 2002 to provide more flexibility in addressing behavioral health problems, such as gambling and other addictive behaviors; houses the AAPS Prevention Network
ACEs	Adverse Childhood Experiences
ADAS	The Commission on Alcohol and Drug Abuse Services; formed under SRS in the 1979 and developed a prevention unit in the early 1980s
CAPT	The Center for the Application of Prevention Technologies under SAMHSA's CSAP
CSAP	The Center for Substance Abuse Prevention under SAMHSA
CTC	Communities That Care model of substance abuse prevention based on reducing/addressing risk factors and increasing/using protective factors
IP	Interested party; an agency, organization, or professional interested in responding to this RFI
KCTC	Kansas Communities That Care student survey
KDADS	Kansas Department for Aging and Disability Services
KFI/KFP	Kansas Family Initiative, which changed its name to Kansas Family Partnership
K-SPF	Kansas Strategic Prevention Framework initiative; implemented within RPC system in July of 2013 to move the SAPT-BG funded system more closely in line with the direction of SAMHSA' s CSAP
KSDE	Kansas State Department of Education
KS SADD	Kansas chapter of Students Against Destructive Decisions
KUWG	University of Kansas Work Group for Community Health and Development
NIDA	National Institute on Drug Abuse
ODSS	Online Documentation and Support System; developed by the University of KUWG to allow coalitions to report and track progress being made in their communities
RADAR	Regional Alcohol and Drug Awareness Resource, AKA the Kansas Resource Clearinghouse; serves as a resource library for materials related to substance abuse prevention
RFA	Request for application; future solicitations
RFI	Request for information; this current solicitation
RPCs	Regional Prevention Centers across the state of Kansas form a regional system to deliver prevention T/TA and services
SAMHSA	The Substance Abuse and Mental Health Services Administration under the U.S. Health and Human Services Division
SAPT-BG	Substance Abuse Prevention and Treatment Block Grant from SAMHSA; awarded to Kansas to fund the majority of behavioral health services, where 24% is earmarked for substance abuse primary prevention initiatives
SAPTR	The Division of Substance Abuse Prevention Treatment & Recovery; formerly SATR but in 2002 integrated managing the work of RPCs so the name changed to include prevention; changed further to APPS
SDRG	The State Development Research Group
SEOW	The State Epidemiological Outcomes Workgroup, AKA the Kansas Substance Abuse Profile Team
SPF	The Strategic Prevention Framework created by SAMHSA
SPF-PFS II	Strategic Prevention Framework Partnership for Success II grant from SAMHSA; awarded to Kansas in September of 2012 for $2.6 million over 3 years to build upon the lessons learned and successes achieved during the SPF-SIG grant, supporting 6 Kansas communities in their efforts to reduce and prevent underage drinking (2012-2015)
SPF-SIG	Strategic Prevention Framework State Incentive Grant from SAMHSA; awarded to Kansas in October of 2006 for $10.5 million over 5 years to support 14 Kansas communities with high underage drinking prevalence to use the SPF (2007-2012)
SRS	The Kansas Department of Social and Rehabilitation Services
T/TA	Training and technical assistance

Attachment 2: RFI Response Template

Behavioral Health Prevention Innovation and Integration Project

[Agency Name and Contact Information]

[Date submitted]

See Attachment 4 for a key focus areas and priorities
1. Describe a system that is community-based and incorporates the priorities listed in the Scope of Request section.
Question 1 Response:
2. Describe a community infrastructure that would enable increasing the number of evidence-based strategies being implemented in more communities.
Question 2 Response:
3. What best practices or strategic concepts from other fields align with the priorities?
Question 3 Response:
4. How should KDADS/BHS structure and allocate funding to achieve a system that is more integrated and that addresses the shared risk and protective factors, inclusive of substance use prevention, problem gambling awareness and prevention, suicide prevention, and mental health promotion?
Question 4 Response:
5. How might the system be organized differently to address substance abuse prevention, suicide prevention, problem gambling prevention and awareness and mental health promotion in a coordinated, cohesive fashion?
Question 5 Response:
6. What challenges, needs or barriers may need to be addressed in regards to the geographic area and diversity of the state?
Question 6 Response:
7. What inhibits implementation of integrated, community level, community-led strategic plans?
Question 7 Response:
8. What new opportunities will arise if KDADS/BHS integrates behavioral health prevention?
Question 8 Response:
9. What are the challenges in integrating all of KDADS/BHS behavioral health prevention areas?
Question 9 Response:
10. What mechanisms and/or innovations in training, technology, and process would strengthen the systematic achievement of behavioral health prevention integration?
Question 10 Response:
11. What technology platforms are being used and are found to be effective in distributing training and resources, increasing collaboration, managing project implementation, capturing process level data or what other details should be considered in a prevention system redesign?
Question 11 Response:
12. What certifications or minimum qualifications are needed for technical assistance providers?
Question 12 Response:
13. What experiences and capabilities are needed to achieve the priorities?
Question 13 Response:
14. What other competencies do you feel are relevant to enhance the system?
Question 14 Response:
Additional comments/thoughts:

Attachment 3: Strategic Prevention Framework Principles

The following SPF principles are essential in achieving the expected population-level change that KDADS/BHS works to achieve. The principles provide broad guidelines that inform each step of the process, from strategic planning and capacity building, through evaluation and sustainability:

The SPF model employs a public health approach that focuses on achieving *population-level* outcomes. In instituting the SPF, Kansas continues to transform from a focus on services to individuals or small groups of consumers to population-based approaches that view community wellbeing as the unit of outcome measurement, and from agency-centered services to coordinated, multi-sector systems approaches that use evidence-based practices to achieve change.

The SPF promotes a systems-based approach to substance abuse prevention. Communities and prevention providers work to support the development of a system that has both long- and short-term effects on bringing down the rates of substance abuse. This process involves gradual change over a long period of time. It also calls for communities to work together strategically to foster the principles of cultural competency and sustainability throughout the SPF process.

The SPF allows communities to build capacity and sustain a culturally-competent infrastructure. The SPF affords communities the opportunity to assess and mobilize community capacity by engaging workforce, financial, and organizational resources to build prevention infrastructure. In working with diverse populations, the principles of cultural competence can ensure that environments, as well as relationships, are built on inclusion and mutual respect. By addressing sustainability, communities can ensure the longevity of prevention systems and their program outcomes.

The SPF is an example of outcome based prevention. The SPF is designed to systematically collect, analyze, interpret, and apply findings from epidemiological and community readiness data about substance use and consequences. Understanding the nature and extent of consumption and consequences from the beginning is critical. This data-driven process guides community-level efforts in identifying problems and setting priorities to determine the selection of policies, practices and programs that can best address issues affecting the health and wellbeing of communities.

The SPF requires evidence-based programs, policies and practices as the basis for program implementation. Communities need to implement evidence-based programs to ensure accountability and effectiveness in community-level prevention efforts.

More information on SAMHSA's SPF can be found online via http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework.

Attachment 4: Key Focus Areas and Priorities

1. Alignment with the SPF

The SPF is a five-step approach built on identifying community-based risk and protective factors and using gathered data to select, implement, and evaluate appropriate evidence-based and sustainable prevention programs, practices, and policies intended to lead to population-level outcomes. Please see Attachment 3 for more information on the SPF.

2. Strategic Integration across Behavioral Health

KDADS/BHS vision is for an integrated, behavioral health system with a focus on outcomes. The model of risk-focused prevention allows for the assessment and identification of shared risk and protective factors common to substance abuse, problem gambling, suicide, and mental health disorders. It is possible to assess and identify shared risk factors, such as Adverse Childhood Experiences (ACEs), for an array of problem behaviors and reduce and respond to these risks with aligned evidence-based interventions funded through braided sources. At a minimum, integration is sought across all behavioral health system prevention programs including substance abuse prevention, problem gambling prevention and awareness, mental health promotion, and suicide prevention.

3. Innovative Approaches and Leverage

To be more in line with SAMHSA funding allocation ratios (85% towards community level processes that lead to the implementation of evidence based strategies and 15% towards administrative costs) and comprehensively address more communities' needs around the totality of behavioral health prevention, KDADS/BHS is compelled to find new and innovative approaches and practices that leverage resources, capture more community-level investment, and achieve intended outcomes.

4. Facilitation of Community Change through Training and Technical Assistance (T/TA)

Training and TA must demonstrate effectiveness in facilitating actionable community level strategic planning and implementation of innovative solutions that are sustainable at the community level. The provision of training and technical assistance should be offered in a manner that builds community capacity, supports, guidance, coaching, and feedback necessary for communities to be able to autonomously engage in effective prevention processes associated with all five steps of the SPF, including cultural competency and sustainability.

5. Community Ownership

Community ownership is crucial to future prevention initiatives, and communities need to autonomously create broad-scope and multi-sector collaborations that are locally-driven and sustainable through:

- Effective technical assistance that consists of comprehensive facilitation of processes versus work on behalf of community groups
- Shifting emphasis and focus to community plans that are broad-based and inclusive of multiple core strategies
- Broader and more diverse public involvement
- Focus on both behavioral and policy/environmental changes
- Enabling shared resources to promote coordination and collaboration, and reduce duplication.