Division of Substance Abuse and Mental Health

Combined Behavioral Heath Assessment and Plan

FFY 2012— 2013 Application (CMHSBG + SAPTBG)

I: State Information

State Information

Plan Year

Start Year:

2011

End Year:

2013

State DUNS Number

Number

134632624

Extension

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

Agency Name

Delaware Health & Social Services

Organizational Unit

Division of Substance Abuse & Mental Health

Mailing Address

1901 N. Dupont HWY Main Administration Building

City

New Castle

Zip Code

19720

II. Contact Person for the Grantee of the Block Grant

First Name

Kevin

Last Name

Huckshorn

Agency Name

Division of Substance Abuse & Mental Health

Mailing Address

1901 N. Dupont HWY Main Administration Building

City

New Castle

Zip Code

19720

Telephone

302-255-9398

Fax

302-255-4427

Email Address

Kevin.Huckshorn@state.de.us

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

From

7/1/2010

To

6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Joseph

Last Name

Hughes

Telephone

302-255-9420

Fax

302-255-4428

Email Address

joseph.hughes@state.de.us

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
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.

Name	Kevin A. Huckshorn
Title	Director
Organization	DHSS/DSAMH

Signature: ______________________ Date: ______________

Footnotes:

I: State Information

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 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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

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)

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.

Name	Kevin Huckshorn
Title	Director
Organization	DHSS/DSAMH

Signature: ______________________________ Date: ______________

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Delaware will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as 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.

Name	Kevin Huckshorn
Title	Director
Organization	DHSS/DSAMH

Signature: ______________________ Date: ______________

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Delaware agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[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 (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Kevin A. Huckshorn
Title	Director
Organization	DHSS/DSAMH

Signature: ______________________ Date: ______________

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

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

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

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

Footnotes:

SECTION II - Planning Steps

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

ADULT BEHAVIORAL HEALTH SYSTEM

Description of the Sate of Delaware's Mental Health System:

The following describes the adult mental health system in Delaware:

Delaware is a small, but diverse state, located in the mid-Atlantic region of the country. Its land area of 2,000 square miles is divided among three counties: New Castle County, Kent County and Sussex County. Sixty-two percent of the state's population resides in New Castle County. The City of Wilmington, which is the state's largest city, is located within New Castle County and has a population of 72,274. This represents 15.38% of New Castle County's total population. Kent and Sussex counties contain 66 percent of the State's land area but only 40% of the population. While the majority of Kent and Sussex counties are considered rural areas, the City of Dover, which is located in Kent County, is designated as an urban area.

Based on the US 2010 Census population and updated estimates by the Delaware Population Consortium, the total state population is expected to reach 909,436 in the year 2012. 76.4% (694,810) of the population will be represented by individuals ages 18 and over, and 23.6% (214,627) of the population will be represented by children and youth (age 0 - 17). African-Americans will comprise 20.5% and individuals of Hispanic origin will comprise 6.7%[1] of the total state population.

The median household income in Delaware for 2010 was $57,618. Delaware's major businesses include chemical, banking and financial services, healthcare and pharmaceutical industries. The single largest employer in SFY 2011 was the State of Delaware, while the Services Industries as a group employed the largest number of Delawareans. More than half a million business entities have their legal home in Delaware including more than 50% of all U.S. publicly-traded companies and 60% of the Fortune 500. Delaware maintained an unemployment rate of 8.4% as of March 2011[2].

It is important to note that there are no city- or county- funded public human services in the state. Responsibility for public mental health services has traditionally been decentralized and divided between two cabinet level State agencies. Delaware Health and Social Services/Division of Substance Abuse and Mental Health (DHSS/DSAMH) provides services to persons 18 years old and older, and the Department of Services for

[1] Data on Hispanic origin is based on US Census Bureau figures. 2005-2009 American Community Survey

[2] State of DE Office of Economic Development website; http://www.dedo.delaware.gov/pdfs/main_root/publications/DelawareDatabook-May2011.pdf

Children, Youth and Their Families/ Division of Prevention and Behavioral Health Services (DPBHS)
serves persons under the age of 18 years. Coordination between the two departments is accomplished through the Governor's Cabinet, direct communication between the Secretaries and Division Directors, and between key staff of the Divisions of Substance Abuse and Mental Health and Child Mental Health Services. The two Divisions have worked to develop and implement two Memorandums of Understanding to formalize their respective roles and responsibilities in meeting federal Community Mental Health Services Block Grant requirements:

1. Clinical MOU that deals with transition of youth from the Juvenile Mental Health System to the Adult Mental Health System.
2. MOU that establishes mutual responsibility for reporting via the Community Mental Health Block Grant Application and the Implementation Report.

In addition, DHSS Division of Medicaid (DMMA) Medical Assistance, which administers the Medicaid program, is involved in the provision of mental health care for Medicaid-eligible adults. Since the adoption of Delaware's mandatory managed care program for its Medicaid population in 1996, mental health services for Medicaid-eligible adults have been provided under the Diamond State Health Plan (DSHP). Under this program, Managed Care Organizations provide a comprehensive benefit package of acute and primary health services, which includes limited behavioral health care services as a part of the Basic Benefit. For Medicaid eligible adults who require intensive community-based behavioral health services, DSAMH (the Division) provide carve out services. The Division and DMMA have worked together to implement this program, and oversee the delivery of services and coordinate determination and referrals of clients.

Delaware's Current and Envisioned Mental Health Service System for Adults

The Delaware Health and Social Services (DHSS) is the largest state department. The Secretary of DHSS directs and integrates the activities of 12 separate divisions. All of the state divisions providing institution based care and community support services to adults with psychiatric disabilities are under the purview of the Secretary, with the exception of the Division of Vocational Rehabilitation, the Department of Public Instruction and the Department of Corrections.

The Division of Substance Abuse and Mental Health (the Division) is responsible for meeting the treatment, rehabilitation and support needs of adults, age 18 years and older, with serious mental illness (SMI). The Division seeks to provide these services to consumers if they are unable to obtain community support through other state agencies. This acceptance of categorical responsibility helps reduce service fragmentation.

The Division's **mission** is *to promote health and recovery by ensuring that Delawareans have access to quality prevention and treatment for mental health, substance use, and gambling conditions.*

The following are the **major goals** of the Division:

1. The consumer is a partner in service delivery decisions;
2. Delawareans receive mental health, substance use and gambling prevention and treatment services in a continuum of overall health and wellness;
3. Disparities in substance use and mental health services are eliminated;
4. Develop the clinical knowledge and skills of workforce;
5. Promote excellence in care;
6. Technology is used to access and improve care and to promote shared knowledge and the free flow of information; and,
7. Quality and efficiency in management and administration.

Administrative Structure and Service System

The Division serves as the Single State Agency for Mental Health and Substance Abuse services. As such, the Division receives Federal and State dollars for the sole purpose of administering mental health, substance abuse and gambling prevention and treatment services in Delaware.

Central Office. Administration of statewide substance abuse services and mental health services for adults 18 years of age and older is the function of the Central Office. The Central Office has the following responsibilities: implementing Delaware Health and Social Services policy; setting the mission, vision and values to serve as decision templates within the Division; strategic planning, allocating resources and developing the service system; managing state and federal inter governmental relations; managing access and use of the service delivery system; and managing the flow of consumers with serious mental conditions and substance use disorders into inpatient, residential, and outpatient state and community programs. The Central Office includes the following sections: Administrative Services (MIS, Fiscal, and Quality Improvement); Planning and Program Development; Human Resource Development and Training; Office of the Director/Deputy Director inclusive of the Office of Consumer Affairs. The Director of Community Mental Health and Substance Abuse Services and Gambling Affairs oversees the mental health, substance abuse, and gambling service system for the Division.

Delaware Psychiatric Center. The Delaware Psychiatric Center (DPC) is the single state mental health psychiatric hospital. It is licensed for 200 beds though we are actively downsizing this facility with the assistance of the USDOJ. DPC operates six discrete units: two acute care units of 18 beds each; a 28 bed geri-psych unit for mostly medically complex individuals with a history of a serious mental condition; a longer stay, 32 bed all male unit for persons who have stepped down from forensic settings, are labeled as sex offenders or who are aggressive; a mixed use longer term, 32 bed unit for persons who have co-occurring disorders including MH, SA, intellectual disabilities, and personality disorders and who are hard to place in community; and a 42bed Level Five forensic

program. The Delaware Psychiatric Center's average daily census was 150 clients for the period ending – 6/30/2011

Crisis Services. These include 24/7 crisis intervention services including a 24/7 emergency hotline, mobile crisis intervention services and constant collaboration with police and hospital emergency room staff in managing crisis interventions, etc. The goal of the mobile crisis approach is to assist in preventing the deterioration of a psychiatric crisis, preventing inpatient hospitalization, and effectively linking individuals to appropriate levels of care in the community.

Community Support Program Structure for Adults

There are currently four *Community Continuum of Care Programs (CCCPs)* in Delaware. Two serve consumers in New Castle County, one provides services in Kent County and the fourth serves Sussex County. The CCCP objectives are to promote, through treatment and supports, the transition of individuals with serious mental conditions (SMI) to less intensive levels of care, to assist them in obtaining employment and stable housing and a life in the community. The CCCP model of care includes a comprehensive array of services designed to address the changing needs of consumers at different stages of recovery.

Each CCCP is designed to serve between 250 and 470 consumers depending on location, eligible population and funding. Services are delivered via a team approach and each CCCP includes at least one Assertive Community Treatment team certified by DSAMH as a *Continuous Treatment Team*, based on the Program of Assertive Community Treatment model.

Four *Community Mental Health Clinics*, located in Wilmington, Newark, Dover and Georgetown, provide outpatient mental health treatment services throughout the state. Services include: shortterm counseling; psychiatric and supportive counseling; crisis intervention; limited case management; and medication administration and monitoring. These are state or community provider run centers.

Additionally, DSAMH requires all mental health and substance abuse service providers to screen for cooccurring mental health and substance abuse disorders. All clinics, ACT Teams, and substance abuse treatment providers administer the adapted ASAM screening instrument on admission.

There are two *day programs* operating in Delaware. One program, serving consumers in New Castle County and one program serving consumers in Kent County, provides communitybased supportive and recovery services in a group format and is run by community provider agencies.

Twentyfour hour supervised residences are either linked as program components to community support services or are organized as selfcontained programs. Throughout

DSAMH's Continuum of Care, there exist 429 beds statewide that provide 24hour supervised residential services. These services are provided via DSAMH's group home, supervised apartment, transitional and permanent housing programs. These programs are currently under review and revision with guidance from USDOJ and consultants.

Description of the Sate of Delaware's Substance Abuse Prevention &Treatment System:

The following describes the adult substance abuse system in Delaware:

The Division operates, directly or through contracts with private agencies, primary prevention and treatment services throughout the state. Treatment services include: outpatient evaluation and counseling; medication assisted outpatient detoxification and treatment, care management services, including intensive multidisciplinary teams; short and long term residential programs; and residential detoxification services. The Treatment Access Center (TASC), providing targeted services and liaison with the Courts and criminal justice system; and services directed toward problem/compulsive gambling.

Eligibility and Enrollment Unit (EEU)

The EEU in Delaware is the gatekeeper to the substance use disorder treatment system. The goal of the EEU is to gather information about the consumers in order to place them in the level of care that is the most appropriate for the individual as determined by best practice assessment tools and the individuals themselves. The EEU uses te ASAM PPC-2 for placement in the most appropriate level of intensity and based on a comprehensive assessment. Information on the ASAM PPC-2R are included below:

- The American Society of Addiction Medicine's (ASAM) Patient Placement Criteria (ASAM PPC-2R) is the most widely used and comprehensive national guidelines for placement, continued stay and discharge of clients with alcohol and other drug problems. Responding to requests for criteria that better meet the needs of co-occuring consumers with both mental health and substance use disorders ("dual diagnosis"), for revised adolescent criteria and for clarification of the residential levels of care, the ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition -– Revised): (ASAM PPC-2R) was released in April, 2001.
- Beginning in January 2011, DSAMH will begin the use of ASAM throughout its continuum of care, including its primary mental health providers. The goal is to establish a statewide common language to define the appropriate levels of care.
- Assessment is a full biopsychosocial completed by the provider. It includes five axis DSM diagnoses. The results of the assessment help make a determination abuout appropriate intensity of care focused on ASAM PPC-2R.

Detoxification Services (Detox)

The State of Delaware currently has one residential detoxification program that provides services for up to five days, although, seven days is available for medication assisted detoxification. DSAMH contracts with Northeast Treatment Centers, Inc. (NET) to provide medically monitored inpatient detoxification. NET's incentive based contract emphasizes successful linkages to the next level of care.

Core services include 24 hour physician, psychosocial services, medical services, linkages to substance abuse treatment facilities. This program now provides Vivitrol (Naltexone). This injection is used along with counseling and social support to help people who have stopped drinking large amounts of alcohol to avoid drinking again. This program offers Buprenorphine for medical management of the detoxification process.

Ambulatory Detoxification (Detox)

DSAMH has witnessed an increase in referrals to admissions for young adults with opioid addiction. DSAMH is implementing ambulatory detoxification programs in the outpatient and methadone programs. DSAMH feels this less restrictive setting will be more attractive to the target population of young adults. It uses Buprenorphine for medical management of the detoxification process. These programs will be fully integrated with outpatient treatment services.

Medication Assisted Recovery

DSAMH funds two providers who offer medication assisted treatment services at three locations throughout the state. Those services include psychiatric and psychological services, and a physician to prescribe addiction treatment medications (e.g. Methadone, Buprenorphine, and Vivitrol) and monitor its administration over time. They also provide links to emergency services if needed. Staff provides services through a multidisciplinary case management approach. Brandywine Counseling and Community Services, Inc. (BCCS, Inc.) provides methadone maintenance in New Castle County. Kent and Sussex Services provide methadone maintenance in both Kent and Sussex Counties. Both programs currently prescribe Suboxone (Buprenorphine) and Vivitrol (Naltexone) for alcohol dependence. Ambulatory detoxification is required for the transition to outpatient services.

Residential Services

DSAMH contracts for three residential treatment programs statewide:

- Gateway is contracted to provide 80 beds for inpatient services, of which 60 are for males, and 20 are for females. This program provides services to a mix of community and criminal justice referred clients.

- Gaudenzia is contracted to provide residential opioid services for young adults aged 18 to 25. While alcohol or any drug can be treated, admission preference is given to those with opioid addiction. This program treats both males and females. During the treatment phase, the core services are to provide services geared to the young adult population, daily regimen of individual and group therapy, daily regimen of community meetings, educational or vocational services. Finally during the reintegration phase of treatment, consumers will develop a continuing care plan, attend outside 12 step programs and engage in other social support activities.

- Brandywine Counseling and Community Services, Inc., “Lighthouse Program” provides residential services in Sussex County for pregnant women with their custodial minor children. Core services include, providing a safe and therapeutic environment, provides 24 hour on-site staff, provide an evidence based model for co-occurring mental health and substance use conditions, psychiatric services, relapse prevention, relationship issues, family counseling, conflict resolution, anger management, improve parenting skills, pre employment training, social skill building, life skills, and instilling empowerment. Finally, the program serves pregnant women.

Outpatient Programs (OP)

DSAMH funds several outpatient programs that provide comprehensive mental health, alcohol, and other drug treatment services. Outpatient services include services to clients in the criminal justice system, community clients, medications, case management, assistance with acquiring entitlements, and working with vocational rehabilitation on employment issues.

Intensive Outpatient Programs (IOP)

DSAMH Funds two IOP programs administered by Connections, Inc. and Fellowship Health Resources (FHR). Both providers utilize evidence based practices. Core services include psychiatric services and treatment for co-occurring disorders. The programs maintain relationships with other agencies that provide services such as housing assistance, vocational assessment and training, education services, child care, and transportation services.

Halfway Houses

DSAMH funds 5 halfway houses throughout the State of Delaware. Two serve women. Core services for all of the half-way houses include safe sober, and drug free residences, 24 hour staffing, intake and assessment, orientation, medical health care, individual and group counseling, education, pre-vocational and vocational training, employment, recreation, self help meeting, continuing care, housing, financial management, nutrition, urinalysis, and conflict resolution

Treatment Access Center (TASC)

The Treatment Access Center (TASC) is the primary liaison between the Division of Substance Abuse and Mental Health (DSAMH) and the criminal justice system. TASC provides assessment, treatment referral and case management services to individuals with legal affairs as they move through both the criminal justice and treatment systems. TASC services are provided statewide to offenders coming through Delaware's Superior Court. Assessments are conducted and treatment recommendations are provided to the Court and other criminal justice officials for use in disposition. Once a case is engaged, TASC ensures that treatment placement occurs in a timely manner.

Drug Diversion Programs

The Division of Substance Abuse and Mental Health (DSAMH) funds community based organizations to provide an array of education, counseling and urine monitoring services, case management services to clients diverted from the criminal justice system by Superior Court and Court of Common Pleas drug court judges.

Drug Court diversion programs funded by DSAMH offer psycho-educational and outpatient counseling services to offenders. Diversion program participants who are determined to need more intense levels of treatment are referred to other programs, in the same or another agency, that provide the appropriate level of care for criminal justice referred clients. All programs providing services to Drug Court diversion clients must be licensed by DSAMH and comply with all DSAMH operational standards.

Diversion programs for offenders from Superior Court are designed to last a minimum of six months but may be longer depending upon client engagement and need. Diversion programs for offenders from the Court of Common Pleas are designed to last a minimum of 14 weeks but may be longer depending upon client engagement and need.

The Diversion programs perform intake assessments, ongoing urinalysis, educational groups, and counseling and case management services.

TASC coordinates and monitors all Drug Court diversion programs that are funded by DSAMH. All offenders diverted by Superior Court and Court of Common Pleas are assigned to a case manager. The case manager is the liaison between the program and the drug court, TASC and other agencies/programs with which the client may be involved.

Cornerstones Residential Program

DSAMH funds Connection, CSP to operate the Cornerstones Residential Program. This program utilizes the IDDT model as the core evidence based practice for those with severe mental health and substance abuse conditions. They offer therapeutic communities, stabilization, engagement, active treatment, relapse prevention, rehabilitation, and continuous individualized treatment plans.

Crisis Services

Services include 24/7 crisis intervention including mobile intervention, crisis phone intervention, collaboration with police and hospital emergency room staff in managing crisis interventions, etc. The goal of the mobile crisis approach is to assist in ameliorating a behavioral health crisis and effectively linking individuals to appropriate levels of care in the community. This service addresses the needs of individuals with any behavioral health issues.

The Bridge Program

The goal of the Bridge Program is to serve people with children receiving Temporary Assistance for Needy Families (TANF) funds. Many people receiving TANF funds have an untreated mental health or substance abuse problem. By treating those conditions, the program aims to assist people with becoming more independent.

Oxford Houses

DSAMH contracts with Oxford House International to provide a network of 33 Oxford Houses. They also use state general funds to maintain a revolving loan fund to open new houses. No Substance Abuse Prevention and Treatment Block Grant Funds are used to maintain the revolving loan fund.

Transportation Services

DSAMH has two contracts to assist in transporting individuals to treatment venues.

1212 Clubs

DSAMH contracts with the 1212 Corporation, Inc., to operate a recovery clubhouse for persons seeking assistance and a safe haven from alcoholism and drug addiction located in Wilmington, Delaware. Services provided include 12 step meetings, therapeutic support for recovering persons, transportation to and from treatment facilities in the tri-state area, substance abuse education/recreational activities, transitional housing for women and men leaving treatment, part-time employment as a Counter Assistant, monthly membership for access to services from 7AM to 10 PM daily.

Project Renewal

DSAMH contracts with Brandywine Counseling and Community Services, Inc. to provide services to homeless in Sussex County. It provides outreach to homeless, transportation, intensive case management, psychiatric assessment and medication monitoring, mental health and substance assessments and treatment, Bi-lingual services, groups, job readiness class, employment retention support, food, laundry and showers.

Delaware Council on Problem Gambling (DCPG)

DSAMH realizes that there is a high rate of gambling among consumers with drug and or alcohol conditions. Due to this fact DSAMH, through DCPG, contracts with several providers statewide to provide a two question quick gambling screen followed by the more thorough South Oaks Gambling Screen (SOGS). If the people score high on the SOGS, they are provided access onsite to gambling counseling or referred to a gambling program. DCPG also offers gambling prevention and a toll free help line.

Needle Exchange Program

During calendar year 2008, the Department of Public Health (DPH) began a pilot program in the City of Wilmington, located in New Castle County. The concept of Needle Exchange Programs comes from the public health concept of harm reduction. By providing clean needles to intravenous drug users reduces their chances of acquiring chronic health conditions such as hepatitis or HIV. These programs provide treatment services as well.

Co-occurring Services

The Division provides integrated services for individuals with co-occurring disorders including screening for co-morbidity, assessment of need, and treatment planning that addresses the individual’s substance abuse and potential relapse. The Division collects data from 12 front door locations including: the States first Comprehensive Behavioral Health Outpatient Treatment Center (3) CMHCs, (4) CCCPs, and (4) AODs representing nearly 100% of our Community Behavioral Health front door sites. There is a 100% screen and assessment rate among those sites.

DSAMH received the Co-occurring State Incentive Grant (COSIG) to build capacity to provide effective services to those with co-occurring mental health and substance use conditions. The COSIG initiative is working with two subject matter experts in their field to transfer their knowledge of theory into practice in our programs and policies. The end result of this initiative is to provide comprehensive, fully integrated programs to serve the diverse needs of this population.

The Division maintains a 100% screen rate for co-occurring disorders for individuals receiving treatment services from Community Mental Health Clinics, Institutes for Mental Disease (IMD), Community Continuum of Care Programs (CCCPs), substance abuse outpatient programs, TASC , residential treatment programs, mental health group homes and the Gambling Council.

Prevention Services

Delaware’s prevention infrastructure has improved significantly over the past five years. There are many factors that have impacted Delaware’s current status, including the newly appointed Governor (2009) who recognized the importance of increasing focus on

prevention and be in alignment with the Substance Abuse and Mental Health Services Administration (SAMHSA) movement to put prevention at the forefront of health care services by reorganizing state agencies to include prevention mandates. There was an increased level of commitment by the Division of Substance Abuse and Mental Health (DSAMH) and the Division of Prevention and Behavioral Health Services (DPBHS) formerly known as the Office of Prevention and Early Intervention (OPEI) and the Division of Child Mental Health Services (DCMHS) to continue working collaboratively to provide prevention services and build community capacity through technical assistance and training initiatives. In addition, the current economic recession had a disproportionate effect on the Delaware economy and brought with it a hiring freeze and severe budget cuts. Despite these factors, and partly because of them, State agencies have worked to develop new bonds with community organizations and with each other.

Due to the increased importance and relevance of prevention in the State, DSAMH and DPBHS with the inclusion of prevention providers throughout the state, developed a Statewide Substance Abuse Prevention Plan targeting individuals throughout the lifespan. The Strategic Plan, using data-driven decision making techniques, will guide the prevention activities over the next three years. The Plan will be reviewed on an annual basis to ensure benchmarks are being met, appropriate services are being provided, and discuss emerging substance consumption and consequence trends.

The staff available to focus primarily on substance abuse prevention services is an asset for the State. DSAMH has one full time Prevention Specialist, Isabel Rivera-Green, MSW, CPS. Isabel Rivera-Green also serves as the National Prevention Network (NPN) Representative for Delaware, and oversees the adult prevention programs, which are funded through the Substance Abuse Prevention Treatment Block Grant (SAPT BG).

Delaware is committed to building the capacity of the prevention network to respond to state priorities identified by the state epidemiological profile and the SPF-SIG process, and working with other state agencies to leverage existing resources to assist in capacity building and achieving the goal of substance use prevention and reduction through implementation of the Strategic Prevention Framework process throughout the state strategic plan.

Delaware's commitment to promote prevention at the forefront of the continuum of care has been demonstrated through the process of professionalizing the field of prevention in Delaware. DSAMH proceeded with the process to provide credentialing for Prevention Professionals in our state. In October of 2010 the Delaware Certification Board (DCB) & the International Certification and Reciprocity Consortium (IC&RC) approved credentialing of Certified Prevention Specialist in Delaware. DSAMH will continue to work toward building our prevention infrastructure to sustaining Delaware's CPS professionals through trainings.

Currently, Delaware has few institutionalized procedures for providing prevention training and technical assistance to either professional staff or to the community. DSAMH provides some professional training each year at the Summer Institute. In the

past the focus is largely on treatment and few sessions have historically been available on prevention. In 2011, the Summer Institute had a full week-long prevention track focusing on environmental strategies, sustainability, coalition building, fetal alcohol spectrum disorders, and ethics. DSAMH will continue to build on this training infrastructure to address the needs of the State's prevention providers. In addition, DSAMH continues to work with Northeast Center for the Application of Prevention Technology (NE-CAPT) and Community Anti-Drug Coalitions of America (CADCA) to provide trainings to the prevention community on an ongoing basis.

Through a competitive Request for Proposal (RFP) process in 2010, DSAMH identified two agencies with whom to contract to provide evidence-based and/or theory driven primary prevention services throughout the State, Brandywine Counseling and Community Services (BCCS) and the Latin American Community Center (LACC).

BCCS will use 4 of the 6 SAPT Block Grant Prevention Strategies to deliver their services throughout the state. The Prevention Strategies that they will use are: Information Dissemination, Prevention Education, Alternative Activities, and Community Based Process.
BCCS will implement a multi-session curricular program validated by the NREPP (*Prime for Life*) which will be conducted using three different approaches. This program will be implemented with fidelity in a personal goal setting and it will offer resilience building formatting applicable to multiple cultures at any state of their adult years.

LACC Prevention Program will be based on the 6 SAPT Block Grant Prevention Strategies. The ATOD Prevention Program will seek to raise awareness on the dangers of substance abuse among Spanish and English speaking Latino adults and others ages 18 – 35 through street outreach to individuals and local businesses, monthly education sessions, drug and alcohol-free activities, and prevention-themed local events in New Castle County, Delaware. The program is an adaptation of the Mpowerment Program, and is based on Psychological Empowerment, Cognitive Behavioral and Diffusion of Innovations Theories. The program also uses Social Marketing theory for their Environmental Approach. Participants are evaluated on their change in knowledge of substance-abuse, sense of empowerment and sense of community. Feedback is solicited after education sessions and activities to more effectively accommodate participants' needs, and ensure that the program remains culturally relevant.
In year 2010 Service to Science (STS) announced a national initiative supported by the Substance Abuse and Mental Health Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) to enhance the evaluation capacity of innovative programs and practices that address critical substance abuse prevention or behavioral health needs. The Division of Substance Abuse and Mental Health (DSAMH) Services nominated several agencies. As a result, the Latin American Community Center was selected and they are actively working with Service to Science to develop their current theory driven Prevention Promoters Program in becoming an Evidence Based Practice Program through rigorous evaluations and research of the work being done through this prevention program.
DSAMH received the Strategic Prevention Framework – State Incentive Grant (SPF-SIG)

in July 2009 to build the prevention infrastructure and provide effective, evidence-based services throughout the State.
Delaware needs and will continue to collect data so that the State's Prevention Plan can be reviewed and modified as needed to identify the state priorities, and provide prevention activities throughout the state.

CHILD BEHAVIORAL HEALTH SYSTEM

The Division of Prevention and Behavioral Health Services, (DPBHS) is the public mental health authority in Delaware for the provision of treatment services for children up to the age of eighteen. The Division of Substance Abuse and Mental Health, Department of Health and Social Services (DSAMH/DHSS) administers mental health services for adults. DPBHS and DSAMH collaborate in the planning of behavioral health services, especially in areas of service transition and prevention for youth reaching adulthood and development of decision-support systems.

DPBHS is committed to addressing the needs of Delaware's children, youth and their families. Our vision has driven significant changes in our state's service system for children in crisis. Beginning with a focus on child safety and evolving into a comprehensive Foster Care Reform. Our child mental health services are community based with less reliance on inpatient or residential care. Our improved partnership with private service providers and community supports significantly reduced juvenile detentions and improved juvenile rehabilitation services.

DPBHS is an integrated children's services agency with responsibility for programs in prevention, mental health and substance abuse (DPBHS), juvenile justice (Division of Youth Rehabilitative Services-DYRS), child protective and prevention/early intervention programs (Division of Family Services-DFS). Within DSCYF, DPBHS is responsible for:

- Planning and implementing the statewide continuum of behavioral health care services for children who require publicly funded services.

- Operating a system of case management with the goal of providing treatment in the least restrictive, clinically appropriate setting, minimizing utilization of hospital or residential programs, and involving families and communities in active treatment partnerships.

- Collaborating with other children's service agencies to plan and implement integrated and supportive systems of care to facilitate the highest possible levels of community functioning

- Providing leadership in children's behavioral health program development, preferred practices policy and training, and data-driven decision-making.

DPBHS System – Present and Future

In response to bi-partisan advocacy in the public and private sectors, the Delaware General Assembly passed legislation creating a Cabinet-level Department of Services for Children, Youth and Their Families (DSCYF) on July 1, 1983. DSCYF remains one of a very small number of integrated state-level children's services agencies. In Chapter 90 of Title 29, Laws of Delaware, the General Assembly:

> ..."declares that the purpose of this Chapter and the policy of the State is to achieve the consolidation of services to children, youth and their families within the jurisdiction of a single agency in order to avoid fragmentation and duplication of services and to increase accountability for the delivery and administration of these services; to plan, develop, and administer a comprehensive and unified service delivery system to abused, neglected, dependent, delinquent and mentally or emotionally disturbed children and youth within a continuum of care which shall include the involvement of their family, within the least restrictive environment possible; to emphasize preventive services to children, youth and their families in order to avoid the costs to the State of individual and family instability."

Each Division within DSCYF is mandated to provide services to targeted populations and to collaborate in the treatment of youth and their families:

- The Office of Prevention and Early Intervention (OPEI) was merged into DCMHS to become the **Division of Prevention and Behavioral Health Services (DPBHS)** on July 1, 2010. Division of Child Mental Health Services (DCMHS) provided a continuum of mental health and substance abuse treatment for youth under the age of 18. The office of Prevention and Early Intervention (OPEI) provided a wide range of community services focused on family and youth education and supportive activities to strengthen families, and lessen the likelihood of entry or reentry into more intensive services. Together our new mission is "***To assist children, youth and families in making positive changes through programs that support child and public safety, behavioral health and individual, family and community well-being***".
- Division of Family Services (DFS) provides intervention services for abused, neglected and dependent children and youth.
- Division of Youth Rehabilitative Services (DYRS) provides treatment, habilitation and rehabilitation for youth involved in the juvenile justice system, both pre- and post-adjudication.
- Division of Management Support Services (DMSS), in addition to providing human resources, fiscal and management information support services, works with the service divisions to provide or coordinate educational services for DSCYF clients in day and residential treatment programs. These services are coordinated through:

DPBHS collaborates in the design and provision of services with other state child and

family-serving agencies and advocacy groups. The Department of Education and local school districts, Division of Vocational Rehabilitation, Department of Health and Social Services the Divisions that is responsible for mental health and substance abuse services for adults, Department of Public Health, Medicaid and SCHIP programs, and the Department of Developmental Disabilities.

DPBHS Central Office functions include strategic and budgetary planning, policy and procedure development, accountability and quality assurance. Functional units within Central Office include Intake and Assessment, Clinical Services Management, Program Administration, Information Management and Training. Units with direct client and family contact, including Clinical Services Management and Assessment, are located in regional offices across the state to facilitate service access. DPBHS is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), as a managed Behavioral Healthcare Organization and in Children and Youth Services.

The DPBHS treatment network is composed of over 100 service agencies operating from more than 81 sites across the state. In two sites services are provided by state-operated programs; all others are contracted agencies or providers. We would be remiss if we did not mention some of the community education that DPBHS brings to the communities statewide.

Tobacco Prevention Programming: Master Tobacco Settlement Funds are used for tobacco prevention programming in community settings statewide. The University of Delaware's Cooperative Extension Office currently provides Botvin's Life Skills training, which is an evidence-based program that seeks to influence major social and psychological factors that promote the initiation and early use of substances. Life Skills has distinct elementary and middle school curricula that are delivered in a series of classroom sessions over three years.

DPBHS Resource Center: Offers videos, pamphlets, curriculums and books on an array of prevention topics such as substance abuse, parenting, child abuse and domestic violence. Videos, curriculums and books are available to Delaware residents for loan at no charge.

Prevention and Early Intervention Training: Coordinated through partnerships with other state agencies and community-based organizations, trainings are designed to enhance the professional skills of Delaware's prevention workforce through dynamic learning experiences. Skills and knowledge are developed through trainings that focus on: Prevention of Child Abuse and Neglect; Alcohol, Tobacco and Other Drug Abuse and Delinquency and Recidivism; Promotion of Health and Wellness; and Family Strengthening Approaches. Trainings are designed for prevention staff, social workers, caseworkers, educators, counselors, family service workers, community leaders, parents, volunteers, law enforcement officers and faith-based leaders.

Media Campaigns: DPBHS coordinates statewide media campaigns that address the

prevention of risky behaviors, while promoting health and well-being. Partnerships with other state agencies, local businesses and non-profit organizations are established for leverage of resources and effectiveness.

The Division of Child Mental Health Services published its first state mental health plan in 1989. At that early stage the long-term goal of the Division was the development of a continuum of services, available in each of Delaware's three counties and offering an appropriate array of levels of intensity and restrictiveness. A case management system emphasizing planning, coordination and continuity of care also was developed, providing the basis for the current Division of Prevention and Behavioral Health Services /Medicaid managed care system.

As the continuum of community-based mental health and substance abuse treatment and now prevention services grew, DPBHS priorities shifted. Although we continue to reduce unnecessary hospital and residential services and increasing community alternatives with a focus on accessibility, family participation and appropriate transitions to collaborating service systems. With current emphasis on broadening the scope and location of services to include, for example, "step-down" therapeutic homes to decrease length of stay in residential treatment centers, greater emphasis on independent living skills and transition to work or education, and expansion of behavioral health services provided in home and school settings. Our current environment is one of active collaboration in program design and service provision with representatives of a wide variety of child and family services. Supporting this effort is the work of a larger, revitalized Community Advisory Council, which includes youth, family members, community advocacy organizations, provider agencies, DSCYF staff from our sister Divisions and staff representatives of a wide array of other state agencies and coalitions. Today DPBHS includes and increased emphasis and focus on prevention and the importance of programs and services designed to reach children and families *before* problems are deeply entrenched and require restrictive, deep-end services. Prevention is not only cost-effective; it's a best practice in our field. Similarly, effective behavioral health services are beneficial across our continuum of care. By combining the expertise and resources available in both of these areas, we will serve families more effectively and efficiently. DPBHS will *provide more effective prevention and treatment services for children through collaboration with families and service partners.*

DPBHS is an integrated children's services agency with responsibility for programs in prevention, mental health and substance abuse (DPBHS), juvenile justice (Division of Youth Rehabilitative Services-DYRS), child protective and prevention/early intervention programs (Division of Family Services-DFS). Within DSCYF, DPBHS is responsible for:

- Planning and implementing the statewide continuum of behavioral health care services for children who require publicly funded services.
- Operating a system of case management with the goal of providing treatment in the

least restrictive, clinically appropriate setting, minimizing utilization of hospital or residential programs, and involving families and communities in active treatment partnerships.

- Collaborating with other children's service agencies to plan and implement integrated and supportive systems of care to facilitate the highest possible levels of community functioning.
- Providing leadership in children's behavioral health program development, preferred-practices policy and training, and data-driven decision-making.

The DPBHS Continuum

When DPBHS was created in 1983 there were relatively few services available for children and adolescents and limited geographic distribution of the existing services. The service system for adolescents consisted largely of psychiatric hospital and residential treatment center slots. The service system for younger children consisted of hospital and day treatment, augmented by a small number of outpatient slots located in New Castle, Delaware's urban county. There was no system of intensive case management for clients and families and little monitoring or evaluation of service process and outcome.

DPBHS has a continuum that consists of Clinical Services Management Teams (CSMTs) with a coordinator assigned to each client and over forty agencies providing a wide array of mental health and substance abuse services for children and adolescents. Although not all service levels are available in each community, most services are available statewide. Services include 24-hour mobile crisis units and short-term crisis beds, clinic and home/community-based outpatient care, community aides ("wraparound"), community and hospital-based day and part-day programs, residential treatment and psychiatric hospitalization. Youth requiring treatment at the residential or hospital levels who cannot return to the care of their families upon completion of treatment are eligible for step-down to specialized therapeutic foster or group homes supplemented by those community mental health and substance abuse services that may be required on a continuing basis.

In DSCYF, the Division of Family Services is the primary agency responsible for providing foster and group homes. DPBHS youth requiring those services are the responsibility of an interdivisional team that develops an integrated plan of care. This multi-disciplinary planning offers significant potential advantages for children who are without family resources and have concurrent needs for treatment, rehabilitative/vocational services or the development of independent living skills.

As is the case in many states, the development of specialized foster care and group home settings has not kept pace with the increasing level of need. In response, DPBHS has developed Individualized Residential Treatment (IRT), a specialized therapeutic foster care program that provides a step-down service to youth leaving hospital or residential care who cannot return to his or her own families. This service level provides a community living situation with skilled foster parents and community-based continuing mental health services. IRT has been effective in preventing unnecessarily long stays in

residential settings

Since FY 90 to FY11 there has been an increase in expenditures for community based services and alternative residential services in group homes and therapeutic foster care have been facilitated by an effective program of Medicaid cost recovery and by DPBHS assertive management of psychiatric hospital usage, an ongoing initiative that has allowed for significant reallocation of resources for the development of community-based programs.

DPBHS continuum of community-based services includes prevention services, mobile crisis, routine and intensive outpatient, day treatment, and wraparound aide services available in each of the three Delaware counties. DPBHS programs operate statewide; there is no county or local government responsibility for the provision of behavioral health services.

Case Management System: Care Assurance

- All children active in intensive service levels in DPBHS are assigned to a Clinical Services Management Team (CSMT) that works with the child and family, mental health / substance abuse providers and related services to design and implement service plans. Each CSMT is led by a licensed mental health professional and includes individually assigned Clinical Services Coordinators and a Family Services Assistant. Psychiatrists, neuropsychologists, assessment and substance abuse specialists on the DPBHS staff provide consultation and evaluation at the request of the teams. Intensive services teams are located across the state; other teams manage acute care (crisis services and emergency hospitalization) and routine outpatient services. A Center for Mental Health Services grant-funded CSMT works closely with special education and the families of special
- Monitor and evaluates client's progress in treatment, re-authorizing services as clinically indicated.
- Facilitating transitions across levels of service and providers.
- Coordinates service provision, including service entry, transition, and discharge or transition to adult services.

The CSMT is expected to provide leadership in interagency planning for services, working in collaboration with other child serving agencies in the development and implementation of a unified service plan which addresses the multiple domains in which the client and family may require services, e. g., child protective services, community probation, education, medical care, housing, etc. DSCYF requires case managers for clients receiving services from multiple DSCYF Divisions to develop a unified service plan.

During FY07, DSCYF adopted department-wide implementation of the Delaware System of Care. The planning process for rollout of the System of Care included all DSCYF divisions, provider agencies, parents, and representatives of other child-serving departments and services, including, for example, the Department of Education, Division

of Substance Abuse and Mental Health Services, and Division of Public Health. The plan for training was initiated in FY04 and is continuing with intensive training on the System of Care and on the Integrated Service Planning policy and procedures for front-line workers and supervisors. The Delaware System of Care is driven by the following principles:

- Services are individualized and include strength strength-based solutions
- Services are appropriate in type and duration
- Services are child-centered and family-focused
- Services are , as much as possible community-based
- Services are culturally competent
- Services are provided within and across a seamless system
- Services are planned and managed within a team-framework which includes the child; the family and whatever natural and system supports are available to them.

Further discussion of the System of Care and the Integrated Service Plan can be found throughout the Children's Services sections.

The Flow of Services: How the DPBHS System Works

Intake and Assessment: Staff or providers performing this function have the first contact with the client, family or other referral agent and assist in the determination of clinical and financial eligibility. A standard screening instrument is used in all instances other than a need for urgent or emergency services. The instrument used in DPBHS was not developed to screen youth *out* of eligibility but to identify factors in history and current presentation that provide immediate guidance to administrators, case managers and providers regarding the urgency of services and the initial problems to be addressed. The intake function may occur at an outpatient agency, mobile crisis unit or the DPBHS central intake unit. If the client and family are eligible for DPBHS services they are assigned to Clinical Services Management Team. If the client and family are not requesting or eligible for DPBHS services, the Intake and Assessment Unit will provide information, referral, and assistance in obtaining services.

Clinical Services Management Teams: Once assigned to a CSMT, the client and family remain active with that team as long as services are provided by DPBHS. Many clients receiving intensive behavioral health services move through several levels of care and may receive services from a number of providers. The CSMT offers a constant contact point for planning, coordination and support, working with the client/family to design and implement services.

Network of Service Providers: The network is made up of public and private treatment agencies and independent practitioners. Service providers are required to involve the family in planning and treatment and to participate in regularly scheduled treatment progress reviews and in inter-agency collaborative efforts.

Network Administrators: Network Administrators have advanced behavioral health

training as well as experience and expertise in the business of operating behavioral health programs. They work closely with the service providers to develop new services and maintain a service array dictated by the changing needs of the DPBHS population, to develop appropriate capacity at each service level and to assure compliance with standards and practices established by DPBHS and DSCYF.

System Support and Improvement Units: Key areas of system support include quality improvement, human resource development, and data management and analysis. These units ensure accountability to clients and other stakeholders, as well as establishing a culture of learning, data-based decision-making and continuous improvement.

In 1997 DPBHS became the first public system and the first children's service system to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under their new standards for Managed Behavioral Health Care (now Health Care Networks). The Division earned re-accreditation in 2000 and in December 2003. DPBHS is currently CARF accredited. DPBHS learned that JCAHO no longer accredits Health Care Network Organizations. After careful consideration and review through DPBHS leadership, Providers and the DPBHS Advisory and Advocacy Committee a decision was made to pursue CARF accreditation in 2007 and the Division continues to hold the highest accreditation achieved through CARF to date.

DPBHS has a website for dissemination of information at:

www.kids.delawre.gov
www.twitter.com/delkids

Integration of Mental Health and Substance Abuse Services

In FY01, DPBHS expanded its focus on integration of mental health and substance abuse services. Research in the field of substance abuse services and DPBHS survey data suggested a high rate of co-occurring mental health and substance abuse issues in the youth population. DPBHS data indicated that up to 52% of youth in mental health treatment exhibited behaviors and had risk factors suggesting the existence of substance abuse problems; only 21% were receiving focused treatment for substance abuse.

In conjunction with the DSAMH CoSig grant, the last two years have included the treatment providers from both our mental health and substance abuse services in consultations with Dr. Mee-Lee. This has enable a conversation about the frequency of co-occurring diagnoses in our adolescent population, the ineffectiveness of the sequential treatment episodes (back and forth between treatment systems), and the core elements of providing concurrent treatment for both identified mental health and substance use disorders. Moving from a general analysis of the system as well as case specific consultation, the DPBHS treatment network providers formed a working group to consider a strategy for moving forward. DDCAT and DDCMHT organizational readiness evaluations were completed by all providers, providing a starting point for building a Dual Diagnosis Capable System. This contract year, all mental health

agencies will use a substance use screen—Global Assessment of Individual Need (GAIN) Short Screener—in intakes with youth 12 and older. The GAIN Core assessment is required of all substance abuse providers and our system has moved to the web based assessment in order to facilitate and improve efficiency in completing the assessment while building agency level and aggregate data to drive our planning. Over the next planning year, the DPBHS work group will develop a strategic plan for implementing co-occurring treatment across our provider network.
In addition, DPBHS is focused on the risk and protective factors that can lead to a youth engaging in substance use or other dangerous behaviors that lead to more restrictive levels of care. As a result of a federal grants, DPBHS has trained 95 clinicians and certified 38 statewide in Trauma Focused-Cognitive Behavioral Therapy. In addition to this, the division is supporting the use of a trauma screen—UCLA—in our schools, juvenile justice settings and child welfare support services. As our system becomes more trauma informed, we hope to see a decline in serious behavioral health problems in our youth. Another federal grant has funded Parent Child Interaction Therapy certification, and approximately 72 therapists in our network are trained to deliver this evidence based practice to very young children in our system. The non-clinical model—CARES—has been offered in a statewide Prevention/Behavioral Health Conference with huge interest and participation. In addition to a trauma informed system, this grant along with our array of prevention services is focused on intervening at a younger age, through families, child care providers and schools.

Consequent to recommendations of Delaware's Child Protection and Accountability Commission's Mental Health Subcommittee, DPBHS has developed a service for children placed in foster care for the first time, foster children presenting with behaviors that may disrupt their placement, and children aging out of foster care. This program provides a brief evaluation (administers the UCLA for all children and the GAIN Short Screener to all children 12 and older), psycho-education around identified issues and diagnosis for the foster care provider, facilitated access to needed treatment and/or other services, a behavioral intervention plan and collaborative transition planning. This is provided statewide, and the process is a home based, team approach with the Division of Family Services frontline staff.

DPBHS has participated with Nemours Health Organization in delivering an evidence based parenting program—Triple P. This primary prevention approach to skill building with parents and other caregivers supports effective behavior management and an understanding of child development. Those trained span a number of family focused services, including daycare providers, shelter workers, treatment providers, juvenile justice workers to name a few. Engaging and retaining parents/caregivers in building relationship and behavior management skills has been difficult given that most of those participating have already encountered serious problems by the time they seek services.

To better identify and treat youth with co-existing substance abuse (SA) and mental health (MH) problems, DPBHS has:

- Established Intake screening procedures to identify risk factors for substance abuse.
- Worked with providers of MH and SA programs to select screening and assessment instruments to identify SA problems in youth referred to MH treatment as well as MH issues in youth referred for SA treatment.
- Developed training for DPBHS staff and MH providers on various aspects of substance abuse and treatment approaches such as Motivational Interviewing, treatment approaches included in the Cannabis Youth Treatment Project. During FY05 providers and DPBHS staff members developed practice protocols and evaluation methods.
- Developed processes and payment structures to encourage SA contractors to qualify as providers of treatment for youth with co-occurring disorders if they met the same training and experience standards as MH providers.
- In 2006 GAIN was implemented. The GAIN is a global assessment of individual need that can be used with children over the age of 12 and adults. The primary focus is substance abuse, but the instrument, when administered in its full version, will give a DSM-IV diagnosis for both MH and SA and an ASAM level of care (substance abuse level of care). It is the assessment instrument that many of the federal grants for substance abuse services require and it is evidence based and nationally recognized.
- Delaware Adjudicated Drug Court- we continue the Adjudicated Drug Court a partnership with Family Court and the Office of the Attorney General, to divert youth from the criminal justice system into appropriate treatment.

Relationship of Primary Health Care and Behavioral Health Services

On January 1, 1996, the State of Delaware launched the Diamond State Health Plan (DSHP), a managed-care health program for Medicaid recipients which is now Delaware Physicians Care (DPC). The plan provides a basic benefit package, including:

- Primary and preventive medical care
- Dental Care
- Inpatient and outpatient hospital and specialty care
- Emergency room services
- Lab and x-ray services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children
- Pharmacy services
- Transportation related to medical services

Additionally, the DPC provides an annual benefit of up to 30 hours of outpatient behavioral health services for Medicaid-eligible children. Outpatient services beyond the 30-hour annual benefit and any more intensive behavioral health service required are provided by DPBHS, acting as a public MCO for mental health and substance abuse services for children. All of the above continues however the plan is currently through Delaware Physicians Care.

Approximately 85% of DPBHS clients are included in the 1115 waiver under which DPBHS provides services to the Medicaid-eligible population. DPBHS also provides

services to clients covered by SCHIP and to those who are uninsured or whose insurance benefits for behavioral health services have been exhausted. DPBHS and providers assist any who may be eligible on the basis of income or disability to apply for Medicaid benefits.

In each assigned case, the CSMT attempts to make contact with the primary health provider and to obtain information about recent health care visits and any health conditions or concerns which the family or health care provider suggest may interact with or influence behavioral health.

While primary health care is well covered in the DPC, dental care remains a problematic issue. Private-sector care for children with family resources or dental insurance is available but not geographically well distributed. For those without private resources, there is a limited availability of dental clinics, augmented by purchase of services for those in the custody of DYRS or DFS, by a flexible spending account to which service coordinators may apply for clients without other resources and by application to the program for Children with Special Healthcare Needs, supported by the Maternal and Child Health Block Grant. Increasing the availability and distribution of dental care is an area of particular concern to the Division of Public Health and the steering committee for Maternal and Child Health, a group on which DPBHS is represented. DSCYF started a 21st Century Fund, a fund that can assist with dental care for Delaware children and youth in our services.

Relationship of Educational Services and Behavioral Health Care

At each level of the treatment continuum, children and youth attend either their home schools or regular and special education programs provided by the public schools, service contractors or DSCYF educational staff associated with treatment programs.

At the initiation of each service plan for a new DPBHS client, the CSMT obtains current school information and the consent of the family to include school personnel in the integrated services planning team. The CSMT and service providers work with the school personnel to ensure that educationally relevant issues are included in the service plan. Although the CSMT has primary responsibility for behavioral health service provision, the Coordinator and Team Leader also share responsibility with the family and education staff for planning coordination and transition from treatment programs to ongoing educational programs.

In an effort to expand capacity for identifying and intervening with children and their families around substance use and substance use prevention, DPBHS collaborated with DOE and the University of Delaware to implement a Capacity Building Grant awarded this year. The behavioral health responsibilities address an array of workforce development, psycho-educational materials (curriculum on marijuana and prescription drugs), enhanced resource lists and an SBIRT framework that is accessible to school staff. This grant also provided funding to expand information and access to this

information through our SAPT-BG funded Resource Center.

DPBHS was just awarded a $350.000 U.S. Department of Education grant for "integration of schools and the mental health system". This grant will allow DPBHS to visit every public school in Delaware and to promote education on mental health and substance abuse signs and symptoms in children and to educate on the mental health services in the State.
Based on longitudinal data collected by our High School Survey and clinical information indicating that most of the youth in Delaware begin to experiment with substances and other risk behaviors in middle school, DPBHS has focused on developing screening, brief intervention and referral services in a few middle schools with hopes of being able to expand over time to bridge this gap in services, better identify youth at risk and intervene early with prevention/early intervention services or treatment services if needed.

Relationship of Rehabilitation and Employment Services and Behavioral Health Care

Given the age range of the DCMHS client population, our focus is on continuation of an appropriate educational program throughout the period of the child's participation in treatment services. The CSMT and DSCYF education staff collaborate with local school, Department of Education (DOE) and Division of Vocational Rehabilitation (DVR) representatives, as appropriate, to develop school-to-work plans. During FY04, DCMHS developed a relationship to a DVR unit with background and experience in mental health services and to the unit responsible for school-to-work planning in DOE. DCMHS provided training on mental health/substance abuse services to DVR and DOE. DVR representatives have made presentations on available services and application procedures for CSMTs; training and the development of service continue to be a focus. A DVR representative has been added to the Community Advisory Council.

Throughout the course of treatment there is an active emphasis in the planning and implementation of services on establishing or re-establishing an age-appropriate course of development in social-emotional-behavioral and educational-vocational spheres. For child and adolescent clients this activity is often more appropriately considered habilitation rather than rehabilitation, but the emphasis is pervasive whether enacted in a given service plan through a focus on continuity of school attendance and achievement, specific vocational training embedded in the school-to-work plan and referral to DVR, or exemplified by a residential program with a milieu which develops social competence and independent living skills. The development of independent living skills, including activities in preparation for entering the work force, such as completing job applications, interviewing skills, and appropriate work behaviors, is a component of all intensive service programs and may be the specific focus of a plan developed, for instance, by a seventeen-year-old, his family, and the community aide associated with the youth's intensive outpatient program.

The interdivisional DSCYF committee on independent living services will continue developing plans for coordination of the various components of independent living,

including DVR and employment services. The DSCYF System of Care Integrated Service Plan requires development of a plan for independent living for any youth 14 or older.

A transition committee has been established as part of the Advisory Council. This committee is made up of youth and families, a representative from DVR, DCMHS, providers and interested parties. One outcome to mention is this group completed a transition guide for youth and families that continue to be circulated today.

Relationship of Housing and Behavioral Health Care

The primary responsibility for housing the population of DCMHS clients rests with the parents. It is our goal that all children in our care will live with their families or in family-like settings and that this "housing plan" will be interrupted only for periods of time during which it is clinically necessary for the child to receive intensive and restrictive treatment services in a 24-hour residential or hospital program. It is the planning goal of the CSMT to work with families and, as necessary, with the Divisions of Family Services or Youth Rehabilitative Services to plan for timely and appropriate return from the intensive service setting to the family home or an appropriate family-like setting at the earliest appropriate date in the course of out-of-home treatment.

In those instances in which the child is unable to remain in or return to the family home, the CSMT works with contracted service providers and the Division of Family Services to place the child in the most appropriate substitute-family or group care setting, including the newly developed DCMHS Individual Residential Treatment homes. The CSMT service plan assures that the child may continue in local community-based mental health treatment services.

Our focus with the Division of Substance Abuse and Mental Health on the transition of eighteen year-olds requiring continuing services includes consideration of the need for supported housing and development of independent living and employment skills.

Principles of an Integrated Child System: System of Care.

DSCYF is enacting the Delaware System of Care whose principles were described earlier in this document. The System of Care is based on the principles of the Child and Adolescent Service System Program (1982) and the Comprehensive Community Mental Health Services for Children and Families Program (1992, P. L. 102-321).

DSCYF is a Department of children's services designed and created with the intent to integrate services previously fragmented or duplicated across numerous agencies. The Department of Services to Children, Youth and Their Families includes units responsible for prevention and behavioral health service (DPBHS), juvenile justice services (DYRS), and child protective services (DFS) and DMSS which houses our Education Department.

Despite the scope of the services mandated to DSCYF, numerous other agencies and programs share responsibility for children's services in Delaware. For example:

- Educational services are provided by the Department of Education (DOE) and 19 school districts as well as numerous private and parochial schools and a growing home-schooling movement.
- DPBHS and DOE have established a partnership through our families and Communities Together (FACT), a CMHS grant under the Comprehensive Community Mental Health Services for Children and Families Program. FACT is responsible for the development of a system of community services for children in special education services who also have serious emotional disturbance and who, prior to the FACT program, would have been placed in long-term residential school settings. FACT is also a significant demonstration of System of Care principles essential to the development of community-based services in all of DSCYF.
- DOE is also responsible for the implementation of IDEA and the operation of the Interagency Collaborative Team (ICT) for services to children under the provisions of IDEA. DSCYF service divisions are partners in the ICT and share planning and monitoring of services for special education students in the ICT program.
- The Medicaid Office in DHSS is responsible for the Delaware Physician Care (DPC), the SCHIP program and numerous waiver programs under which services may be provided to children and families. DPBHS acts as a public MCO in the DSHP for behavioral health services beyond the 30-unit outpatient annual benefit for Medicaid-eligible children.
- The Division of Developmental Disability Services in DHSS is responsible for services to the population of persons with developmental disabilities. DPBHS participates on the Steering Committee.
- The Division of Public Health in DHSS has responsibility for community clinics, wellness centers in the high schools, services to children with special health care needs, and the Maternal and Child Health Block Grant (MCHBG). DPBHS is represented on the Steering Committee for the MCHBG. DPH is also the lead agency for the Early Childhood Comprehensive Systems (ECCS) Initiative planning grant. A DPBHS staff member sits on this steering committee.
- The Family Court deals not only with adjudication of juvenile and domestic issues, but also provides substance abuse treatment through the Drug Court Program. DPBHS manages the clinical services and progress monitoring for youth assigned to the Drug Court program, implemented in October 2002 and continues today with great achievements and accomplishments.
- The State Interagency Council on Children and Youth (ICCF). A forum to facilitate ongoing communication and collaboration across all agencies dealing with children at both the local and the state level. County Level ICCF groups meet monthly to address challenges to collaboration and work at creative solutions for serving children and families. The State Level ICCF addresses systems and policy level challenges to the ongoing collaboration.
- The Division of Substance Abuse and Mental Health (DSAMH) provides behavioral health services to adults. During FY03 DSAMH and DPBHS initiated leadership meetings to improve communication, coordination and project collaboration.

Activities range from sharing new information, to Data Infrastructure Grant activities to a mutual emphasis for on continued improvements in transition planning for youth served by DPBHS as they approach age 18. These meeting remain however; there is frequent informal meeting that take place when situations arise.

- Last but not least, DPBHS community partners, families and youth, along with our stake holders are an integral part of our system.

Targeted Services for Rural Populations

Only the northernmost of Delaware's three counties, New Castle County, is defined as urban. Kent and Sussex Counties, with the exception of the town of Dover in Kent County are rural. These areas account for over 42% of the Delaware child population and is projected that these numbers will grow by 10,600 more kids in this decade alone.

The challenges facing our rural counties are daunting and further complicated by the rural nature of the county, the lack of transportation, the influx of non-English –speaking residents and the seeming inability to recruit human professionals to work in most rural areas. There is reported numbers of higher rates of poverty and of the hourly employment setting that may make it difficult for parents to travel with children for clinic-based treatment programs.

Starting in 1990, DCMHS used the Mental Health Block Grant to support an initial program in Intensive Outpatient services that provided direct services in the immediate environment of the child, youth and family functioning, e.g., home, school, community center or church. These services were first opened in Kent and Sussex Counties to address the special needs of the rural population.

Our Department used our own data paired with the 2000 Census statistics to prepare a multi-year strategic and financial plan to address challenges and opportunities to assure ongoing continuation of services to all children who come to our door. One of these challenges is our growing population in rural areas.

We have increased our budget request which has allowed our Department to continue to include significant investments in services for our rural areas.

Today all of our prevention, mental health and substance abuse services mention earlier in the application are state-wide with a continuous focus maintaining providers in our rural areas. The Division continues to look tele-psychiatry as an option to assist in strengthening our continuum.

Additionally, our staff is better trained and we have increased the use of evidenced based practices throughout our state-wide system. We will continue to implement sound business practices, including data analysis, best practice, performance outcomes and a balanced scorecard. We have received four Delaware Quality Awards, CARF Accreditation and continuous improvements as noted on various reviews and audits.

DPBHS will maximize our most valuable resources: staff and our providers/contractual services, which are 51% and 45 % or our budget respectfully. Delaware is committed to identifying and addressing ongoing needs to ensure a comprehensive system of care for Delaware's children and families. Additional information on needs and plans to address un-met needs are discussed throughout this application.

Prevention Services

DPBHS has three prevention staff focused primarily on the substance abuse prevention services funded through the SAPT Block Grant. These staff members are Yvonne Bunch (Program Manager), Chiara Fox (Program Administrator) and Christopher Miller (Program Analyst). Yvonne Bunch has been working in the prevention field for the State for the last 16 years and formerly served as the National Prevention Network representative for 6 years. Ms. Bunch position is 100% funded through State general funds, and she supervises Chiara Fox and Christopher Miller. Both Chiara Fox and Christopher Miller positions are fully funded through the SAPT Block Grant.

DPBHS and DSAMH continue to collaborate with three other key State agencies responsible for providing substance abuse prevention services and enforcement efforts. These agencies are the Department of Education, Division of Public Health, and the Office of Highway Safety.

In 2010, DPBHS and DSAMH collaborated with the Department of Education in the submission of the Building State Capacity for Preventing Youth Substance Use and Violence Program Grant. Delaware was awarded the grant and is using these funds to build or strengthen existing partnerships and sustain the capacity of State Educational Agencies and other state agencies that are involved in preventing drug use and violence among children and youth.

DPBHS has been working very closely with the Office of Highway Safety in their underage drinking and driving prevention effort. The Office of Highway Safety manages the Enforcing Underage Drinking Laws Grant program provided by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention Program. In 2011, the Office of Highway Safety supported DPBHS in their *Step Up* underage drinking prevention campaign through the dissemination of campaign literature to all of the licensed alcohol retailers in Delaware. DPBHS' *Step Up* campaign urges parents/adults to look critically at the role they play in making it OK for teens to drink, and offers practical methods to change those behaviors. With support from SAMHSA's Underage Drinking Prevention Education Initiative, DPBHS was able to produce an award winning video to complement its overall campaign strategy. In June 2011, DPBHS was notified by SAMHSA that our Delaware video entitled "*Time to Rethink, Teens & Drink* won the award of Excellence for the **2011 Communicator Awards!**

DPBHS and DSAMH continue to collaborate with the Division of Public Health to prevent the use of tobacco products through its Tobacco Prevention and Control Program. The Tobacco Program offers two programs to help smokers quit, conducts media campaigns, and funds youth-led campaigns and peer-education groups. Both DSAMH and DPBHS

serve on the IMPACT Tobacco Prevention Coalition. In 2010, DSAMH and DPBHS participated in a series of strategic planning sessions held by the Division of Public Health to update the five year strategic plan for a Tobacco-Free Delaware. This 2011 Plan for a Tobacco-Free Delaware was presented to state and community partners on May 17, 2011.

Currently, DPBHS does not have a comprehensive plan for workforce development to address the core competencies needed by the different sectors of the prevention workforce. For the last 17 years, DPBHS through the former Office of Prevention and Early Intervention has been offering substance abuse prevention trainings and some skills building workshops to prevention professionals at their annual Prevention Forum. However, on May 2 -3, 2011, DPBHS held a joint Delaware Prevention and Behavioral Health Forum on best practices, evidence-based strategies and policies from some of the nation's leading experts in the field of prevention, mental health and youth development. CSAP Director Francis Harding delivered the keynote address on the first day, and workshops were presented on evidence-based strategies by the Mendez Foundation and Pacific Institute for Research and Evaluation. The Forum attracted over 500 participants throughout the state. In the past, DPBHS has utilized the services of CADCA to support the development of coalitions. DPBHS has established a contract with CADCA to continue these services.

DPBHS will also continue to collaborate with DSAMH to develop a comprehensive plan for workforce development that addresses the core competencies needed by the different sectors of the prevention workforce.

In 2011, DPBHS issued an RFP complementing the DSAMH RFP and the prevention priorities identified in the State Substance Abuse Prevention Plan. Currently, DPBHS is in contract negotiations with two potential providers. Contracts will begin October 1, 2011.

II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must 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 serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse 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 behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

SECTION II

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

ADULT

COMMUNITY MENTAL HEALTH SERVICE SYSTEM

The major areas/issues were identified as areas of need in the Delaware service system for the upcoming year. Efforts to address these needs will be through the DSAMH Strategic Plan and the Delaware Combined Behavioral Health Assessment and Plan. Funding for these initiatives will come from the 2012-13 Community Mental Health Services Block Grant, other grants, and with Delaware General Fund State dollars. Some areas will need to be addressed in the 2013 and 2014 State Funding Year as more funds are requested by the Division.

- Youth receiving mental health and substance abuse services need improved transition mechanisms and engagement tactics to successfully serve the young adult in the adult behavioral health system. A recent report estimated that 106 youth will age out of the Delaware Foster Care system during 2011. The same report indicated overall better linkages among the vast number of identified services, programs and partnerships that already exist as and identified opportunity to improve. This opportunity is highlighted by the fact that some youth indicated that the paperwork required to extend Medicaid after aging out of foster care is complicated and, without assistance, youth often do not realize they can extend their coverage. This becomes a particular impediment to individuals whom are receiving treatment for a mental illness while simultaneously aging out of the youth system. Often times, the adult system doesn't come into contact with these individuals until 2-3 years later when they have had an episode which leads them into the adult system of care.
- Services and access by individuals in need of mental health or substance use services will be co-occurring as a general rule. Delaware is well on its way to be fully co-occurring but this will continue to be a focus in the upcoming years through the co-occurring State Incentive Grant (COSIG).
- Specialized services for the elderly continue to be an area for improvement for Delawareans. While progress has been made in partnership with the Division of Services for Aging, more services need to be offered to this population. DSAMH has launched a psycho-geriatric outreach team as of nine months ago that is mobile and available to do in home or community agency assessments and make treatment and support recommendations and provide services to try and maintain current placements of these clients.

- Peer Support Programs are finally gaining ground in Delaware. To date we have implemented a inpatient service at DPC and a Peer Bridger Program, as well as three

drop in resource centers run by consumers. Peer run services will continue to be a priority focus this year and in future years as Delaware has a lot of catch up to do. Ongoing trainings and the continued development of another 25 positions are planned to support the development of Peer Supports.

- Care management services are needed at the less-intensive community health clinics to offer consumers support to successfully reside in the community. These services are being offered at the Wilmington and Newark community clinics during this FY2012-13. The growth of what is usually called "targeted care management" is a priority focus for the coming years. We are requesting general funds to support this new service that will allow DSAMH to assure that all clients have access to some level of care management.
- Continued improvement in coordination of care is needed between DSAMH and the multiple other agencies that interface with consumers of mental health and substance abuse services. Examples of agencies identified as key partners are: Department of Corrections, Emergency Departments, Federally Qualified Health Centers, Division of Vocational Rehabilitation, Public Health, Medicaid, and Nursing Homes
- Recovery and hope must always be a part of the conversations with providers and consumers. An ongoing effort is to help doctors and clinicians understand and focus on recovery as a system as well as an individual goal.
- DSAMH has evaluated our overuse of provider managed representative payees and will be developing a plan to RFP this service to a stand alone, non provider agency in the near future. Similarly, DSAMH is again proposing changes to the DE involuntary commitment statute to assist in reducing the abuse of this law and the unnecessary hospitalization of individuals in inpatient settings..
- Continue to support consumers with nicotine addiction as the treatment system moves increasingly more towards smoke-free environments. Continue efforts that focus on maintaining smoking cessation efforts and continue support in other treatment modalities to address nicotine addiction
- Continue to offer information about access to services in numerous modalities to ensure consumers are able to obtain the information they need about services in a quick and easy manner
- Continue to expand services that focus on health and wellness, and improve collaborations between DSAMH providers and primary health care providers.

Sources of Needs Data

DSAMH relies on various sources of information in order to identify needs and establish planning and programmatic priorities. These include routine management information data such as occupancy rates and utilization of services, services costs as well as data collected from clients from the Consumer/Client Satisfaction Survey, the Annual Consumer Status Survey, CO-SIG/NIATx Screening Assessment, the Annual Consumer Reporting Form, American Society of Addictions Medicine (ASAM) data and LOCUS data. Other sources of information include reports from other organizations such as the Homeless Planning Council and its member agencies, the Delaware HIV Consortium, and federal/national issue papers and evidence-based practice guidelines.

CHILD BEHAVIORAL HEALTH SYSTEM

The Departments infrastructure today is strong and secure but Delaware joins the entire country in facing significant challenges and anticipate more challenges ahead as the economic downturn continues.

Through task forces, workgroups, and performance reviews we have identified the following to need attention:

- Transition services for children into the adult system
- Out of state placements
- Legislative and gubernatorial changes
- Diminishing work force
- Continuing to build hope & resilience within our youth

As a first step our Governor kicked off a review of state services through the Delaware Government Performance review, which challenges agencies to develop strategies for creating program efficiencies across state government.

To reach our goal, we must go even further and focus on four areas:

- Smarter Budgeting-strategically positioning ourselves so we are buying results that citizen's value, at the price they are willing to pay.
- Smarter Sizing-through strategic reviews, rightsizing that is doing the right work, the right way, with the right staff.
- Smarter spending-rewarding performance, not just good intentions
- Smarter management- using flexibility to get accountability

As we look ahead, it is clear that we must find new ways to meet Delaware's children and family's needs and in the most effective and efficient way possible. We will continue to be mindful and steadfast when addressing children's safety and the need to focus on positive outcomes, thereby minimizing the need for re-occurring interventions.

SUBSTANCE ABUSE PREVENTION & TREATMENT SERVICE SYSTEM

Substate Planning Areas:

There are three counties in the State of Delaware. According to the Delaware Population Consortium, Delaware is home to 895,173 people in 2010. The most northern county, New Castle County (NCC), is urban and there are 538,170 residents. It contains the largest city in the state, the City of Wilmington. There are 73,022 residents in the City of Wilmington. The next county is Kent County (KC) which is rural. It is home to 160,058

residents and the capitol, Dover, is located in this county. Dover is home to 37,341 residents. The most southern county is Sussex County (SC) and there are 296,945 residents in Sussex. This county is rural as well.

Data Collection and Analysis:

Data is collected through the completion of the CRF by service providers in the field, upon admission into services by consumers. Data is also collected through the DDATA collection and analysis system. Information is also gathered during licensing and monitoring visits conducted by the DSAMH Quality Assurance Unit. This data is traditionally used by the DSAMH Director of Community Services, and other DSAMH staff, when developing program initiatives or modifications, or to confirm information received through less formal practices. This data is also used to complete National Outcome Measure (NOMS) reports and other data requests. Data is also used to confirm services provided upon receipt of invoices from providers. Analysis of the data is conducted by the DDATA working group, formerly known as the SEOW for the State of Delaware.

DSAMH also uses data provided by the Behavioral Risk Factor Surveillance System (BRFSS) conducted by the CDC for the entire nation, and data compiled by neighboring states using the BRFSS. DSAMH also uses data collected from the evaluation components of other grants, SPF-SIG, COSIG, Mental Health Transformation Grant, etc.

Future data collection will include semi-annual reports directly from service providers regarding the compliance, progress and intentions for the use of SAPTBG funding in reference to the grant goals and objectives. There will also be specific reporting requirements for positions funded by SAPTBG funds, programs for pregnant women and women with dependent children, as well as waiting lists and capacity reporting requirements, to be submitted quarterly. These new forms of data collection are being developed and implemented during FY12 results to be described in the development of the FY14 Block Grant application.

Unmet Needs and Gaps

There are still a significant number of people needing but not receiving treatment services in the State of Delaware. The goals in the grant surrounding this need are to conduct more outreach to inform the community of methods for accessing treatment services; making treatment access easier, and the system easier to navigate; increasing the percentage of people needing services seeking and receiving treatment.

Conducting significant prevention activities such as increasing prevention capacity through the Strategic Prevention Framework, and increasing involvement in prevention activities with other state agencies such as the Division of Alcohol and Tobacco Enforcement and the Department of Children, Youth and Their Families, and the Division of Public Health.

Prevention Service System Gaps

There are some areas/issues that were identified as areas of need in the Delaware prevention service system for the upcoming year, regarding data collection as well as unmet service needs. Efforts to address these needs will be through the DSAMH Strategic Plan and the Delaware Combined Behavioral Health Assessment and Plan. Funding for these initiatives will come from the 2012-13 Prevention and Treatment Block Grant, SPF-SIG and other grants, as well as with general state funds. Some areas will need to be addressed in the 2013 and 2014 State Funding Years as more funds are requested by the Division. Delaware's State Epidemiological Outcomes Workgroup (SEOW), known as the Delaware Drug and Alcohol Tracking Alliance (DDATA), creates state and sub-state Epidemiological (Epi) Profiles each year which outline the current substance abuse consumption and consequence patterns in the state. The main sources of data for these Profiles are the Youth Risk Behavior (YRBS) and College Risk Behavior Surveys (CRBS). The YRBS produce great data which discuss the consumption patterns of 5th, 8th, and 11th public school students throughout the state. However, this data does not reflect school drop-outs, and many individuals in alternative school settings such as individuals who are home schooled, delinquent, or individuals enrolled in private schools. The CRBS focus is on the University of Delaware student body, and while efforts are being pursued to expand the survey to other institutions of higher education in the state, there are still gaps with this data collection method. Through the initial assessment of the current data collection systems in the state, it was identified the Epi Profiles also utilize data from the BRFSS and other state and community systems, however, other gaps that have been identified in data for specific populations are as follows: Emergency Room, military families, Historically Black Colleges/Universities, LGBT populations, etc. The state will continue to enhance the data collection methodology through continued work with the SEOW and other state and community agencies.

In addition to gaps in the data collection system, one need that was identified in the assessment was enhanced training needs in the state. A formalized system is not currently in place to provide ongoing training to the prevention community. There are currently some training opportunities available (for example, the Summer Institute), there was no consistency or continuity in the overall efforts. A formalized system would help to ensure systematic, effective and sustainable support to communities. The system would be a component within the statewide prevention system reflecting the needs identified through data collected as a result of both SPF-SIG and SAPT BG efforts.

Another gap identified is in relation to working with individuals and families affected with Fetal Alcohol Spectrum Disorder (FASD). In 2010, Isabel Rivera-Green, NPN, and two other prevention staff attended a national FASD conference in Nashville, Tennessee where additional resources were identified to enhance Delaware's efforts in addressing this topic. Beginning in 2010, Mrs. Rivera-Green has been working with community stakeholders to develop an FASD Task Force and a statewide strategic plan to address the gaps in services for this population. In May 2011, Sharon Dorfman and Dan Dubovsky, consultants from the SAMHSA FASD Center for Excellence, provided on-site technical assistance in Dover, Delaware to begin a formalized process of gathering individuals and

information for the Task Force and strategic plan. Mr. Dubovsky returned to Delaware in July 2011 to conduct a presentation at the 40th Annual DSAMH Summer Institute to increase awareness on FASD. Ms. Dorfman and Mr. Dubovsky will return again in September 2011 to revisit the strategic planning process with the newly identified Task Force members. The plan will identify resources and action steps to address gaps in data and services for this community/topic. The first phase of the strategic plan will be implemented in 2011-2013.

Through a competitive Request for Proposal process (RFP) in January 2011, DSAMH identified the Latin American Community Center (LACC) and Brandywine Counseling and Community Services (BCCS) as community providers for substance abuse prevention services targeting 18 and older, supported by the SAPT BG. In another RFP process to fund agencies through SPF-SIG Cohort IV funds, an RFP identified an additional six community organizations to provide substance abuse prevention services. LACC and BCCS will also be funded through the SPF-SIG; however, their target population, geographic reach, and planned approach will be different for this second set of funds. The six other agencies that are supported through SPF-SIG will go through the SPF process to collect community level data and develop community level strategic plans to identify and implement appropriate prevention services statewide. The eight grantees will consist of 3 planning grants and 5 implementation grants. LACC and BCCS will be SPF-SIG implementation grantees.

Through these new contracts, as identified in the approved state prevention plan, the state aims to meet unmet services that have not been previously provided, targeting high risk populations, as well as taking a comprehensive environmental approach to create change in consumption and consequence patterns associated with substance use and abuse throughout the state. Some areas of specific focus of the state plan and contracts have identified are working with active and veteran military families as well as sustainable coalition development.

As of 2011, Delaware is beginning to build a relationship with the Nanticoke population in Delaware. This Tribe is state recognized and they are currently working toward becoming federally recognized. Ms. Odette Wright from the Nanticoke Tribe has attended the Delaware Prevention Advisory Committee (DPAC) meeting as of August 18, 2011. The DPAC is supported by the Prevention Set-aside funds to drive the delivery of prevention services. This advisory committee drives the efforts of Delaware's Substance Abuse Prevention Strategic Plan across the Lifespan. DSAMH recognizes this community as being an area that is not directly receiving substance abuse prevention services. The Single State Agency is at the infancy state of developing a state and tribe relationship through the participation of Ms. Wright's membership to the DPAC.

As we continue to meet benchmarks in our timeline through the implementation of Delaware's Substance Abuse Prevention Strategic Plan across the Lifespan, we will address these critical gaps in the delivery of services through the Prevention Set-Aside funding.

Needs Statistics:

<u>2010 College Risk Behavior Study</u>

According to the 2010 College Risk Behavior Survey, 63% of students reported alcohol use alone, 18% reported using neither drugs nor alcohol, and 19% reported using both. For past month binge drinking, 62% reported past month binge drinking. They were most likely to be male. 12% of students reported past month marijuana use, 4% reported past month other drug use. 15% reported past month cigarette use. 12% of males self reported DUI, and 16% reported drug related DUI.

<u>National Household Survey on Drug Use and Health (NSDUH) 2004, 2006, 2008 Averages</u>:

<u>Person Aged 12 or Older: Needing But Not Receiving Treatment for Alcohol in Past Year:</u>

Delaware, at 6.4%, is lower than the national average of 7.2% for those needing, but not receiving treatment for alcohol. 16.8% of those aged 18 -25 reported needing but not receiving treatment for alcohol in the past year followed by 5.5% of those 26 years or older.

<u>Persons Aged 12 or Older: Needing But Not Receiving Treatment for Illicit Drug Use in Past Year:</u>

The highest rates for needing treatment for illicit drugs and not receiving treatment over the past year was in Kent County at 3.2%, Sussex County at 3.1% and the City of Wilmington at 3.2%. 16.8% of those aged 18 -25 reported needing but not receiving treatment for illicit drugs for the past year, followed by 4.2% of those aged 12 -17.

<u>Injection Drug Users</u>

According to the National Household Survey on Drug Use and Health, “Demographic and Geographic Variations in Injection Drug Use” (NSDUH, 2007), Males were more than twice as likely to inject drugs and the Northeast, .45% of people reported injecting drugs.

<u>Women, Pregnant Women, Recent Mothers:</u>

According to the National Household Survey on Drug Use and Health (NSDUH), Alcohol Use Among Pregnant Women and Recent Mothers 2001 to 2007, (NSDUH, 2008), Past month alcohol use was lower for pregnant mothers (11.6%) than for mothers that just gave birth (42%).

According to the National Household Survey on Drug Use and Health (NSDUH), “Substance Abuse Treatment among Women of Childbearing Age” (NDSUH, 2007), For women aged 18 to 49: A total of 9.4% needed treatment for a substance abuse problem.

A total of 10.4% needed treatment, but did not receive treatment at a specialty substance use treatment facility

According to the Delaware Drug and Alcohol Tracking Alliance, Vol. 6, Issue 3, "Drinking During Pregnancy in Delaware – Most Likely to be White, Educated, Married Mothers", There were over 1,200 live births in Delaware in 2008. Mothers who over the age of 35 were six times more likely than teen mothers and more than twice as likely as mothers 20 – 24 years old to report alcohol use.

Veterans in Delaware

According to the US Census Bureau, there are 78,336 veterans in Delaware. According to the National Household Survey on Drug Use and Health (NSDUH, 2007) Report, "Serious Psychological Distress and Substance Abuse Disorder Among Veteran's", 7% of veterans experienced past year severe emotional distress (SED). 7.1% met the criteria for substance use disorder (SUD). Veterans aged 18-25 were more likely than older veterans to have higher rates of SPD, SUD, and co-occurring disor0ders.

Elderly Populations

According to the Drug and Alcohol Services Information System, "Older Adults in Substance Abuse Treatment: 2005", (DASIS, 2007), 10% of all treatment admissions were for people over 50. 65% reported alcohol as the primary substance of abuse. Admissions for people aged 50 to 64 had more extensive treatment histories than admissions for those 65 or older. Opiates were the second most commonly reported substance

LGBTQ Trends 2009

The Delaware school survey reports trends in sexual minorities compared to the heterosexual population.

- Past Month Alcohol Use
  - 42.5% of heterosexuals compared to 61% of homosexual s or bisexuals
- Binge Alcohol Use:
  - 24.3% of heterosexuals compared to 36.5% of homosexuals or bisexuals
- Past Month Marijuana Use:
  - 24.4% of heterosexuals compared to 47.7% of homosexuals or bisexuals
- Heavy Marijuana Use:
  - 11.6% of heterosexuals compared to 21.5% of homosexuals or bisexuals
- Ever Used Painkillers
  - 18.4% of heterosexuals compared to 40% of homosexuals or bisexuals.
- Past Month Cigarette Use:

        - 20% of heterosexuals compared to 42% of homosexuals or bisexuals
- It appears that this is a high risk group that needs to be considered when planning prevention or treatment programs, policies, or practices.

Division of Substance Abuse and Mental Health Treatment Admission Trends 2005 to 2009

Over the past five fiscal years, there was an average of total 8,508 admissions and the number varied little from year to year.

- Primary Drug at Admission:
    - Alcohol admissions annually averaged 2,184 and there was not much variation from year to year.
    - Marijuana admissions annually averaged 1,805 and 21% of total admissions. There is some variation year to year.
    - Heroin admission annually averaged 2,103 and 25% of total admissions. There is little variation year to year for this period.
    - Methamphetamines and Amphetamines admissions averaged 26 admissions and are a small fraction of total admission each year.
    - Opiates and Other Synthetics admissions have been increasing at a staggering rate from 2005 286 admission to 1,400 admissions in 2009.
        - This represents a 389% increase in admissions over a five year period
            - Over this five year period New Castle County and Sussex County are the primary geographic area impacted by this issue.
            - Kent County also witnessed a growth in admissions over this period as well.

Annual Aids Diagnosis Rate 2009 per 100,000:

According to the Division of Public Health, "2010 HIV Statistics - Epidemiology/Surveillance Profile", in 2009, 1,291 Delawareans were living with HIV and another 2,181 were living with AIDS. In that same year, the cumulative number of HIV/AIDS cases in Delaware reached 5,139. Delaware's AIDS incidence rate at 14.8 cases per 100,000, is among the highest in the nation. In 2007, Delaware's AIDS incidence rate was the 6th highest in the United States. By 2008, Delaware's AIDS incidence rate had decreased marginally to a level which ranked 8th highest in the nation. (CDC, HIV/AIDS Surveillance Report, 2008) The number of new infections diagnosed in Delaware currently stands at 165 cases per year.

In 2009, the racial distribution by county:

- 67% of the cases were Caucasian
- 21% were African American
- 7% were Hispanic
- 5% were Other races

From 2005 to 2009, the most common mode of transmission:

- Injection Drug Use (IDU) accounted for 35% of the cases
- Men having sex with men (MSM) accounted for 30% of the cases
- Heterosexual contact with partner who has HIV/AIDS accounted for 19% of cases
- Heterosexual contact with an IDU accounted for 8% of cases
- IDU and are MSM accounted for 5% of cases
- No identified risk accounted for 2% of cases

TB Rate 2010 per 100,000

According to the Division of Public Health (DPH), Delaware case rate is 2.2 compared to the national case rate of 3.5. The rate in New Castle County was 2.5. The rate for Kent County was 1.9. The rate in Sussex County was 1.5.

YOUTH AT RISK OF SUBSTANCE ABUSE DISORDERS

DRUG USE

Trends in Drug Use by County

→In general, use of any of the drugs illegal for youth, including cigarettes and alcohol, did not differ significantly among the three Counties in Delaware. This pattern was true for each of the 5th, 8th, and 11th grade samples. In general, there is no evidence that illegal substance use by Delaware youth is, for example, an urban problem or a Northern Delaware problem; the problem of substance use is consistent and persistent across the state. The notable exception to this pattern may be greater use of

smokeless tobacco and cigarette use in Sussex County across all grades.

Trends in Tobacco Product Use

→ Between 1989 - 2005, reports of monthly drug use by 5th graders have remained low and stable.
→**Cigarette use by 8th and 11th graders has fluctuated greatly since 1989 with statistically significant increases in the early 1990s and significant declines since 1998**. The levels of past month cigarette smoking reported in 2010 for 8th graders (7%) and 11th graders (14%) were the lowest since the surveys began in 1989. The decrease in youth smoking since the late 1990s is one of the great public health success stories nationally. The declines have been even more dramatic in Delaware where smoking prevention efforts have been a priority of the State and schools.
→ **Cigars are much more prevalent among youth than either smokeless tobacco or bidis/kreteks**. In 2010, 15% of 8th graders have tried cigars, while 9% have tried smokeless tobacco. For 11th graders, 34% have tried cigars and 17% have tried smokeless tobacco

Trends in Alcohol Use

→ **Almost two in five 11th graders (37%) and one in five 8th graders (19%) report past month alcohol use.** There have been gradual declines in rates of alcohol use and current rates are the lowest measured since the beginning of the surveys. However, alcohol remains the most consistently reported drug in all grades.
→ **High levels of binge drinking (defined as 3 or more drinks at a time in the past 2 weeks) were reported by both 8th graders (9%) and 11th graders: 21%**.

Trends in Marijuana Use

→ In 2008, a trend in decline of marijuana use by 8th and 11th graders ended, and rates have increased slightly since that time, with 12% of 8th graders and 24% of 11th graders reporting past month use in 2010.
→ **Both 8th and 11th graders are more likely to report past month marijuana use than past month cigarette use – not just because marijuana use is up, but also because cigarette use is down.**

Trends in Prescription Drug Abuse

→ Narcotic painkillers (Oxycontin, Codeine, Percocet and Tylenol 3) were first asked about in 2002**. Reported use of pain killers by 11th graders**

was at its highest in 2003 at 12%. It has dropped slightly since, with 10% of 11th graders reporting past year painkiller use in 2010.
→ **Painkillers were the most commonly abused drugs in the past year for both 8th and 11th graders after cigarettes, alcohol, and marijuana.**
→ Painkillers were followed in the list of most abused "other illegal drugs" by psychoactive medications (Ritalin, Adderall, Cylert, and Concerta), downers, and uppers. **These data support recent national findings that the illegal diversion of prescription medications is an emerging youth drug problem**.
→ Use of psychoactive medications was significantly associated with current cigarette, alcohol, marijuana, and other drug use for both 8th and 11th graders. In 2010, the survey asked about non-prescribed use of Ritalin and similar drugs "to get high**." One percent of 8th graders and 5% of 11th graders reported use of Ritalin and like drugs to get high in the past year.**

Driving Under the Influence

→ **Reported levels of drinking and driving remain very close to reported levels of driving under the influence of marijuana**. In 2010, 11th graders reported the same levels, 6%, of 11th graders driving after smoking marijuana and driving after drinking alcohol in the past month

Delinquency

→**Among both 8th and 11th graders, past month substance use – whether cigarettes, alcohol, or marijuana – was highly correlated with other delinquent behaviors such as gang fights, stealing, illegal entry, and trouble with police.**

RISK AND PROTECTIVE FACTORS

Individual

Grade

→ **In the 5th grade, most students have not yet experimented with drugs. Even the most common drug tried – alcohol -- has only been tried by 15% of 5th graders**. Cigarettes and inhalants have been tried by 5% and marijuana by 2%. Fifth graders who have tried cigarettes declined from 18% in 1998 to 8% in 2005. In 2005, 2% of 5th graders have tried a cigar and 2% have tried smokeless tobacco

Gender

→ **8th grade girls were slightly more likely to drink alcohol and to use illegal drugs other than marijuana than 8th grade boys**. For 11th

graders, cigarette and inhalant use was similar for girls and boys, but boys were a little more likely to drink alcohol and were significantly more likely to binge drink.
→ **For 11th graders, boys were significantly more likely to use marijuana than were girls**

Peers as a Source

→ **For all students who are current smokers, the most likely place they get cigarettes is from friends: about three-quarters of smokers get cigarettes from friends.** Getting cigarettes from siblings and an unknowing parent are the next most common ways of getting cigarettes. Also of note is the high percentage of 5th and 8th grade smokers who steal cigarettes from their parents without the parents knowing.

Family/Parents

Family Relationships

→ **For all grades, the more students reported that they got along well with their parents, did not fight with their parents, and communicated well with their parents, the less likely they were to use drugs**. Positive parental involvement seems to be a strong protective factor, and this is particularly true for middle school students.
→ **Students whose parents or siblings smoked cigarettes were more likely to smoke cigarettes and to use other drugs**.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

Page 23 of the Application Guidance

Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Consumers throughout Delaware's behavioral health system become the focus of a service system that is designed to provide person-centered services throughout.
2	Ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LBGTQ individuals	Consumers throughout Delaware's behavioral health system will have access to a system of care that is culturally and lingustically competent.
3	Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Consumers throughout Delaware's behavioral health system receive services in a manner that promotes hope, recovery, and resiliency and community integration as components to their recovery planning process.
	Increased accountability	

4	for behavioral health services through uniform reporting on access, quality, and outcomes of services.	Delaware's behavioral health system agencies employ increased accountability standards for behavioral health services through uniform reporting on access, quality, and outcomes of services.
5	Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.	Delaware's behavioral health system agencies and provider organizations provide services to prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
6	Conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.	Delaware's behavioral health system agencies and provider organizations conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.
7	Provide HIV prevention as early intervention services at the sites at which individuals receive substance use disorder treatment services.	Delaware's behavioral health system agencies and provider organizations provide HIV prevention as early intervention services at the sites at which individuals receive substance use disorder treatment services.
8	Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	Delaware's behavioral health system agencies and provider organizations employ increased accountability standards for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.
9	Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case	Delaware's behavioral health system agencies and provider organizations ensure access to a comprehensive system of care, including education, employment housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.

management, rehab,
dental and health services.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:

2011

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Ensure treatment and recovery support agencies are versed on referral and access to other health and social services available to substance abuse clients.	Work with provider agencies to determine their current level of knowledge on sister agency services. Coordinate educational opportunities and outreach material to service providers for other agency services. Incorporate referral and outreach services for other health and support service agencies are required in service provider contracts	All provider agencies are educated on referral and access to other health and social services available to their clients.	Survey substance abuse and treatment service providers for current capacity for referral and access to other health and social services; track participation of provider representatives in educational opportunities; survey substance abuse and treatment service providers for capacity for referral and access to other health and social services at the end of the project period.
		Implementation Strategies Teach families skills and strategies for better		

Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Hire 24 Peer Specialist	supporting their family members' treatment and recovery in the community. Supports include training on identifying a crisis and connecting people in crisis to services, as well as education about mental illness and about available ongoing community-based services. Family supports can be provided in individual and group settings. Peer supports are services delivered by trained individuals who have personal experience with mental illness and recovery to help people develop skills, in managing and coping with symptoms of illness, self-advocacy identifying and using natural supports. Peer supports can be provided in individual and group settings, in person or by phone. •By July 1, 2012 the State will provide family or peer supports to 250 individuals per year. •By July I, 2013 the State will provide family or peer supports to 250 additional individuals per year.	Increased Family and Peer Supports	Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties") are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice annually with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance. Measure: DSAMH MIS databases will be used to substantiate progress towards the goal and activities listed above.

Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Increase by 1% the number of consumers who respond positively to questions on the Consumer Satisfaction Survey regarding their role in setting goals and treatment strategies	• Evaluate the annual Consumer Satisfaction Survey to determine changes in those measures that reflect consumers as managing partners. • Provide a variety of trainings to staff, contractor organizations and consumers that focus on recovery and the consumers' role in recovery. • Infuse, through a focused clinical supervision program in each of the CMHCs, the concept of recovery, consumer strength focused treatment and outcomes.	The percentage of consumers receiving community-based services who actively participate in their own treatment planning.	Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) administered Consumer Satisfaction Survey (CSS). Measure: Numerator: Number of survey participants reporting active involvement in treatment planning. Denominator: Total valid responses on customer satisfaction survey items. Specific items include consumer comfort with asking questions about treatment and consumer determination of their own treatment goals.
		Implementation Strategies: • Develop clinic procedures that reflect the organization and philosophy of the Division's redesigned CMH clinic system. • Develop clinic forms that streamline paperwork, support engagement of new clients and assist clinical and administrative staff in managing service delivery. • Continue the use of the LOCUS criteria throughout the clinic system and integrate this tool		

Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Increase by 1% those consumers responding positively to the consumer satisfaction survey regarding satisfaction with the type, location, frequency, timeliness, and level of services	into the clinic service operations. • As a part of the Division's Technology Plan, select a vendor for MIS supports required by clinic staff to support clinical and administrative activities. • Refine performance outcome measures for clinic services; begin collecting data to establish a performance base line for clinic services. • Implement a statewide clinical supervision program. • Expand the role of the RN in clinics to include the provision of a wide range of educational services including forums about primary health concerns, sexually transmitted diseases, nutritional awareness classes, etc. The goal is to provide consumers and their families with more general medical and nutritional information that can directly influence the consumer's quality of life.	Consumers responding positively to the consumer satisfaction survey regarding satisfaction with the type, location, frequency, timeliness, and level of services	Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) administered Consumer Satisfaction Survey (CSS). Measure: Numerator: # surveys who marked "agree" or "strongly agree" on specific items. Denominator: Total valid responses on consumer satisfaction survey items
		Implementation Strategies: • Continue to implement the functions of the centralized Eligibility and Enrollment Unit		

Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Increase by 1% those individuals responding positively in the Consumer Satisfaction Survey to the summary question categories regarding access, quality, appropriateness, participation in treatment planning, and overall adequacy of services provided.	(EEU) as a single portal for eligibility determination/re-determination for DSAMH long-term mental health and substance abuse programs; integrating the LOCUS level of need criteria into the eligibility and re-determination process; and conducting utilization review of individuals receiving services in the Division's high intensity community-based programs. • Continue to monitor the implementation of LOCUS within the Division's intensive community programs to ensure its use in assessing need and determining needfocused programmatic supports; • Implement and routinely use both the LOCUS and the Addiction Severity Index (ASI) assessment in the community mental health centers.	Percentage of consumers reporting positively regarding perception of care.	Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) administered Consumer Satisfaction Survey (CSS). Measure: Measure: Percentage survey participants reporting satisfaction with outcomes. Numerator: # surveys who marked "agree" or "strongly agree" on specific items. Denominator: Total valid responses on consumer satisfaction survey items.
Promote				

participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Increase the number of consumers responding positively about level of functioning by 2%	****NEED DATA****	Percentage of consumers who are satisfied with their level of functioning.	Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) administered Consumer Satisfaction Survey (CSS). Measure: Numerator: Number of surveys marked "agree or "strongly agree" on specific items relative to level of functioning Denominator: Total number of consumers that complete the survey
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Increase the number of consumers responding positively about social supports/social connectedness by 2%	*****NEED DATA*****	Positive responses regarding social supports/social connectedness	Data will be collected via DSAMH Management Information System (MIS), Consumer Status Survey (CSS) Measure: Numerator: Persons reporting satisfaction with their level of social supports/social connectedness Denominator: Total number of consumers that complete the survey
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Maintain 36% of children not re arrested in 2012 attendance	DPBHS has been following these measures as they develop. DCMHS has invested 50,000 last year alone to be able to report on SED/ Juvenile Justice Recidivism rate. Our Departments strategic plan contains a well-balanced combination of initiatives to transform our Juvenile justice system. Continuing to look into ways to report this indicator.	Decrease Criminal Justice Involvement (KIDS)	Number of SED children involved in Juvenile Justice (1 arrested) Division of Youth Rehabilitation Services, FACTS System, Department of Education
		Work with family organization to		

Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Support family/youth participation in the Advisory/Advocacy council, evaluation	identify methods of increasing family participation across DPBHS programs and activities. Utilize lessons learned from teen client involvement in development of anti-stigma campaign to increase teen involvement in additional program and planning areas. Include family members in DPBHS evaluation projects, building on training from parent/support groups. Provide additional opportunities for DPBHS staff to learn from FF projects and collaborate in encouraging all families and youth to participate.	Recruit youth and family partnership at all levels annually	Number of families participating in Advisory/Advocacy council/planning. CSMT reports, report from family organization, satisfaction survey re: involvement in planning, advisory council roster.
	Ensure cultural	Work with the prevention community providers, both contracted and otherwise, to determine current level of knowledge on cultural competence as well as the level of cultural competence being implemented in their programs. Engage faith based resources relevant for the community planning and service delivery of substance		

Ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LBGTQ individuals	competency through all substance abuse prevention programs, policies, and practices to reduce health disparities among diverse populations related to substance abuse.	abuse prevention; Develop culturally competent training programs for faith based agencies, coalitions and staff of agencies providing services; Develop media campaign that promotes prevention strategies that are specific to the community needs; Work with colleges and universities to mentor and recruit bi-lingual students interested in providing substance abuse prevention services; Ensure that all prevention materials are available in multiple languages and multiple forms of communication as needed by the target group.	All contracted organizations and community prevention providers are educated on cultural competence to ensure community members have access to culturally sensitive programs/services.	Survey substance abuse prevention service providers for level of knowledge attained during cultural competence trainings through pre- and post tests instruments; implement assessment surveys on a regular basis to providers implementing prevention surveys to assess the current level of cultural competence (semi-annually) and any changes in cultural sensitivity.
Ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LBGTQ individuals	To develop a relationship between (DSAMH) Single State Agency and the state recognized Delaware Nanticoke Indian Tribe.	Enhance communication and participation of the Tribe in our Delaware Prevention Advisory Committee (DPAC).	Dissemination of information regularly to the tribal contact on substance abuse and misuse. Extend support and resources to the tribe's current efforts in becoming a federally recognized tribe through the support of our CSAP Federal Project Officer.	Number of communications with the Nanticoke Indian Tribe and the number of individuals in attendance at the DPAC meetings.
				Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties")

Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Establish (4) crisis apartments throughout the state	Implementation Strategies: • Stabilize individuals as quickly as possible and assist them in returning to their pre-crisis level of functioning. • Establish apartments where individuals experiencing a psychiatric crisis can stay, up to seven days to receive support in stabilization prior to returning home to the community. • By July 1, 2012, the state will make operational two crisis apartments. • By July 1, 2013, the state will make operational a minimum of two additional crisis apartments, ensuring that the four apartments total are spread throughout the state.	Establish 4 crisis apartments throughout the state	are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice annually with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance. Measure: State and local service provider databases pertinent to the data required to satisfy the adequate tracking of the information will be used to substantiate progress towards the goals and activities listed above.
				Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties") are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"),

Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Establish 2 Crisis walk-in clinics statewide	Implementation Activities: In addition to the crisis walk-in center in New Castle County serving the northern region of the State, by July 1, 2012, the State will make best efforts to make operational one crisis walk-in center in Ellendale to serve the southern region ofthe State. The crisis center in Ellendale shall be operational no later than September 1,2012.	Establish (2) Crisis walk-in clinics statewide	42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance.
Promote hope, recovery, resiliency and community integration for adults with serious	Increase the number of individuals served	In Accordance with (State Strategic Goal #2: Delawareans receive mental health, substance abuse and gambling prevention and treatment services in continuum of overall health and wellness) Implementation Strategies: Continue to improve the CMHC front door screening	Increased access to	Delaware Division of Substance Abuse and Mental Health (DSAMH) will collect data via the Management Information System (MIS) Consumer database (DAMART)and DSAMH

mental illness and children with serious emotional disturbances and their families.	in the DSAMH Mental Health System by 3%.	and triage process to ensure that: • The CMHCs continue to practice "open access" services regardless of individual need. • Continue to expedite the Eligibility and Enrollment Unit (EEU) review for "carve out" services and meet the 3-day response time to individuals seeking these services.	services	Clinical Care Information System (CCIS). The goal will be measured by the total number of all persons receiving services in programs provided or funded by DSAMH.
		• Evaluate the annual Consumer Satisfaction Survey to determine changes in those measures that reflect consumers as managing partners. • Provide a variety of trainings to staff, contractor organizations and consumers that focus on recovery and the consumers' role in recovery. • Infuse, through a focused clinical supervision program in each of the CMHCs, the concept of recovery, consumer strength focused treatment and outcomes. • Continue to strengthen the discharge planning process among all providers for		

Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Reduce the number of readmissions to the State psychiatric hospital within 180 days by .5%.	individuals who are hospitalized. • Increase medication and treatment continuity between hospital and community providers through physician-to-physician contacts. • Continue the role of the DSAMH Crisis programs in evaluating individuals for inpatient and seeking community alternatives. • Support the development of community based crisis respite capability by integrating respite services into Staffed Apartment programs. • Continue to develop and evaluate the DSAMH "High-end" program. This program, targeting individuals who are the highest users of in -patient care, coordinates hospital and community care, provides individuals with specialized inpatient services and emphasizes continuity of care in all aspects of client care and recovery.	Reduce the number of readmissions to the State psychiatric hospital within 180	Data will be collected via the Delaware Division of Substance Abuse and Mental Health (DSAMH) Management Information System (MIS) Consumer Information Manager (CIM), CRF MH Master Table and DPC Episode Table. Numerator: Total number of adults with SMI who were readmitted within 180 days Denominator: Total number of adults with SMI who were discharged during the fiscal year
		Implementation Strategies: • Provide a variety of trainings to staff, contractor organizations and consumers that focus		

Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Reduce the number of readmissions to the State psychiatric hospital within 30 days by .5%.	on recovery and the consumers' role in recovery. • Infuse, through a focused clinical supervision program in each of the CMHCs, the concept of recovery, consumer strength focused treatment and outcomes. • Continue to strengthen the discharge planning process among all providers for individuals who are hospitalized. • Increase medication and treatment continuity between hospital and community providers through physician-to-physician contacts. • Continue the role of the DSAMH Crisis programs in evaluating individuals for inpatient and seeking community alternatives. • Support the development of community based crisis respite capability by integrating respite services into Staffed Apartment programs. • Continue to develop and evaluate the DSAMH "High-end" program. Promote continuum of care between inpatient facilities and all community based	Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)	Data will be collected via Delaware Division of Substance Abuse and Mental Health (DSAMH) Management Information System (MIS) Consumer Information Manager (CIM), CRF MH Master Table and DPC Episode Table. Numerator: Total number of adults with SMI who were readmitted within 30 days Denominator: Total number of adults with SMI who were discharged during the fiscal year.

		programs targeting individuals who are the highest users of in -patient care, coordinates hospital and community care, provides individuals with specialized in-patient services and emphasizes continuity of care in all aspects of client care and recovery. • Continue efforts to establish a crisis unit modeled on the Wilmington Hospital's CAPES unit, in southern Delaware.		
Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Reduce utilization of inpatient hospitalization by 25%	Study success factors in reduction of hospital readmissions from 2010 to 2011, Identify client and service factors associated with multiple readmissions, e.g., adequacy of discharge planning with family and local providers, gaps in continuity of care when clients move from DPBHS services to private sector services. Study patterns of hospitalization from residential treatment centers outside Delaware.	Reduced Utilization of Psychiatric Inpatient Beds - 180 days (KIDS)	Total number of children readmitted with 30 days. Denominator: Total number of children discharged within the fiscal year. Use of the Family and Child Tracking System (FACTS)
		Identify client and service factors associated with multiple readmissions,		

Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Reduce utilization of inpatient hospitalization by 15%	e.g., adequacy of discharge planning with family and local providers, gaps in continuity of care when clients move from DCMHS services to private sector services. •Study patterns of hospitalization from residential treatment centers outside Delaware.	Reduced Utilization of Psychiatric Inpatient Beds - 30 days (KIDS)	Total number of children readmitted with 30 days. Denominator: Total number of children discharged within the fiscal year. Use of the Family and Child Tracking System (FACTS)
Increased		Implementation Strategies: • Continue DSAMH data mart (DAMART) and consumer/client satisfaction survey initiatives in order to further develop the decision support system. In addition, the Division will work with CMHS and other States in refining a uniform reporting format that will allow the State to describe system components and track its progress on various outcomes over time. • Continue to develop and refine the Division's information system infrastructure for related processes needed for decision support in a managed care environment. • Continue to maintain		

accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.	Complete 100% of the DIG Data Tables (19 total)	HIPAA compliance and implement the National Provider Identifier for all programs. • Review current clinical data base systems available to staff with the goal of developing a comprehensive system that assists in the provision of State provided services; can provide assessment, utilization review, pre-authorization and case/contract monitoring as a part of the Division's move toward centralized managed care oversight and management and; is integrated into existing data base systems via the MCI. The current project plan calls for an operational system effective January 2008. • Continue to assist in the implementation of LOCUS system wide by providing technical support.	Completion of the Basic and Developmental Tables under the Data Infrastructure	Data collected via CMHS Block Grant Basic and Developmental Tables under the Data Infrastructure Measure: Numerator: CMHS Block Grant, Section V Report Denominator: DSAMH Data
		Implementation Activities: The State will -use Quality Service Reviews (QSRs) to evaluate the quality ofservices at an individual, provider and system-wide level. QSRs will collect information through a		Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§

Increased accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.	Ensure that all behavioral health services funded by the State are ofgood quality and are sufficient to help individuals achieve positive outcomes, including increased integration and independence. and self-determination in all life domains.	sample offace-to-face interviews of the consumer, relevant professional staff, and other people involved in the consumer's life and through review ofindividual treatment plans. QSRs will evaluate, among other things; whether individuals' needs are being identified, whether supports and services are meeting individuals' needs, and whether supports and services are designed around individuals' strengths and meeting individuals' goals. The State will design a process for implementing QSRs in conjunction with the independant monitor, with inputfrom the United States. The State wiHconduct QSRs annually, with each community provider providing services under this. agn:ement to be revieWed at least once every two years. Each new provider will be reviewed in the first year it offers services under' this agreement.	Implement Quality Service Reviews (QSRs) system-wide	12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties") are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance.
		Develop an online system utilizing KIT Solutions Utilize, to		

Increased accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.	Monitor and evaluate the effectiveness of programs and services funded through the SAPT BG and utilize outcome measures to drive decision making for prevention services through-out Delaware.	monitor program activities, process, and outcomes of prevention strategies. KIT Solutions allows providers to upload all relevant prevention information, including a work plan and assessment/evaluation reports onto a web-based system to track community change. Delaware will continue to utilize the State Epidemiological Outcomes Workgroup (SEOW), also known as the Delaware Drug and Alcohol Tracking Alliance (DDATA) to monitor effectiveness and evaluate programs and services. In addition, DSAMH will outreach to new institutions of higher education, community organizations, and faith-based agencies to participate in the evaluation process for understanding the outcomes of programs and services.	All contracted providers will utilize KIT Solutions to monitor program process and outcomes. DDATA will continue to develop annual state and substate Epidemiological Profiles.	KIT Solutions program will identify contractor programs and outcomes. Pre/Post tests for activities and programs will be developed and uploaded to the system to monitor program outcomes. The annual state and substate Epidemiological Profiles will identify data trends in relation so substance abuse consumption and consequence patters. Comparison reports from year to year will be analyzed to determine change.
		Use a variety of evidence-based principles, programs and practices as well as environmental strategies to dissuade use of opiates. Recognize that environmental		

Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.	10% reduction in the misuse of prescription opiates and use of illegal narcotics across the life course	strategies and harm reduction approaches to address opiate misuse and abuse can be part of a comprehensive priority strategy. Use information Dissemination/Raising Awareness--support media campaigns and provide information in public settings targeting parents to reduce youth; provide information to legislators and state and community decision-makers concerning prevalence and risks associated with youth abuse; collaborate with other state agencies to provide timely and accurate information concerning state laws and policies concerning abuse of opiates; Education--provide professional development opportunities for state and community-based prevention workers (CADCA and other trainings) and support and promote parent trainings and trainings of volunteers; Alternative Activities--support and promote events and regular activities contraindicative to youth substance	Misuse of prescription opiates and use of illegal narcotics (Youth Prevention)	Repeated measures of the Performance Indicators updated quarterly for short term measures and at least annually for long term measures Changes in laws, policies and operating procedures

	abuse; Use contracts and other Community-Based Processes to promote and support community engagement and involvement in strategic planning, leveraging of resources, collaborative activities (grants to and support of community coalitions); Environmental Strategies--work with legislators and state and community-based decision-makers to provide timely and accurate information on evidence-based environmental policies and practices; support use of evidence-based environmental strategies at community and state levels; Problem Identification and Referral--support and promote and provide training in SBIRT for use in community settings to include judicial, school-based health centers and private health-based practices		
	Use a variety of evidence-based principles, programs and practices as well as environmental strategies to dissuade		

youth use of alcohol. Recognize that environmental strategies and harm reduction approaches to address binge drinking can be part of a comprehensive priority strategy. Use Information Dissemination/Raising Awareness--support media campaigns and provide information in public settings targeting parents to reduce youth access to alcohol (Town Hall Meetings, Step Up Campaign); provide information to legislators and state and community decision-makers concerning prevalence and risks associated with youth consumption and young adult abuse; Collaborate with other state agencies to provide timely and accurate information concerning state laws and policies concerning underage use and abuse of alcohol and provision of alcohol to minors; Education--provide professional development opportunities for

Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.	Decrease alcohol use, misuse, and abuse by 10% for those underage and 5% for young adults	state and community-based prevention workers (CADCA and other trainings) and support and promote parent trainings and trainings of volunteers; Alternative Activities--support and promote events and regular activities contraindicative to underage drinking (Youth Summit, extra hours at community centers, curfew center, school-based activities and after-hours access); Use contracts and other Community-Based Processes to promote and support community engagement and involvement in strategic planning, leveraging of resources, collaborative activities (grants to and support of community coalitions) Environmental Strategies--work with legislators and state and community-based decision-makers to provide timely and accurate information on evidence-based environmental policies and practices; support use of evidence-based environmental strategies at community and state	Underage alcohol use and misuse prevention (Youth Prevention)	Repeated measures of the Performance Indicators updated quarterly for short term measures and at least annually for long term measures Changes in laws, policies and operating procedures

		levels Problem Identification and Referral--support and promote and provide training in SBIRT for use in community settings to include judicial, school-based health centers and private health-based practices		
Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.	Engage prevention stakeholders and coordinate substance abuse prevention services in Delaware through the implementation of State and Community-level Strategic Prevention Plans supported by state funded community contracts.	Support a comprehensive theory/promising practices and evidence -based prevention programs, policies, and practices (EBPs) through community-based contracts. Implement community prevention contracts utilizing the Strategic Prevention Framework (SPF); assessment, capacity, planning, implementation, evaluation, cultural competence, and sustainability. Contracted organizations will provide a comprehensive implementation plan, based on the needs identified within their communities, including the following six CSAP prevention strategies: Information Dissemination; Prevention Education; Alternative Activities;	Development and implementation of community-based substance abuse prevention contracts.	Number of DSAMH prevention contracts; number of individuals served by contracts; number of prevention activities, strategies, and events.

	Community-Based Process; Environmental Approaches; and Problem Identification & Referral.	
	Use a variety of evidence-based principles, programs and practices as well as environmental strategies to dissuade youth use of marijuana. Recognize that environmental strategies and harm reduction approaches to address marijuana use can be part of a comprehensive priority strategy. Use information Dissemination/Raising Awareness--support media campaigns and provide information in public settings; provide information to legislators and state and community decision-makers concerning prevalence and risks associated with youth consumption and risks associated with initiation of medical marijuana policies and practices; Collaborate with other state agencies to provide timely and accurate information concerning state laws and policies	

Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.	Reduction in marijuana use, for youth and young adults by 10%	concerning underage use Education--provide professional development opportunities for state and community-based prevention workers (CADCA and other trainings) and support and promote parent trainings and trainings of volunteers; Alternative Activities--support and promote events and regular activities contraindicative to underage use; Use contracts and other Community-Based Processes to promote and support community engagement and involvement in strategic planning, leveraging of resources, collaborative activities (grants to and support of community coalitions); Environmental Strategies--work with legislators and state and community-based decision-makers to provide timely and accurate information on evidence-based environmental policies and practices as Delaware initiates policies on medical marijuana; support	Marijuana use, for youth and young adults (Youth Prevention)	Repeated measures of the Performance Indicators updated quarterly for short term measures and at least annually for long term measures Changes in laws, policies and operating procedures

		use of evidence-based environmental strategies at community and state levels; Problem Identification and Referral--support and promote and provide training in SBIRT for use in community settings to include judicial, school-based health centers and private health-based practices		
Conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.	Increase the number of participants in the needle exchange program	Work with the needle exchange program service provider to increase the outreach opportunities for the program. Provide funding to increase the number of syringes purchased for the program. Collect data on the number of different participants in the program. Ensure outreach material is available for distribution with syringes.	Number of participants in the needle exchange program	Identify monthly statistics of needle exchange usage; identify number of individuals utilizing these services; compare monthly statistics from previous project period with statistics collected during current project period.
		Provide outreach material to HIV early intervention programs throughout the state. Ensure that HIV early intervention programs are versed on		

Conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.	Increase the number of participants in treatment for illicit and/or licit drugs	methods for accessing the treatment system throughout the state. Ensure social service agencies, courts, and correctional agencies are provided with outreach materials for accessing the drug treatment system in the state. Track the number of outreach materials that are used for distribution to known drug users.	Number of participants in treatment for illicit and/or licit drugs.	Identify number of participants currently in treatment for illicit and/or licit drugs; collect statistics from Consumer Reporting Form (CRF) for project period; compare project period statistics with previous project period statistics.
Provide HIV prevention as early intervention services at the sites at which individuals receive substance use disorder treatment services.	Ensure HIV prevention educational material is available at every substance use treatment provider throughout the state.	Work with the Division of Public Health to distribute educational material for HIV prevention to all substance use treatment providers throughout the state. Ensure service providers are versed in methods for accessing HIV prevention services. Work with substance use service providers to ensure providers to ensure they are aware of access to HIV early intervention services.	HIV prevention educational material is available at every substance use treatment provider throughout the state.	Meet with the Division of Public Health and develop a memorandum of understanding for distributing educational material; Review educational or instructional content provided to substance abuse treatment providers to ensure applicability to project; meet with substance abuse providers and evaluate their ability to relate subject matter to the substance abuse population.
		Develop and maintain a set of core competencies for prevention providers to adhere to. Provide training and technical assistance at the community level (programmatic		

Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	Build state and community capacity to implement and sustain professional development through training and technical assistance for substance abuse prevention programs, policies, and practices throughout the goals outlined in the state prevention plan	assistance and building of a community-level prevention infrastructure) to obtain and sustain credentialed prevention providers (Certified Prevention Specialists). Facilitate a workforce development workgroup to assess the training and technical assistance needs within the state to develop and implement appropriate and adequate trainings. Partner with state and community agencies to leverage current capacity building resources to develop the current prevention workforce.	Relevant substance abuse prevention trainings and technical assistance are provided to both contracted and additional community agencies to build the prevention workforce in order to enhance the prevention services being provided throughout the state.	Number of core competencies for prevention providers; Number of Certified Prevention Specialists (CPS); number of Trainings provided; number of individuals served at prevention trainings.
Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	Create aa annual report to comply with DOJ requirements	MIS will work with DSAMH Executive staff and Planning staff to develop an annual report format, develop data requirements, and create a narrative section.	DSAMH will complete this report by June 30th 2013	DSAMH is not currently reporting on this data.

Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	Implement KIT Solutions web reporting software to track reporting for prevention outcomes	DSAMH and DPBHS will provide providers access to this Web Based Reporting software. This software will collect data on Evidence Based Practices (EBPs), Primary Prevention activities, Institute of Medicine (IOM strategies, and expenditures for each of these items. During State Fiscal Year (SFY) 2012, the providers will begin reporting data into this system.This data will help with our annual reporting duties.	Increase the number of providers using this system from 0% in FFY 2012 to 100% during FFY 2013	DSAMH and DPBHS will track the number of providers reporting during FFY 2012 and during FFY 2013 to determine if this goal was achieved.
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Completion of one prevalence estimation	Implementation Strategies: • Using Delaware's 2000 census data and the Delaware Population Consortium estimates for 2010, determine the prevalence of SMI in the State of Delaware, using the standard estimation methodology published by SAMHSA in the June 24, 1999 Federal Register, Vol. 64, No. 121.	Determination of prevalence estimate of SMI and SPMI for adults	Delaware's 2000 census data and the Delaware Population Consortium estimates for 2010, determine the prevalence of SMI in the State of Delaware, using the standard estimation methodology published by SAMHSA in the June 24, 1999 Federal Register, Vol. 64, No. 121.
Ensure access to a comprehensive behavioral health		Ensure that treatment access information is		

system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Decrease the percentage of people needing treatment for drug and alcohol dependency and not receiving services	made available through all state service centers and service agency providers; evaluate outreach mechanisms employed by service agency providers; assess referral services so that they are effective	Percentage of people needing treatment but not receving it decreasing	Compare statistics for people needing treatment and not recieving services for the project period with prior years statistics.
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Ensure sister health and social service agencies under the Department of Health and Social Services are versed and knowledgeable of methods for accessing the treatment and recovery support system.	Coordinate educational opportunities with sister agencies for providing outreach for treatment and recovery services. Ensure outreach materials are available for sister agencies to provide to their clientele. Coordinate agreements with sister health and social service agencies to provide outreach and educational information to their clientele.	Education is provided to service agencies for accessing treatment and recovery support services.	Track participation of service agencies in educational opportunities; Track the amount of outreach material distributed by service agencies; Add soliciting questions to the Consumer Satisfaction Survey and collect data from responses.
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management,	Ensure support to prevention stakeholders to allow access to prevention and behavioral health system resources.	Provide regular communication and access to and with communicate with prevention stakeholders.	Dissemination information regularly on emerging trends and issues within the behavioral health field; provide access to information on supports and resources for individuals to take advantage of within the state.	Number of emails and correspondence made with community to promote prevention and additional behavioral health strategies, initiatives, events, and activities.

rehab, dental and health services.				
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Improve the appropriateness of treatment	Participate in defining evidence-based processes and practices for children's behavioral health services through NASMHPD and NRI work groups. Provided training in evidence-based practice as part of annual DPBHS training plan. Define evidence-based practice protocols with participation of case management and direct provider staff members. Evaluate any available tool kits and fidelity scales. Develop protocols for evaluation of outcome of treatment approaches that constitutes "promising practices". Include measures of evidence-based practice in provider monitoring protocols. Continue building an electronic library of information on evidence-based practice and fidelity measurement.	Increase the number of EBP practices provided bi-annually (KIDS)	Number of EBP practices provided. Provider survey and monitoring reports Family and Children Tracking System (FACTS)
		DPBHS continues to strengthen this NOM. Our FACTS system currently can report on attendance: Regular, Sporadic, Not		

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Improvement in school attendance.	at all, Expelled/not enrolled or dropped out. With additional funding we are enhancing our data system to provide more data for use. DPBHS is currently working with The Department of Education (DOE) to create a system where this information will come directly out of DOE and into our system. DOE has implemented a new statewide tracking system which is currently up and running. DPBHS has been following this NOM while in development phases and will be prepared to fully report in the future.	% of children in DPBHS services who reported improvement in their school (KIDS)	Number of children attending school and reporting improvement FACTS System, Department of Education.
		Coordinate with DYRS and DFS training schedule. Cross-train		

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase access through outreach and prevention activities for special populations	sister divisions train the trainer. Provide information on DPBHS services and access to mobile crisis services to targeted programs and facilities. Track and analyze referral and service patterns related to identified programs and facilities. Expand outreach and prevention activities to include HIV and suicide prevention and coordinate with DSCYF and community organizations.	Implement at 2 new outreach activities to special populations (KIDS)	Number of activities/trainings conducted. DPBHS FACTS System. DFS and DYRS program administrators. DPBHS outreach database and community partners. Communication and Outreach Plan.
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase by 1% the number of adults with SMI receiving services that reside in Kent and Sussex counties	• Provide services in conjunction with DPH primary health care Clinic in Georgetown targeting monolingual Hispanic populations. • Continue to expand outreach activities and enhance engagement and access services for individuals in Kent and Sussex Counties via Front-Door teams and the Federally Supported PATH program.	Percentage of adults with SMI residing in Kent and Sussex Counties who receive publicly funded mental health services provided by the Division of Substance Abuse and Mental Health, Delaware Physicians Care, Inc. (DPCI), and the Diamond State Health Plan (	Data will be collected via DSAMH MIS CIM service files and provider files. Measure: Numerator: DSAMH MIS CIM service files and provider files Denominator: Division estimate of number of adults with SMI residing in Kent and Sussex counties.
		Implementation Strategies: • Continue to "roll-out" the integration of evidence based services for individuals with co-occurring mental illness and		

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase by 1% the number of persons who report receiving one or more EBP	substance abuse diagnoses within all community based programs. • Continue to include language that requires the use of EBPs in SA outpatient/Day Treatment/IOP contracts. • Continue to include language that requires the use of EBPS in MH services contracts. • Review the use of EBPs during program monitoring visits • Continue to provide training opportunities both for core EBPs and promising practices. • Develop an evaluative mechanism to monitor the outcomes of services for cooccurring disorders.	Number of persons receiving evidence based practices (system-wide)	Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) administered Consumer Satisfaction Survey (CSS). Measure: Number of consumers who report receiving one or more EBP provided by the State.
Ensure access to a comprehensive behavioral health		•Implement activities that will allow operation of a statewide employment project that applies a more flexible approach to employment services within the context of the CCCP model. •Support statewide initiative to reduce barriers to employment for persons with disabilities through the implementation of benefits counseling services based on the		Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties") are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting

system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase by 50% the number of adults w/ SMI that receive Evidence Based Supported Employment	Delaware Division of Vocational rehabilitation's (DVR) Project CLIMB. •Provide training opportunities to providers regarding employment Evidence Based Practices. •Collect and analyze employment data among the Division's CCCP providers to establish employment benchmarks to be used in developing incentive targets among contracted providers. •By July 1, 2012, the State will provide supported employment to 100 individuals per year. •By July 11, 2013, the State will provide supported employment to 300 individuals per year.	Adults with SMI or COD receiving Evidence Based Supportive Employment as part of their recovery plan.	appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance. Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) database. Numerator: Number of CSP consumers employed. Denominator: Total CSP caseload as of 6/30/11.
		Implementation Strategies: • In conjunction with local providers in New		

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase permanent housing opportunities for persons served via the Delaware behavioral health service system	Castle and Sussex Counties, continue to implement one grant funded by the Department of Housing and Urban Development's (HUD) Supportive Housing Program, currently providing transitional housing and support services for 30 homeless adults with cooccurring severe and persistent mental illness and other disorders residing in New Castle County, Kent County and Sussex County.	Adults receiving permanent housing assistance via the Delaware behavioral health service system	In accordance with the DHSS/USDOJ Settlement Agreement Agreement data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS). Measure: The number of individuals receiving supported housing via HUD funded Supported Housing Program (HUD-SHP) or the Delaware State Housing Authority (DSHA) funded Statewide Rental Assistance Program (SRAP) for persons with disabilities.
		Implementation Strategies: • Continue to explore opportunities to increase the number of available permanent and permanent supported housing services for homeless adults with SMI. • DSAMH will continue to fund a total of eight supervised apartment programs. • By July 11, 2011, the State will provide housing vouchers or subsidies and bridge funding to 150 individuals. • By July 1, 2012, the State will provide housing vouchers or subsidies and bridge funding to 250 individuals. • By		Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties") are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase the number of available permanent and permanent supported housing opportunities for persons with SMI by 50%	July 1, 2012, the State will provide housing vouchers or subsidies and bridge funding to 250 individuals. • By July 1, 2013, the State will provide housing vouchers or subsidies and bridge funding to 450 individuals. • As part of the state's client assistance funding, provide housing assistance, such as security deposits, first month's rent and assistance with utility costs for homeless persons with serious mental illness. • In conjunction with the National Alliance Mentally Ill in Delaware, Connections CSP Inc., and other service providers implement two grants funded by the Department of Housing and Urban Development's (HUD) Supportive Housing Program, currently providing permanent housing and support services for 13 homeless adults with severe and persistent mental illness.	Permanent and permanent supported housing opportunities for homeless and disabled persons with SMI	be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance. Measure: Number of Statewide Rental Assistance Vouchers and (HUD SHP) funded units for homeless or disabled adults with SMI receiving public mental health services during the fiscal year. Data will be collected via DSAMH MIS CIM service files, CMHC referral records, PATH provider records; denominator: Division estimate of homeless adults with SMI and/or dual diagnosis in the State.
				Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131•12132) The State of Delaware ("the State") and the United States (together, "the Parties")

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase the number of consumers receiving ACT by 1%	•ACT teams deliver comprehensive, fudividualized, and flexible support, services, and rehabilitation to individuals in their homes and communities. •By July 1, 2012 the State will expand its 8 ACT teams to bring them into fidelity with the Dartmouth model. •Continue developing a relationship with local hospitals in the southern Delaware region to establish an ACT Team presence at one of the local hospitals. By September 1, 2013 the State will add 1 additional ACT team that is in fidelity with the Dartmouth model.	Adults w/ SPMI receiving ACT in the DSAMH behavioral health system	are committed to full compliance with Title II of the Americans with Disabilities Act ("the ADA"), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. The agreement is intended to ensure the State's compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 ("Section 504"), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved. As part of the settlement agreement the State and the United States of America mutually agree that monitoring for compliance of the terms established by the agreement will be conducted by an independent third-party monitor that reports to the U.S. District court with jurisdiction over the agreement. The fore stated goal was established within the agreement and will be evaluated at least twice with its findings recorded in a report submitted to the Parties and the Court as comprehensive public report on the State's compliance including recommendations, if any, to facilitate or sustain compliance. Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) Measure: Numerator: # of consumers who received ACT services Denominator: Total DSAMH service population.
Ensure access to a comprehensive behavioral health system of care of				

prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase the number of consumers treated for COD by 2%.	MUST DEVELOP	Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (Percentage)	Data is collected via the DSAMH CO-SIG Coordinator and the UPenn Delaware COD Database Measure: Numerator: the # of persons treated for co-ocurring disorders Denominator: the # of persons screened for for COD upon admission at 11 front door sites.
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increase the number of staff participating in training opportunities by 1 -2%.	****NEED INFORMATION HERE****	Percentage of staff of community support programs participating in training	DSAMH Training Department Database Measure: Numerator: Number of staff from community support programs participating in training opportunities during fiscal year. Denominator: Cumulative number of staff registered in training database.
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Increased access to services provided by DCMHS by 5%.	Target SED children and youth eligible for DPBHS services through outreach and education and collaboration.	Increased to Assess to Services (KIDS)	Family and Child Tracking System (FACTS)
		elements and once the measure is		

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Maintain 80% of families reporting improved functioning in their child.	defined, we will be able to query the appropriate data. DPBHS currently survey for consumer functioning from both the parent and the child. Some of the areas include: need for constant supervision, unable to function in almost all areas, moderate degree of interference in functioning, some difficulty in a single area just to name a few. As we report on this measure there may be changes as our Division grows and enhances its data sets.	Improved functioning of children and youth (KIDS)	Parents/caregivers reporting positively about their child's functioning. Number of positives responses reported in the functioning domain using the Ohio Scales. FACTS system, Ohio Scales
		Implementation Strategies: • Transformation activity - the Division will continue to move research into practice through an existing contract with the University of Pennsylvania for an evaluation of the EBP's provided through the CCCP's. • Additional efforts in moving research to practice include ongoing support and technical assistance in the continued operation of the Supported Employment EBP. •		

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Maintain a total of six EBPs provided by the State service system.	Continue to "roll-out" the integration of evidence based services for individuals with co-occurring mental illness and substance abuse diagnoses within all community based programs. • Continue to include language that requires the use of co-occurring disorders (COD) in SA outpatient/Day Treatment/IOP contracts. • Continue to include language that requires the use of EBPs in MH services contracts. • Review the use of EBPs during program monitoring visits • Continue to provide training opportunities both for core EBPs and promising practices. • Monitor the outcomes of services for co-occurring disorders. • Monitor protocols for the continued operation of the EBP Illness Management and Recovery in the four CCCP programs and the contracted day programs. Measure: This measure is defined by the number of evidence based practices fully implemented in the state service system.	Number of Evidence Based Practices (system-wide)	Data will be collected via Delaware Division of Substance Abuse and Mental Health Management Information System (MIS) administered Consumer Satisfaction Survey (CSS).

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Maintain the current number of training programs and seminars provided (18)	Implementation Strategies: • Identify and train a cadre of health and social service professionals statewide in Crisis Counseling and Critical Incident Stress Debriefing techniques as part of the State's emergency management planning and preparedness. • Provide mental health training component offered as part of the Emergency Medical Technicians/Paramedic training curriculum offered throughout the state. • Provide mental health trainings and debriefings to police, fire and other emergency services workers throughout the state. • Coordinate with Division of Public Health to identify and provide training on mental health issues to health professionals working with persons HIV, Hepatitis and Tuberculosis. • An increase in future disaster-related trainings will be attributed to an increase in funding for such programs.	Mental health training for emergency, health and human services professionals	Data will be collected via CMHC Emergency Services Director and DSAMH Training Office Measure: The number of mental health training programs and seminars for emergency health services professionals and other first responder and human services professionals during fiscal year.
Ensure access to a				

comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Promote State-wide Suicide Prevention Activities	Implement statewide prevention activities in collaboration with schools, community partners and Delaware families, youth and children	To identify youth at risk for suicide (KIDS)	University of Delaware, evaluates and monitors training programs, Contract with providers and contract outcome.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 CMHS - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	not applicable
Grant/contract reimbursement	The majority of services provided by both Substance Abuse and Mental Health Treatment providers are reimbursed through contract reimbursement. Each service provider submits a proposed budget of expenses to be reimbursed for the year, which are negotiated through questions and justification periods. Expenses are then reimbursed based on the providers proposed budget and documentation supporting said expenses.
Risk based reimbursement	not applicable
Innovative Financing Strategy	We have built in performance incentives into many of the contracts providing for opportunities for providers to exceed the minimum expectations of the contract.
Other reimbursement strategy (please describe)	Not applicable

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:

2011

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	not applicable
Grant/contract reimbursement	The majority of services provided by both Substance Abuse and Mental Health Treatment providers are reimbursed through contract reimbursement. Each service provider submits a proposed budget of expenses to be reimbursed for the year, which are negotiated through questions and justification periods. Expenses are then reimbursed based on the providers proposed budget and documentation supporting said expenses.
Risk based reimbursement	not applicable
Innovative Financing Strategy	We have built in performance incentives into many of the contracts providing for opportunities for providers to exceed the minimum expectations of the contract.
Other reimbursement strategy (please describe)	Not applicable

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10%
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10%
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	>75%
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10%
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10%
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10%
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10%

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10%
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	<10%
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10%
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	10-25%
System improvement activities		N/A
Other		N/A

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

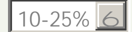
Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10%
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10%
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	>75%
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10%
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10%
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10%
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10%

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10%
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	<10%
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10%
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	 10-25%
System improvement activities		N/A
Other		N/A

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

Page 34 of the Application Guidance

Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$0	$	$	$	$
Information Dissemination	Selective	$0	$	$	$	$
Information Dissemination	Indicated	$0	$	$	$	$
Information Dissemination	Unspecified	$0	$	$	$	$
Information Dissemination	Total	$0	$	$	$	$
Education	Universal	$23,000	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$0	$	$	$	$
Education	Unspecified	$0	$	$	$	$
Education	Total	$23,000	$	$	$	$
Alternatives	Universal	$0	$	$	$	$
Alternatives	Selective	$0	$	$	$	$
Alternatives	Indicated	$0	$	$	$	$
Alternatives	Unspecified	$0	$	$	$	$
Alternatives	Total	$0	$	$	$	$
Problem Identification and Referral	Universal	$0	$	$	$	$
Problem Identification and Referral	Selective	$0	$	$	$	$
Problem Identification and Referral	Indicated	$0	$	$	$	$
Problem Identification and Referral	Unspecified	$0	$	$	$	$
Problem Identification and Referral	Total	$0	$	$	$	$

Community-Based Process	Universal	$620,202	$	$	$	$
Community-Based Process	Selective	$50,000	$	$	$	$
Community-Based Process	Indicated	$0	$	$	$	$
Community-Based Process	Unspecified	$0	$	$	$	$
Community-Based Process	Total	$670,202	$	$	$	$
Environmental	Universal	$0	$	$	$	$
Environmental	Selective	$0	$	$	$	$
Environmental	Indicated	$0	$	$	$	$
Environmental	Unspecified	$0	$	$	$	$
Environmental	Total	$0	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$0	$	$	$	$
Other	Selective	$37,692	$	$	$	$
Other	Indicated	$0	$	$	$	$
Other	Unspecified	$0	$	$	$	$
Other	Total	$37,692	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist

Page 36 of the Application Guidance

Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$236,452	$	$	$	$
Information Dissemination	Selective	$2,368	$	$	$	$
Information Dissemination	Indicated	$0	$	$	$	$
Information Dissemination	Unspecified	$0	$	$	$	$
Information Dissemination	Total	$238,820	$	$	$	$
Education	Universal	$591,942	$	$	$	$
Education	Selective	$5,978	$	$	$	$
Education	Indicated	$0	$	$	$	$
Education	Unspecified	$0	$	$	$	$
Education	Total	$597,920	$	$	$	$
Alternatives	Universal	$4,950	$	$	$	$
Alternatives	Selective	$50	$	$	$	$
Alternatives	Indicated	$0	$	$	$	$
Alternatives	Unspecified	$0	$	$	$	$
Alternatives	Total	$5,000	$	$	$	$
Problem Identification and Referral	Universal	$0	$	$	$	$
Problem Identification and Referral	Selective	$0	$	$	$	$
Problem Identification and Referral	Indicated	$0	$	$	$	$
Problem Identification and Referral	Unspecified	$0	$	$	$	$
Problem Identification and Referral	Total	$0	$	$	$	$

Community-Based Process	Universal	$390,720	$	$	$	$
Community-Based Process	Selective	$3,947	$	$	$	$
Community-Based Process	Indicated	$0	$	$	$	$
Community-Based Process	Unspecified	$0	$	$	$	$
Community-Based Process	Total	$394,667	$	$	$	$
Environmental	Universal	$382,336	$	$	$	$
Environmental	Selective	$3,862	$	$	$	$
Environmental	Indicated	$0	$	$	$	$
Environmental	Unspecified	$0	$	$	$	$
Environmental	Total	$386,198	$	$	$	$
Section 1926 Tobacco	Universal	$0	$	$	$	$
Section 1926 Tobacco	Selective	$0	$	$	$	$
Section 1926 Tobacco	Indicated	$0	$	$	$	$
Section 1926 Tobacco	Unspecified	$0	$	$	$	$
Section 1926 Tobacco	Total	$0	$	$	$	$
Other	Universal	$70,444	$	$	$	$
Other	Selective	$711	$	$	$	$
Other	Indicated	$0	$	$	$	$
Other	Unspecified	$0	$	$	$	$
Other	Total	$71,155	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year:

End Year:

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$698,182	$	$	$1,312,500	$	$
8. Administration (Excluding Program and Provider Level)	$32,712	$	$	$0	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$32,712	$	$	$0	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$730,894	$	$	$1,312,500	$	$
11. Total	$730,894	$	$	$1,312,500	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SAPT - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year:

End Year:

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$4,474,474	$	$	$23,566,172	$	$
2. Primary Prevention	$1,693,780	$	$	$	$	$
3. Tuberculosis Services	$0	$	$	$	$	$
4. HIV Early Intervention Services	$334,247	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$0	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$0	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$182,445	$	$	$412,972	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$6,684,946	$	$	$23,979,144	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$182,445	$	$	$412,972	$	$
11. Total	$6,684,946	$	$	$23,979,144	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

Page 40 of the Application Guidance

Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$ 0	$ 154,522	$ 0	$ 0		$154,522
2. Quality Assurance	$ 0	$	$ 0	$ 0		$0
3. Training (Post-Employment)	$ 0	$ 77,526	$ 0	$ 0		$77,526
4. Education (Pre-Employment)	$ 0	$ 96,826	$ 0	$ 0		$96,826
5. Program Development	$ 0	$ 504,389	$ 0	$ 0		$504,389
6. Research and Evaluation	$ 0	$ 3,500	$ 0	$ 0		$3,500
7. Information Systems	$ 0	$ 152,522	$ 0	$ 0		$152,522
8. Total	$0	$989,285	$0	$0	$	$989,285

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

SECTION IV - Narrative Plan

Section D. Activities that Support Individuals in Directing the Services

Consumer Activities

Delaware's self-directed care and consumer participation movement among persons with psychiatric disabilities began in 1985 with the formation of the first consumer group in Georgetown, Delaware. Since that time, different groups have formed throughout the state. These groups are diverse in their program designs in order to ensure cultural competency throughout consumer-driven activities and best serve the multiple needs of Delaware's consumer population.

In FY 1993, Delaware was awarded a State Service Improvement Grant sponsored by the Center for Mental Health Services. This grant provided support to strengthen Delaware's statewide Community Support Program through the initiation of activities designed to enhance the involvement and integration of consumers into the total operation of the public mental health service system. Grant activities emphasized consumer-driven policy development, program development and advocacy. Accomplishments included: establishing an independent statewide consumer organization which dissolved in 2001; creating an Office of Mental Health Consumer Relations within the Division's Central Office; and promoting collaboration among consumers, family members, and other advocacy organizations.

During FY 2006, the Division supported consumer provided services, employed seven consumer-interviewers as part of the Consumer Client Satisfaction Survey, and provided training on consumer advocacy to enhance planning for community integration and supports. The Division also supported the development of a new group of consumer leaders and the development of the consumer-run Rick Van Story Resource Center. The Division is currently working to open a consumer arts program that is slated to open during the calendar year.

As a primary proponent of consumer recovery and full inclusion in the community, DSAMH will take further steps in the next 20 months to provide increased consumer employment opportunities, and engagement in planning activities. DSAMH has in the past assumed a role in the development and evaluation of services provided by the CCCPs by contracting with the University of Pennsylvania's Center for Mental Health Policy and Services Research.

In addition, DSAMH reorganized the Office of Consumer Relations, the goals of which are to increase the planning role of consumers in the Division's program planning and evaluation process; to ensure a consumer voice in contract development and monitoring; and to provide a forum in which consumer complaints, suggestions and concerns can be heard and effectively acted upon. The Division is in the process of developing and implementing a computer based tracking system for complaints.

Pursuant to the settlement agreement between the United States of America vs. Delaware (28 U.S.C. § 1331; 28 U.RC. § 1345; and, 42 U.S.C. §§ 12131·12132) The State of Delaware ("the State") and the United States of America reached a voluntary agreement. The following actions included in that settlement agreement detail Division activities directly related to consumer-directed supports:

- The State of Delaware and the United States of America intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved.

- Delaware will develop a continuum of support services intended to meet the varying needs of individuals with mental illness. The support system will be flexible and individualized to meet the needs of the individual; promote successful community living, including the retention of housing; help individuals to increase individuals' abilities to recognize and deal with situations that may otherwise result in crises; and increase and improve individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention.

- Utilize enhanced ACT teams to deliver comprehensive, fully individualized, and flexible support, services, and rehabilitation to individuals in their homes and communities. The ACT teams will be a multidisciplinary group of professionals including a psychiatrist, a nurse, a psychologist, a social worker, a substance abuse specialist, a vocational rehabilitation specialist and a peer specialist. Services are customized to an individual's needs and vary over time as needs change. Among the services that may be offered to a client at a given time are: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to allow the individual to live independently in the community. (By 7/1/2013 the state will feature 9 ACT Teams in full fidelity with the Dartmouth model)

- Intensive Case Management teams provide coordination of treatment and support services. The teams are supervised by licensed, master's level, clinical mental health professionals who supervise case managers and offer direct support to individuals as needed. Case managers will work with individuals to help them identify and access community supports and services, including needed medical, social, educational; housing, and other services. (By 7/1/2013 the State will utilize 4 ICM Teams)

- The State shall develop additional options for people to work or access education and rehabilitation services. The supported employment and rehabilitation services will offer integrated opportunities for people to earn a living or to develop academic or functional skills, and provide individuals with opportunities to make

connections in the community. (By 7/1/2013 the State will provide supported employment to 300 additional individuals annually)

- Provide family supports that are designed to teach families skills and strategies for better supporting their family members' treatment and recovery in the community. Supports include training on identifying a crisis and connecting people in crisis to services, as well as education about mental illness and about available ongoing community-based services in individual or group settings. (By 7/1/2013 the State will provide 250 additional family or peer supports annually)

- Provide peer supports are services delivered by trained individuals who have personal experience with mental illness and recovery to help people develop skills, in managing and coping with symptoms of illness, self-advocacy, identifying and using natural supports. (By 7/1/2013 the State will provide 250 additional family or peer supports annually)

At the conclusion of the implementation of all items listed in the settlement agreement between Delaware and the United States of America, 100% of individuals receiving services via the Delaware behavioral health system will receive self-directed care.

It is important to note that, the previously stated agreement between the United States of America and Delaware speaks specifically to a target population of individuals with severe and persistent mental illness (SPMI) but the processes and activities implemented are being implemented throughout Delaware's integrated behavioral health system, thus all behavioral health consumers will benefit from the activities.

IV: Narrative Plan

E. Data and Information Technology

Page 41 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

SECTION IV - Narrative Plan

Section E. Data and Information Technology

ADULT BEHAVIORAL HEALTH MANAGEMENT SYSTEMS

A list and brief description of all unique IT systems maintained and/or utilized by DSAMH that provide information follows:

DHSS Master Client Index (MCI) system: The Delaware Department of Health and Social Services maintains a Master Client Index (MCI) system for all of the clients served in the department. This is a unique 10 character numeric identifier that is unique to each client. A robust client search engine allows users to search for clients in the system based on a number of characteristics, to minimize the possibility of a client having a duplicated MCI # or multiple clients sharing the same MCI#. DSAMH uses the MCI in all of its client systems.

Patient Management Information System (PMIS): The Patient Management Information System is a client tracking system used by Delaware Psychiatric Center. It tracks client admissions, discharges and transfers during their treatment at the facility. There is a clinical component associated with the Recovery Academy that tracks a client's participation in specific classes at the Recovery Academy and allows brief notes to be recorded. A full DSM-IV-TR diagnosis can be recorded in the system and updated as often as needed. An event tracking system is available to record and track tasks that are needed to provide comprehensive care.

DSAMH Data mart System (DAMART): The DAMART System has many components but foremost if functions as a client tracking system used by the DSAMH central office to track client admissions, discharges and transfers during their treatment in DSAMH funded mental health and substance abuse programs. In addition to episodes and demographics, the system stores client services provided by the DSAMH Community Mental Health Center (CMHC) clinic programs. As part of the DAMART system, DSAMH maintains a Referral Table, which contains the Provider Identification Number, the Start and End Date of the program, the treatment unit type (outpatient community mental health, Group Home, Intensive Outpatient, Inpatient mental health, etc.), the parent company, whether it's a methadone program, its most recent data submission, its Medicaid Provider ID, and other descriptive information used internally within DSAMH.

QS/1 Prime Care (Used at Delaware Psychiatric Center): This is a pharmacy management system used by the DSAMH contractual pharmacy staff. It is used to track all prescriptions and medication administration at DPC. This system is dosage based and is designed for inpatient programs. Besides the standard reporting system provided by the system, DSAMH extracts data for further analysis of pharmacy usage.

QS/1 NRx (Used at DSAMH CMHC Sites): This is a pharmacy management system used by the DSAMH contractual pharmacy staff. It is used to track all prescriptions and medication administration at the state run CMHCs, and certain contractual Community Mental Health (CMH) and Substance Abuse (SA) treatment programs. This system is prescription based and is designed for retail pharmacies. Besides the standard reporting system provided by the system, DSAMH extracts data for further analysis of pharmacy usage.

ADL Patient Accounting: This is DSAMH's patient accounting system that is used at both the CMHC and DPC facilities. This system has the capability to track clients, events, census, and insurance and generate paper and electronic invoices for billing. DSAMH reconciles payments to invoices, although this is not currently done automatically. At DPC the system also provides patient trust functionality.

Provider characteristics: DSAMH maintains a Referral Table, which contains the Provider Identification Number, the Start and End Date of the program, the treatment unit type (outpatient community mental health, Group Home, Intensive Outpatient, Inpatient mental health, etc.), the parent company, whether it's a methadone program, its most recent data submission, its Medicaid Provider ID, and some other identifiers used internally within DSAMH. This typology is used to track the source and destination of clients as the move from one level of care to another.

Client enrollment, demographics, and characteristics: These data elements are captured through three different systems: the Enrollment and Eligibility Unit (EEU) work sheets, the DAMART episode data, and the DPC Patient Management Information System (PMIS). Query tools are available and widely used by non-technical staff to query the data mart and track both clients and programs over more than ten (10) years of data.

Admission, assessment, and discharge: These are similarly obtained through the EEU, DAMART, and PMIS systems. This data, combined with the client data make up the heart of the episode data set.

Services provided, including type, amount, and individual service provider

DSAMH receives data on services provided to its clients through the Service Ticket, which is completed by select providers after contact with a consumer, and the Summary of Services, which is an aggregate of services provided by select programs each month. While entry level contractual providers don't collect and submit service level data, more intensive programs such as the Community Continuum of Care Programs (CCCPs) do provide both encounter level and aggregate service information.

Prescription drug utilization: DSAMH receives a pharmacy download each month from the Delaware Psychiatric Center's pharmacy and its Community Mental Health Clinics pharmacy. Extensive reporting is available from both the prescribing and consumption perspective.

For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?

State Providers and often their individual clinicians obtain National Provider Identifiers. State run programs maintain these in a separate list and update them monthly as new staff are hired or move between programs. The NPI numbers are maintained in the patient accounting system for billing purposes. Contractual providers maintain the information in their own systems and it is their responsibility to obtain and manage this information. NPI numbers are not required by DSAMH for billing or any of its systems, but DMMA has required the use of the NPI number as the exclusive identifier for its providers since March of 2003. Thus, any DSAMH provider that is also a Delaware Medicaid provider will have an NPI number.

Does the system employ any other method of unique provider identification that providers the ability to aggregate service or other information by provider?

DSAMH uses a Treatment Unit Identifier for internal reporting purposes. The parent organization receives a six-digit identifier, and the treatment units of the parent company receive the six-digit identifier with a two-digit treatment unit number added after a dash. For example, Parent Company A's Provider Identifier would be 123456, and the treatment units would be 123456-01, 123456-02, etc. This identifier is used on all consumer data forms to identify from which agency the individual is currently receiving services, or has received services in the past. The six-digit identified of the parent organization are based on the national provider identification systems maintained by CMHS and CSAT.

Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?

DSAMH consumers, like all DHSS service recipients, receive a unique client-identifier called the Master Client Index (MCI). This allows DSAMH to track its consumers not only across providers, over time, but also across systems within the Department of Health and Social Services, such as the Medicaid office. The MCI number is used in conjunction with all data collected on consumers. The MCI is obtained from a DHSS mainframe system used by all DHSS agencies.

Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?

State CMHCs and selected contractual providers submit service ticket forms or data which contain the consumer's MCI number, date, type, location, and quantity of services. Both the treatment unit and the staff member are identified for state run programs.

Does the system comply with Federal data standards in the following areas: use of ICD-10 or CPT/HCPCS codes?

DHSS currently complies with ICD-9, and is preparing for compliance with the ICD-10 standard.

Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that providers the ability to aggregate Medicaid and non-Medicaid provider information?

The MCI number is the same as the Medicaid recipient identifier, so DSAMH is able to easily link Medicaid and non-Medicaid client and provider information. This capability is useful for reporting and preparing and updating billing information. The Delaware Medicaid office allows DSAMH staff access to the Medicaid Management Information System (MMIS) data warehouse.

Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?

Yes, DSAMH routinely uses Medicaid download data to produce reports for its consumers. Reports routinely contain information about client Medicaid eligibility status, Medicaid Managed Care Organization (MCO) enrollment, and claims and payment information.

Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system inoperability, electronic health records, Federal IT requirements or similar issues?

The DHSS Information Resources Management (IRM) provides information technology support for the entire Department of Health and Social Services, which includes the Division of Medicare and Medicaid Assistance (DMMA) and DSAMH. The unit maintains an active program of promoting IT uses, based on a high level of knowledge of both IT developments and the business operations of DHSS, so as to maximize the degree to which the Department utilizes information technology. IRM includes representatives from each of DHSS's eleven divisions in the discussion of IT issues, as well as in planning and implementation of IT projects.

DMMA is kin the process of implementing HER Incentive payments for Medicaid providers authorized under ARRA.

Does your state have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

Delaware does have a grant to expand its statewide health information exchange called the Delaware Health Information Network (DHIN). DSAMH is slated to participate in this expansion, however a number of legal and ethical concerns regarding client privacy and confidentiality have not been resolved yet.

Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

DSAMH is in communication with DMMS only insofar as it relates to the sharing of data on DSAMH consumers. DMMA would be improving its IT systems in the same ways as DSAMH, in ways that help to bring each Division more in line with Federal reporting standards.

Provide information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

A number of DSAMH's contractual providers have developed or are in the process of developing electronic health records. DSAMH IT staff will provide as much information and assistance to providers undertaking this as possible, although most contractual providers have remained fairly independent in these efforts.

DSAMH has made steady progress in the use of web-based information technology. DSAMH has a web site that contains a variety of information about the agency, its data collection forms, and key reports. DSAMH is currently in the process of implementing a web-based Consumer Reporting Form, which would enable providers to enter real-time consumer data directly into a

web-based platform. DSAMH has also initiated a Secure File Transfer Protocol (SFTP) over the web for direct submission of client and service data to DSAMH from contractual provides. This speeds the transmission of data and increases security.

Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment.

DSAMH currently has a mixed approach to reimbursement of contractual providers. These reimbursement mechanisms include cost reimbursement, unit of service reimbursement and case rate payments. At present DSAMH has no initiative to move to an encounter/claims base approach to payment. Barriers to this would include the cost of developing such as system and a desire to expand unit of service reimbursement.

Identify the specific technical assistance needs your State may have regarding data and information technology specifically in Section 3.k.

- Assistance with exploring legal and ethical issues associated with participating in the DHIN.
- Assistance with migrating to a claims based information system from the current multifaceted approach to reimbursement
- Assistance with the design and selection of an Electronic Health Record system

CHILDREN'S BEHAVIORAL HEALTH DATAMANAGEMENT SYSTEMS

In the mid-1990's, the Department received federal support for the development of an integrated data system, incorporating the major function of case management. The Family and Child Tracking System (FACTS) is a result of this effort. The FACTS allows all DSCYF workers appropriate access to case information on clients for whom they have case management responsibilities. Data from the FACTS include:

- Client demographic, health and education
- Diagnosis, risk factors, strengths and other service planning factors
- Assessments, including Ohio Scales and other tools
- Client safety and Provider incidents
- Treatment progress and service discharge

FACTS contains a Behavioral and Mental Health section for Prevention and Behavioral Health Services (PBHS). Clients are identified with a Unique 1-7 Digit Personal Identification Number (PID) which stays with the client throughout their entire treatment history with PBHS. The system stores demographic, information as well as complete service history by date based service

episode which is identified with a unique case identifier. We capture admission and discharge dates, assessments, treatment plans, specific service information, contact information, case treatment notes, provider treatment records, billing records and client educational information. PBHS' system includes a contracts module with provider information and service information tied directly to the provider and the client's service records and history. The PBHS system includes national provider identifiers. We are able to store and aggregate Services by client, by provider, by service type and level, duration of service, and cost of service. In addition, PBHS can analyze client outcomes by service and provider. The data is also stored in a client (pid) and treatment episode (case id) specific form and is instantly accessible by our workers who monitor and guide the treatment plans of our clients.

There is a comprehensive security module that restricts what employees of the department can see and access to ensure the confidentiality of our clients treatment records as well as providing an appropriate level of availability for this information. PBHS' Client Identifiers map to the Master Client Index, MCI number, used by the Department of Health and Social Services (DHSS)and Medicaid and other identifiers used in the delivery and billing of PBHS services. Our provider identifiers map to Medicaid provider IDs as well as other national provider identifiers. PBHS can aggregate Medicaid and non Medicaid provider data.

Modifications are made to FACTS and new versions of the system are released about every 9-12 months to incorporate changes due to reporting requirements, improvements in workflow, data validation logic and other items.

Technical developments for new items and for major modifications are provided through contracted resources. DPBHS staff manages administration of FACTS and routine maintenance.

In 2005, with the assistance from the SAMHSA Data Infrastructure Grant, DPBHS began development of a business intelligence reporting environment populated with data from the FACTS system. This environment now supports approximately 150 work books and other reports used by PBHS 'leadership and operations management to guide priority-setting, decision making, resources allocation and performance improvements. Examples include:

- Utilization on each level of PBHS
- Manage cases and identify problems that affect the safety of our children
- Minimum data sets on each PBHS child client to support URS tables, TEDS and Block Grant performance reporting
- Client histories across PBHS
- Caseload information for case management
- Information on timeliness and quality of provider services, deliverables and other factors
- Client outcomes for each service level and provider, consider 180 day post discharge service needs.

In 2009, PBHS in partnership with DSAMH, was one of the nine states selected to participate in SAMSHA'S Client Level Reporting Project. This selection was in part due to the data and reporting capabilities that were already in place. This project has also provided a means to leverage the base data sets created for the pilot project for additional longitudinal analysis of client cohorts and other client level data analysis.

Due to fiscal constraints, including a previous two year hiring freeze, staff previously assigned to reporting and analysis have been diverted to more mission critical activities, this has significantly impacted our ability to keep pace with request for new reports.

Currently, the State has authorized funds for development and implementation of FACTS II. Requirements for FACTS II include functionality to work with the State of Delaware's efforts to implement Electronic Health Information Technology. Delaware has its own federally compliant HIE called the DHIN, Delaware Health Information Network which currently provides a statewide electronic prescription and other functionality. We plan to fully participate in the electronic heath exchange in our current and future IT systems.

Implementation is expected to take about three years. Beyond an upgrade to the underlying technology of the current system, FACTS II is expected to provide more uniform case and care management functionality across the department's operating divisions and significant integration with providers and other State government agencies. This is expected to make work more efficient and allow the Department to meet the needs of federal mandates and daily business requirements.

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

SECTION IV - Narrative Plan

Section F. Quality Improvement Reporting

DSAMH requires all providers receiving $500,000 or more in DSAMH contractual funds, regardless of funding source, to be accredited by a nationally recognized organization such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and/or the Commission on the Accreditation of Rehabilitation Facilities (CARF). .

These two private accreditation organizations require stringent standards of care. The accreditation assures quality control by establishing a process that guarantees continual review of program goals and objectives and program changes according to data collected:

- According to the CARF site, "…accreditation process is based on the concepts of peer review, networking, and sharing ideas. CARF's hallmark is a consultative approach to surveys, not an inspective one. The purpose of the CARF on-site survey is for a team of peers to provide an impartial, external review based on conformance to the standards. Link: http://www.carf.org/Providers.aspx?content=content/Accreditation/Opportunities/BH/AccreditationStandards.htm
- According to the JCAHO website, "the accreditation process for JCAHO Joint Commission's accreditation process concentrates on operational systems critical to the safety and quality of client care. To earn and maintain accreditation, a behavioral health care organization must undergo an on-site survey by a Joint Commission survey team at least every three years. The objective of the survey is not only to evaluate the organization, but to provide education and guidance that will help staff continue to improve the behavioral health care organization's performance. The survey process evaluates actual care, treatment or services provided by tracing clients and analyzing key operational systems that directly impact the quality and safety of client care." Link: http://www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare/bhc_facts.htm
- Staff from our DSAMH Licensing Unit conducts these reviews. DSAMH conducts annual licensure and Medicaid Certification audits of 100% of our licensed and Medicaid Certified programs. We do a 5%-10% audit of each program's total census.

Throughout the year, DSAMH facilitates two types meetings with providers that meet the elements of peer review. The first type of meeting is exclusively with substance abuse treatment providers. Because Delaware is small in size, we are able to fit all of our providers in one room to meet. The group meets to discuss the performance based contracts in the promotion of evidenced based best practices. Providers share their experiences and receive feedback, support and advice from other programs. Programs are also afforded an opportunity to share program success. Items discussed at this meeting are at the programmatic and agency level.

The second type of meeting is the “Joint Provider Meeting” which includes substance abuse and mental health clinical staff. The purpose of these meetings is to share practices and receive feedback. Most commonly discussed the referral processes as well as medication management. Providers offer feedback and help each other resolve problem to ensure a smooth flow of clients within the continuum of care. Items discussed at this meeting are at the clinical direct care level

The Division tracks utilization and capacity through the contract agency monthly admission/service utilization reports, as well as through the Division Eligibility and Enrollment Unit (EEU) which reviews all recommendations for intensive alcohol and drug treatment services. The Division regularly monitors the number of people and the length of the wait on waiting lists for services, including those providing treatment for IV/injecting drug users. If the waiting list is eliminated and the number in treatment goes below 90% of the capacity, the Division will obtain information from the methadone maintenance programs when they again reach 90% of the capacity through the required monthly reports.

AOD programs are reviewed annually unless they have Deemed Status in which case they are reviewed at a minimum once every 2 years. This is standard practice for licensure and certification surveys. In addition to DSAMH's review, the program conducts reviews according to their own Policies and Procedures. DSAMH’s QA unit reviews the following items during on-site inspections:

- Review of treatment plans
- Review of assessment process
- Review of admission process
- Review of discharge process.

During calendar year 2010, DSAMH began assessing the current EEU process. DSAMH concluded that it had gotten away from taking a stronger role during the referral process and began working with Dr. Mee Lee to improve this process. Dr. Mee Lee assisted DSAMH with revising the ASAM criteria to best fit DSAMH’s needs. This revised EEU package will be distributed to TASC to pilot during FFY 2011.

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

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, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

SECTION IV

4. Consultation with Tribes

Delaware does not currently have any federally recognized Native American tribes within our state border. Should the presence of a nationally recognized Native American tribe establish a presence within the state, we will work diligently with SAMHSA and neighboring states to best establish action steps and a plan to ensure their inclusion in our planning efforts and the execution of activities funded via the Delaware Behavioral Health System.

In the absence of having a federally recognized tribe in DE, DSAMH values having a relationship with a state recognized tribe, the Nanticoke Indian Tribe in Sussex County and will treat that relationship with the same level of care and attention that would be afforded a Federally recognized tribe until a pending application for federal recognition had been ruled upon.

This Tribe is state recognized and they are currently working toward becoming federally recognized. Ms. Odette Wright from the Nanticoke Indian Tribe has attended the Delaware Prevention Advisory Committee (DPAC) meeting as of August 18, 2011. The DPAC is supported by the Prevention Set-aside funds to drive the delivery of substance abuse prevention services. This advisory committee drives the efforts of Delaware's Substance Abuse Prevention Strategic Plan across the Lifespan. DSAMH recognizes this community as being an area that is not receiving substance abuse prevention services at this time. The Single State Agency is at the infancy state of developing a state and tribe relationship through the participation of Ms. Wright's membership to the DPAC. DSAMH will disseminate information regularly to the tribal contact on substance abuse and misuse. DSAMH will extend support and resources to the tribe's current efforts in becoming a federally recognized tribe through the support of our CSAP Federal Project Officer Mr. John O'Donnell. DSAMH will measure our efforts through the tracking of communication with the tribal contact and their participation of attendance to the DPAC meetings. Also, through the collection of documentation on the contribution to our state plan in meeting timelines and reaching benchmarks that is inclusive of the Delaware Nanticoke Indian Tribe.

IV: Narrative Plan

H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

SECTION IV - Narrative Plan

Section H. Service Management Strategies

The State of Delaware collects a significant amount of data regarding the consumers involved in treatment services, as well as the services themselves. The methods for collection vary and data is received from a number of different resources. The State is strategizing to improve current methods for managing the data that is received, identifying the data that is still missing, and how to best organize all of the data so that it may be retrieved in routine, organized reporting, to be used in planning, and graphing trends and identifying gaps and needs.

The executive team is meeting on a regular basis with the monitor assigned to evaluate the State's strategies for addressing the gaps identified and agreed to resolving in the 2011 Settlement Agreement. Additionally, new funding and budget review reporting documents have been created and monthly meetings will be conducted with budget and planning teams to identify spending habits and shortcomings. The contract management team has expanded to include contract monitors who will manage communication between DSAMH and the service provider, and will be responsible for bringing any significant issues to the attention of the executive team.

These management strategies are expected to evolve into formal policies and procedures for quality improvement of services to the consumers, service to provider agencies, and an improved organization and management of state and federal funding.

Resources required are potentially technical assistance, we may need human resources, and time. We may need some assistance determining courses of action. We have staff with experience in many facets of business processes, as well as a contractor with expertise in systems management. Several years ago the state did away with allot of positions, which we are now finding that we may need some of them back to conduct the various review and analysis functions required. Time may be an issue as we are just scratching the surface of the strategies to be invoked for meeting the requirements of the Settlement Agreement. There are deadlines included in the agreement with which we intend to meet or exceed, they may not coincide with some of the goals of this grant application and may receive less priority as a result.

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2012

Priority	Performance Indicator	Selected
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	All provider agencies are educated on referral and access to other health and social services available to their clients.	∈
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Increased Family and Peer Supports	∈
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	The percentage of consumers receiving community-based services who actively participate in their own treatment planning.	∈
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Consumers responding positively to the consumer satisfaction survey regarding satisfaction with the type, location, frequency, timeliness, and level of services	∈
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Percentage of consumers reporting positively regarding perception of care.	Ь
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Percentage of consumers who are satisfied with their level of functioning.	Ь
Promote participation by people with mental health and substance abuse disorders in shared decision making person-centered planning, and self direction of their services and supports.	Positive responses regarding social supports/social connectedness	∈
Ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LBGTQ individuals	All contracted organizations and community prevention providers are educated on cultural competence to ensure community members have access to culturally sensitive programs/services.	∈
Ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LBGTQ individuals	Dissemination of information regularly to the tribal contact on substance abuse and misuse. Extend support and resources to the tribe's current efforts in becoming a federally recognized tribe through the support of our CSAP Federal Project Officer.	∈
Promote hope, recovery, resiliency and community integration		

for adults with serious mental illness and children with serious emotional disturbances and their families.	Establish 4 crisis apartments throughout the state	∈
Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Establish (2) Crisis walk-in clinics statewide	∈
Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Increased access to services	Ь
Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Reduce the number of readmissions to the State psychiatric hospital within 180	Ь
Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.	Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)	Ь
Increased accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.	Completion of the Basic and Developmental Tables under the Data Infrastructure	∈
Increased accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.	Implement Quality Service Reviews (QSRs) system-wide	∈
Increased accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.	All contracted providers will utilize KIT Solutions to monitor program process and outcomes. DDATA will continue to develop annual state and substate Epidemiological Profiles.	∈
Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.	Development and implementation of community-based substance abuse prevention contracts.	∈
Conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.	Number of participants in the needle exchange program	∈
Conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.	Number of participants in treatment for illicit and/or licit drugs.	∈
Provide HIV prevention as early intervention services at the sites at which individuals receive substance use disorder treatment services.	HIV prevention educational material is available at every substance use treatment provider throughout the state.	∈
Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	Relevant substance abuse prevention trainings and technical assistance are provided to both contracted and additional community agencies to build the prevention workforce in order to enhance the prevention services being provided throughout the state.	∈
Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	DSAMH will complete this report by June 30th 2013	∈
Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp	Increase the number of providers using this system from 0% in FFY 2012 to 100% during FFY 2013	Ь
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Determination of prevalence estimate of SMI and SPMI for adults	∈
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Percentage of people needing treatment but not receving it decreasing	∈
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Education is provided to service agencies for accessing treatment and recovery support services.	∈
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Dissemination information regularly on emerging trends and issues within the behavioral health field; provide access to information on supports and resources for individuals to take advantage of within the state.	∈

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Percentage of adults with SMI residing in Kent and Sussex Counties who receive publicly funded mental health services provided by the Division of Substance Abuse and Mental Health, Delaware Physicians Care, Inc. (DPCI), and the Diamond State Health Plan (	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Number of persons receiving evidence based practices (system-wide)	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Adults with SMI or COD receiving Evidence Based Supportive Employment as part of their recovery plan.	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Adults receiving permanent housing assistance via the Delaware behavioral health service system	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Permanent and permanent supported housing opportunities for homeless and disabled persons with SMI	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Adults w/ SPMI receiving ACT in the DSAMH behavioral health system	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (Percentage)	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Percentage of staff of community support programs participating in training	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Number of Evidence Based Practices (system-wide)	
Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.	Mental health training for emergency, health and human services professionals	

Footnotes:

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Section 4 – Narrative Plan

J. Suicide Prevention

DSAMH is a member of the Delaware Suicide Prevention Coalition which recently produced Delaware's Suicide prevention Plan. The plan specifically details initiatives targeted at reducing suicide among the elderly population. These initiatives include:

- Increasing the number of public and private organizations active in suicide prevention
- Collaborating with faith-based groups to develop plans to assist their members in identifying risk factors, encouraging treatment for depression, increasing protective factors, and offering support and guidance to individuals.
- Increasing the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities.
- Increasing the number of seniors who view mental and physical health as equal and inseparable components of overall health.
- Increasing the number of individuals who view senior mental health disorders as real illnesses that respond to specific courses in treatment.
- Increasing the number of individuals who view consumers of mental health substance abuse and suicide prevention services as pursuing fundamental care and treatment for overall health.
- Increasing the number of senior centers and senior-serving programs with best practices and evidence-based programs designed to address serious mental distress in the elderly.
- Increasing the number of education programs available to caretakers, family members and community members in close relationships with seniors.
- Develop and implement groups for providing education to family members of seniors receiving care for the treatment of mental health and substance abuse disorders with risk of suicide in facilities.
- Increasing the number of television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness in the elderly.

- DSAMH and MHA are co-leading a suicide prevention coalition.
- DSAMH and CMH fund suicide prevention programs targeting children, adolescents, and adults, DSAMH will continue to engage in coalition initiatives to increase surveillance, early intervention, and post incident activities in order to improve the quality of clinical services for clients contemplating or attempting committing suicide.

YOUTH BEHAVIORAL HEALTH SYSTEM

DPBHS is a member of the Delaware Suicide Prevention Coalition which recently produced Delaware Suicide Prevention Plan. Below you will find goals and descriptions of initiatives used to reduce suicide amongst Delaware's, children, youth and their families.

Demographics of your target population(s);

Project LIFE is a statewide venture, which encompasses a broad spectrum of individuals. The grant currently funds positions in the Child Development Community Policing (CDCP)

initiative. One position is in lower Delaware, which is rural and lacks resources and services. Another position is located in northern Delaware, which is much more urban with all socioeconomic classes, minorities and very complex environmental factors. The college students being served are of diverse ethnicities and many are from out-of-state. Statewide statistics show that 13% of Delaware children reside in poverty, 35% of children reside in one-parent families, 86% of college students report binge drinking, 14% of 5th graders have tried inhalants, 40% of 8th graders drank alcohol in the past year, 32% of 8th graders have reported having sexual intercourse as Delaware has one of the highest rates nationwide for sexually active middle schoolers, 28% of 11th graders meet the criteria for alcohol dependence and 45% have used alcohol, marijuana or other illegal drugs in the past month. There remains an increased rate of youth gambling as well as alcohol, heroin and prescription drug use in the state. Delaware is higher than the national average for teen deaths by accident, homicide or suicide (53.9% compared to 50% nationally), with suicide currently being the second leading cause of death for youth and young adults. Middle School Youth Risk Behavior Survey data show that 20% of Delaware youth are bullied by others, 21% have thought of suicide and 19% have tried to hurt or kill themselves. College and high school students are less likely to report seriously considering suicide in the past 12 months than the national average, though the differences are not statistically significant.

Description of your service area(s) (e.g., urban, rural, frontier, suburban);

Delaware encompasses urban, suburban and rural communities and is the 45th most populated state. The two downstate counties are more rural and insular with a lack of resources, and the Hispanic population is higher downstate due to poultry work being readily available. Many elderly and retired persons live in the coastal areas downstate while divergent socioeconomic circumstances exist across the state. The urban upstate county has many growing social ills such as poverty, high rates of violence, high dropout rates and high infant mortality and low birth weight rates. Delaware has a diverse population as well and its teen and Hispanic populations are growing rapidly throughout the state.

Goal 1 – Strengthen DSPC infrastructure – all workgroups have been created and the Delaware Suicide Prevention Coalition (DSPC) continues to meet monthly to offer guidance on grant implementation. The DSPC has also been expanded to include other entities and participants to support coordinated efforts. This reporting year, we created a Cultural Competency Goal which is that: *All activities with Project LIFE are presented in a culturally competent manner that values diversity, is vigilant in cultural differences, expands cultural knowledge and adapts services and programming to meet cultural needs.* We also developed and disseminated Cultural Competency Guidelines to all DSPC members as well as ensured that all Project LIFE contract providers reflect these values.

Goal 2 – Promote awareness of suicide prevention as a public health problem – Project LIFE utilizes our Communication Plan to guide activities. During this reporting period, the Crisis

Helpline took a total of 25,443 calls from individuals in distress. Of these calls, 1,008 were from callers 10-24 seeking confidential counseling on various presenting problems. The Crisis Helpline received an additional 176 calls from adult individuals seeking help, information and referral for a young person between ages 10-24. The Crisis Helpline received 1,496 calls through the National Suicide Prevention Lifeline (NSPL) where the caller was assessed using the ContactLifeline Suicide Lethality Assessment during this reporting period. The delteenspace website received 155,957 hits this year, and 31,443 visits. In addition, there were 34 referrals made to the state's crisis hotline for immediate follow-up. The Social Marketing Committee convened monthly to develop and implement strategies to bring about awareness that suicide is a public health problem and to decrease stigma regarding depression and suicide among youth. This year, we created the *GetRightSideUp* campaign and website to inform Delawareans about how suicide affects children, teens and young adults – no matter where they live or what their circumstances may be. The *GetRightSideUp* campaign is currently being implemented in schools, with health care providers and in the community to change attitudes and behaviors by providing information that depression and suicide can affect anyone and that suicide is preventable. The four messages target specific audiences: Youth: "Find Balance in an Uneven World", Parents & Family: "Your Support Can Help Your Teen Get Back on Solid Ground", Educators: "Your Involvement Can Help your Students Get Right Side Up" and Community: "Reach Out to Create a Suicide-Safe Community". These four messages are also included in the suicide prevention Toolkits. The Social Marketing Committee also developed two newsletter inserts with articles relating to signs and symptoms of depression and suicide, how to locate national and local resources, a teen page filled with related articles, puzzles, and activities, social marketing activities, and promoting www.delteenspace.org and the social marketing website, www.getrightsideup.org. Toolkits were developed and disseminated to Delaware high school wellness centers, middle schools, youth-centered community groups, mental health agencies, and various community members. In addition, 10 high schools (public, charter and private) were selected and were given Toolkits for the entire 9th and 12th grade students. For this past grant year, there have been nearly 11,000 Toolkits disseminated.

As part of the *GetRightSideUp* campaign, 13 youths (ages 11-22) were involved in learning about the *GetRightSideUp* campaign and participating in developing a poster, calendar, website and a brochure. 500 posters have been disseminated to date.
A *GetRightSideUp* academic calendar was developed, printed and disseminated to wellness centers, health fairs, and community centers as well. The 12-month academic calendar included survival tips for teens around suicide prevention. 12 artworks from a youth art submission contest were chosen to be a part of the calendar. There were a total of 37 art submissions and 12 were chosen. The Social Marketing Committee also developed, filmed and produced a 9-minute DVD for youth. The DVD is in its final stages of editing and is expected to be completed by January 2011. 2,000 copies will be disseminated. The DVD includes signs, risk factors, and symptoms of depression and suicide. It also encourages individuals to seek help and addresses myths and facts about suicide. To get the word out about *GetRightSideUp* campaign, there was also active participation in exhibiting at youth events, conferences and community health fairs.

Goal 3 – Develop broad based support for suicide prevention – the peer-to-peer mentoring programming (YSPN) took on a slow start due to Coordinator medical issues and has been

complicated by several high school deaths by suicide during the fall. The program has been totally re-vamped and is in the process of being implemented.

Goal 4 – Develop and implement anti-stigma reduction strategies – our two websites offer much information on suicide and its prevention as well as the promotion of health and well-being, articles for greater understanding have been disseminated via the newsletters and Toolkits haven been disseminated to medical offices and hospitals. We have also provided anti-stigma brochures from NIMH and Mental Health America at outreach events and community health fairs. Our posters, calendars and DVD also address the reduction of anti-stigma of suicide and depression.

Goal 5 – Education, training and outreach initiatives – During this reporting period, a total of 1,548 individuals were trained in the community. There were nine ASIST workshops, 7 SafeTALK trainings, 10 QPR trainings and 15 awareness workshops. Participants included: educators, youth, clergy, college students, youth substance abuse treatment center staff, community mental health center staff, hospital emergency department staff, paramedics and police officers and community members. There were also 547 University personnel trained in *Campus Connect.* The University of Delaware training went exceedingly well again this year with a diverse group of staff participating to include: 7 Student Centers/Greek Life staff, 50 Public Safety staff, 20 Career Services staff, 78 Army ROTC members, 53 Peer Mentors, 50 Health/Wellness staff, 7 Engineering outreach staff, 6 Academic Services staff, 270 Residence Life staff and 6 Housing Assignment staff. The two Child Development Community Policing (CDCP) positions that are funded through the grant have been working diligently throughout the year. One position is situated in the city of Wilmington, which has a very high violence rate, and works with youth ages 10-18 and their families that have experienced a traumatic event. The position focuses on family stability and the youth's overall health and well-being, and also supports youth by providing case management services to include employment engagement, alternative activities, counseling and school connectedness. The second position is located downstate in Sussex County. This position also concentrates on outreach and supportive services to youth and their families who are experiencing extensive emotional disturbances. During this reporting period, this position has been intensively involved in an extremely traumatic community event. A local pediatrician has alleged to have sexually abused female patients over the past ten years with the trial looming in early 2011. The families and entire community is slowly coping with the aftermath of such a devastating event. The CDCP position has become an integral part of a coordinated response between law enforcement, the judicial system and the mental health system to ensure that youth and families are receiving the support and services that they so desperately need. A huge component of the role has been to outreach to vulnerable families that are hesitant to come forward while coordinating care for those that do. Both positions have seen over 60 youth and their families this reporting period, which included numerous visits and contacts for each. The upstate CDCP worker participated in five police canvasses to locate youth following an traumatic event and provide services, represented Project

LIFE at six local outreach events, conducted presentations at six elementary and middle schools and also presented at Wilmington Police's Academy Class of 2010 to elicit support for our efforts through law enforcement. The downstate worker participated in twenty community outreach events which included school districts, hospitals, the American Red Cross and community-based organizations.

Goal 6 – Develop and implement suicide prevention programs – Project LIFE is using only evidence-based programs, practices and policies; the YSPN is now up and running; the Child Development Community Policing (CDCP) program has been expanded by one full time position in Sussex County over the course of the grant with other state/federal resources being leveraged; Gatekeeper trainings are statewide and have been very successful; the hotline and websites build upon one another and are currently in full use and all programs are delivered with cultural and literary competence.

Goal 7 – Evaluate and monitor education and training programs –The evaluation of Project LIFE includes survey distribution, data analysis and reporting/presentations. University of Delaware's Center for Drug and Alcohol Studies (CDAS) monitors the training activities of Project LIFE to ensure that training contractors have sufficient blank TES forms and associated cover sheets for upcoming training sessions.

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

SECTION IV - Narrative Plan

Section K. Technical Assistance Needs

Technical assistance specific to mental health prevention is an area that the State is requesting technical assistance to acquire a greater knowledge of activities that are being conducted regionally and nationally by other states.

Delaware's behavioral health system of care currently transforming to a system that embraces the principles of trauma informed care throughout the service system. Beyond trauma informed care we are extremely interested to know what other activities are being implemented throughout the country to address mental health prevention and effective methods for data collection in the area.

Another area of technical assistance should be focused on offering public access to the applications created in WebBGAS 2.0. WebBGAS 1.0 provided the access that many seasoned reviewers, including MHPC members and members of the general public embraced as the review method of choice.

The final area we are seeking technical assistance involves service management strategies. Many of the newly implemented requirements of the Block Grant require the use or dedication of additional human resources, and time. The State has staff with experience in many facets of business processes, as well as a contractor with expertise in systems management. Several years ago the State eliminated a sizeable amount of positions in response to a down trot economy and shrinking state revenue. We are now finding that several of the eliminated positions may be required to conduct the various review and analysis functions required under the current Block Grant design. Time and available resources may be an issue as we are just scratching the surface of the strategies to be invoked for meeting the requirements of the evolved Block Grant and the Division's commitments under the Settlement Agreement Delaware and the USDOJ. There are deadlines included in the Settlement Agreement which we intend to meet or exceed, but they may not coincide with some of the goals of this grant application. The Division doesn't want either document to receive less priority, thus we are requesting some insight into how other states faced with similar circumstance were able to successfully meet the requirements of both programs.

IV: Narrative Plan

L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Section 4 - Narrative

4.9 Involvement of Individuals and Families

The Delaware Behavioral Health system was recently transformed to a system that places the consumer at the core of the recovery process via true person centered planning. The person-centered recovery plans focus which focus on stabilization; rehabilitation and recovery are developed in partnership with the consumer. The planning process emphasizes the consumer's role in shaping the nature and scope of services and outcomes, and the ability of the treatment team, which includes the consumer, to review and update the treatment plan as the needs of the individual change.

During this grant cycle the Division will continue to implement new features and activities throughout the behavioral health system that will further increase consumer involvement in directing their care during the recover process. All aspects of the Delaware's behavioral health system feature "hope" at its foundation.

The following activities detail current opportunities for consumer and family involvement:

- As a primary proponent of consumer recovery and full inclusion in the community, DSAMH will take further steps in 2012 to provide consumer employment opportunities, and engagement in planning activities. DSAMH has in the past assumed a role in the development and evaluation of services provided by the CCCPs by contracting with the University of Pennsylvania's Center for Mental Health Policy and Services Research.

- Throughout the CCCPs and CMHCs, consumers increase the skills of daily living and social functioning of consumers and are encouraged to expand their role in community life, particularly in the areas of social relationships, work and school. Recovery plans that are monitored in CCCPs are consumer-centered and responsive to individual, cultural and linguistic needs.

- Delaware's behavioral health system is a team based service system that provides consumers with access to a variety of the disciplines relevant to their rehabilitation and recovery services regardless of where they are in the continuum. The end result is that the consumer is afforded the opportunity to establish relationships to support their recovery.

- The majority of behavioral health services are delivered to individuals in a community setting, i.e., in vivo, and not "on-site." The end result of this transformational activity is that the consumer's recovery process occurs in the least restrictive manner; promotes social connectedness and functionality as keys to recovery process; .and affords family members and other interested persons increased opportunities to participate in the consumer's recovery process.

- Delaware's behavioral health system includes a consumer ombudsman that provides consumers with a ready means for making complaints or stating concerns regarding provider services and staff behavior. The goal is to provide a forum in which to present and mediate client concerns and to ensure that clients are seen and treated as "managing partners" in their treatment design and delivery. DSAMH is continuing to work on an automated system that will allow tracking of complaints and concerns. This system will result in better management of providers. Additionally, there is strength in volume. If a consumer's complaint has been heard several times regarding a specific issue it provides more strength to the process of change with the provider. Consumers should have the ability to see and make determinations of which providers are delivering services at a level to their liking when making a service provider choice.

- The Division reorganized the Office of Consumer Relations, the goals of which are to increase the planning role of consumers in the Division's program planning and evaluation process; to ensure a consumer voice in contract development and monitoring; and to provide a forum in which consumer complaints, suggestions and concerns can be heard and effectively acted upon. The Division is currently developing a computer based tracking system for complaints.

- During this grant cycle the Peer Specialists program will be expanded to nearly double the current capacity and increase opportunities to promote shared decision making and assist the consumer in directing their care. Peer Specialists routinely work with consumers and their families in refining their recovery goals.

- The Division employs consumer-interviewers as part of the Consumer Client Satisfaction Survey, and provides training on consumer advocacy to enhance planning for community integration and supports.

- The Division supported the development of the consumer-run Rick Van Story Resource Center. The Division is actively working to open a consumer arts program that should open during FY2012.

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

SECTION IV - Narrative Plan

Section M. Use of Technology

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care and recovery support services. ICTS are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

Delaware is very interested in using Interactive Communication Technologies (ICTs) to support traditional therapies and supports for clients. The basic strategy is to partner with local providers to adopt new technologies using state funding to initiate the project and use provider resources as in-kind or matching support

b. What specific application of ICTs does the State plan to promote over the next two years?

Delaware has three projects underway that specifically use ICTs to supplement traditional treatment and recovery approaches. These are…

1) Telepsychiatry – a pilot is being planned for remote locations
2) Common Ground Software – contract negotiations are underway
3) My Outcomes Software- a business plan is being finalized

c. What incentives is the State planning to put in place to encourage their use?

Delaware has taken the initiative by purchasing the product and making it economical for providers to use. The cost to providers will be much less if participating as part of the state project than if they purchased the products on their own.

d. What support system does the State plan to provide to encourage their use?

Delaware has made every effort to involve the providers early in the process and to communicate clearly the level of effort needed to participate as well as the benefits to both providers and clients. In come cases the providers have made the first move and purchased the product, in this case My Outcomes, on their own. This will provide a useful model for implementations in other parts of the state.

e. Are there barriers to implementing these strategies? Are there barriers to wide-

scale adoption of these technologies and how does the State plan to address them?

There are several barriers to implementing Delaware's strategies to adopting ICTs. First, of course, is funding. Both the state and provider agencies are under pressure to contain costs and operate in tighter budgets. Also, the recent US DOJ settlement in Delaware could be a big distracter if the State isn't vigilant in maintaining it's goals for ICTs. Finally, there is always the normal demands on manager's time to meet an every increasing demands on their time. Consumer buy in is also critical, these projects can't success without a client population that is both engaged and supportive of these strategies.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

Delaware will communicate in several ways with the aforementioned organizations to secure their support. Buy in by all parties involved is critical to success. Delaware will support the ICT initiatives with email, conference calls, and meetings to provide the information needed for acceptance by all of the concerned parties.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

The plan is definitely to use the data collected from ICTs to evaluate programs at the client level. Use at the provider level remains uncertain at this time.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

As with all projects Delaware will solicit feedback from all its constituents at once. These include consumers, providers, and advocacy groups who will have opportunities to provide their reaction to the initiative in various forums. These will include regular staff meetings, provider meetings, meetings with clients, and advocates. This information will be solicited during regular meetings, ad hoc meetings, client surveys, and interactions with both clients and staff during the treatment process. If will be interesting to see if any changes can be detected in the annual consumer survey conducted by the state.

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

DELAWARE HEALTH
AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

August 22, 2011

Ms. Kevin A. Huckshorn, Director
Division of Substance Abuse and Mental Health
Department of Health and Social Services
1901 N. Dupont Hwy, Main Administration Bldg.
New Castle DE 19720

Dear Ms. Huckshorn:

I am pleased to take this time to provide a letter of support for the 2012 – 2013 Combined Behavioral Health Assessment and Plan, to be submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) in September 2011. The Division of Public Health (DPH) is happy and proud to partner with the Division of Substance Abuse and Mental Health (DSAMH) in a number of ways in support of these important program initiatives:

- The DPH HIV Prevention Program is interested in the joint effort for reaching out to injecting drug users for HIV testing as early intervention. We anticipate developing strategies with DSAMH for reaching more of the injecting drug user population through public health and mental health clinics, and contracted service providers. Also in providing educational and outreach information to our HIV and TB patients on how to access treatment and recovery services.

- The DPH Office of Maternal and Child Health is interested in advancing the process of making expecting mothers a priority for addiction treatment services to preserve the health and welfare of unborn children. Also in identifying those individuals within the Public Health system that may be at risk for drug and alcohol addiction and referring them to the appropriate access point for treatment.

- The DPH Tobacco Prevention and Control Program will continue to support the SYNAR enforcement programs, further reducing the percentage of youth and young adults from accessing tobacco products, and reducing tobacco addiction in the state of Delaware.

The Division of Public Health is happy to partner with the Division of Substance Abuse and Mental Health in improving the health of individuals with addiction disorders, and assist in reducing the number of individuals needing treatment who are not receiving services. Thank you for giving me this opportunity to express my support of this important plan submission. Please feel free to contact me should you need any further support in this effort.

Sincerely,

Karyl T. Rattay, MD, MS
Director

JESSE S. COOPER BUILDING • FEDERAL STREET • DOVER • DELAWARE
MAILING ADDRESS: 417 FEDERAL STREET • DOVER • DELAWARE • 19901

State of Delaware

The Department of Services for Children, Youth and Their Families

Division of Prevention & Behavioral Health Services

"Integrating prevention, early intervention and mental health to enhance services for children & families"

(302) 633-2600 o Prevention & Substance Abuse Treatment o Fax: (302) 622-4475

Aug. 26, 2011

Ms. Kevin A. Huckshorn, Director
Division of Substance Abuse and Mental Health
Department of Health and Social Services
1901 N. DuPont Hwy, Main Administration Bldg.
New Castle, DE 19720

Dear Ms. Huckshorn:

On behalf of the Division of Prevention and Behavioral Health Services (DPBHS), Department of Children, Youth and Their Families (DSCYF), we are happy to partner with the Division of Substance Abuse and Mental Health (DSAMH) and support the 2012 – 2013 Combined Behavioral Health Assessment and Plan. As a co-author of the application, DPBHS has a mutual interest in the funding of the goals and activities proposed in the application.

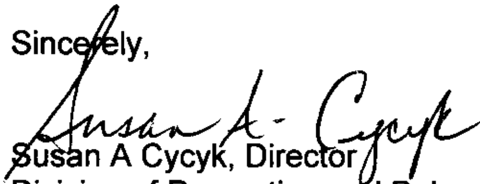
DPBHS is excited about the prevention goals and objectives. We have worked tirelessly in collaboration with DSAMH to develop the statewide strategic plan recently implemented. Pursuant to this plan, we have combined efforts to issue significant contracts to service providers further enhancing prevention capacity within the state. We have been significantly involved in the Strategic Prevention Framework (SPF) project as well--participating in initial planning efforts, enhancing evaluation strategies and data access and partnering to award contracts to service providers to plan and implement prevention capacity building projects throughout the state.

We are also excited about the growing partnership between DSAMH and DPBHS as it relates to the joint commitment to closing the gap for those consumers aging out of the youth services programs, and into the adult services programs. We have worked closely with DSAMH to provide education, parenting and treatment services for caregivers to decrease risk and enhance protective factors that are critical to the wellness of Delaware's children. We continue to develop strategies to bridge the gaps in services for youth preparing to enter the adult world, engage in adult relationships, and manage behavioral issues that interfere with their ability to function as healthy, productive members of their communities.

Delaware Youth and Family Center
1825 Faulkland Road Wilmington, Delaware 19805 (Fax) 302-622-4475

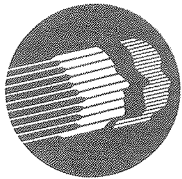
It is an honor and a privilege to co-author such an important document that will direct the mental health and addiction services for the state of Delaware for the next two years. Please do not hesitate to call on me for any additional assistance in the support of this grant application. Thank you.

Sincerely,



Susan A Cycyk, Director
Division of Prevention and Behavioral Health Services

Delaware Youth and Family Center
1825 Faulkland Road Wilmington, Delaware 19805 (Fax) 302-622-4475



DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

OFFICE OF THE DIRECTOR

August 26, 2011

Ms. Kevin A. Huckshorn, Director
Division of Substance Abuse and Mental Health
Department of Health and Social Services
1901 N. Dupont Hwy, Main Administration Bldg.
New Castle, DE 19720

Kevin

Dear Director Huckshorn,

On behalf of the Division of Medicaid and Medical Assistance (DMMA), we are happy to provide this letter of support for the 2012 – 2013 Combined Behavioral Health Assessment and Plan being submitted by the Division of Substance Abuse and Mental Health (DSAMH) as the Single State Agency (SSA) for Behavioral Health Services in the state of Delaware.

DMMA and DSAMH have been working for some time now to develop strategies to maximize Medicaid and CHIP funding of behavioral health services in the state. This funding will become increasingly important as the Medicaid population expands in 2014 under the Affordable Care Act. Work has begun to identify opportunities to cover behavioral health care services that are currently funded by state general funds and block grant funds with Medicaid funds, in some cases using new authority under the Affordable Care Act. For example, we are working together to develop a Health Home demonstration for Medicaid members with chronic conditions, including behavioral health needs. The goal would be to ensure seamless access to behavioral and general health services to persons with serious mental illness and addictions in order to improve their quality of life.

It is a pleasure to support such a worthy cause. Please feel free to call on me or my staff should you need any further assistance in the support of this application.

Sincerely,

Rosanne Mahaney

Rosanne Mahaney
Director

P.O. BOX 906 • NEW CASTLE • DELAWARE • 19720 • TELEPHONE: (302) 255-9500

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

SECTION IV

1. Behavioral Health Advisory Council

ADULT BEHAVIORAL HEALTH SYSTEM

The Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health is designated by the Governor as the sole administering agency in the State of Delaware for the Community Mental Health Services (CMHS) Block Grant. The Governor's Advisory Council (GAC) to the Division of Substance Abuse and Mental Health serves as the State Mental Health Planning Council pursuant to Section 1914 of the PHS Act (42 U.S.C. 300x-3). The membership of the Governor's Advisory Council includes 17 voting members appointed by the Governor and 10 associate members elected by the membership of the Council. Pursuant to section 1915 (a) [42 USCS Sec. 300x-4(a)], the Governor's Advisory Council reviews and makes recommendations regarding the state mental health plans and reports prepared by the Division and DCMHS in fulfillment of the Community Mental Health Block Grant requirements. There are currently 12 consumers or family members of consumers on the GAC.

The (GAC) to the Division of Substance Abuse and Mental Health is currently exploring ways and methods to become representative of the entire Behavioral Health System in Delaware. This effort is not one that is easily accomplished as each member of the committee is Governor appointed and in accordance with state legislation. DSAMH is currently working with the Chair of the (GAC) to determine how soon and what steps are required to add Substance Abuse Prevention and treatment to the Committee’s oversight.

DSAMH recently reviewed two things. First, DSAMH reviewed the legislation that currently establishes the GAC. DSAMH found that our legislation will not be a barrier to expanding the GAC to include substance abuse members. DSAMH also reviewed the current voting membership and non-voting membership and found that it already includes consumers and providers representative that from mental health interests and substance abuse interests.

In order to increase consumer representation and assure the adequacy of representation of children’s issues on the GAC, an estimated six new associate member appointments were recently made. These six associate members are family members of consumers and current members of the Children’s Advisory Council to the Department of Services for Children, Youth and their Families. In addition, the GAC established a Children’s Committee that also serves as a liaison between the GAC and the DCMHS Community Advisory Council.

The GAC recently established a Community Mental Health Services Block Grant Subcommittee which consists of Planning Council members, consumers and family members of consumers. The subcommittee provides additional opportunities for Planning Council membership, consumers and family members of consumers to be involved with the development of the Community Mental Health Services Block Grant

and State Plan.

The GAC-DSAMH has as its mandate to advise the Governor, Cabinet Secretary and DSAMH Division Director on issues affecting mental health services in the State. The Council also plays an active role in reviewing the Division's budget and advocating to the State's legislative bodies on issues relevant to substance abuse and mental health.

CHILD BEHAVIORAL HEALTH SYSTEM

In addition to the (GAC**)**, DPBHS participates on and facilitates two youth-specific planning committees. The DPBHS Community Advisory and Advocacy Council, described in this section, collaborate with the GAC through the facilitative efforts of the Children's Committee, a standing committee of the Governors Advisory Council and the Advisory Council's Transition Committee.

Advocacy & Advisory Council: The DPBHS Community Advocacy and Advisory Council is comprised of youth and families, representatives from advocacy groups, service providers, other state and private sector child-serving programs and our sister divisions in DSCYF. Meetings of the Council are held bi-monthly and as scheduled by task-specific committees. Responsibilities include:

- Collaboration with DPBHS staff in review of service continuum, utilization, process and outcome reports.
- Reviewing the CMHS State Plan and Implementation Report; collaboration with the Governor's Advisory Council to DSAMH.
- Review and comment on program proposals and grant applications.
- Providing comments to the State Budget Office, the Governor's Office, the Joint Finance Committee, and other review bodies as requested.
- Providing information regarding outreach, partnership and public information opportunities.
- Strategic planning.
- Providing information regarding outreach, partnership and public information opportunities.
- Annual goals for the Division.

Further DPBHS-DSAMH Collaboration: One DPBHS senior staff member is an appointed member of the Governor's Advisory Council to DSAMH, and one DSAMH senior staff member is a member of the DPBHS Advocacy & Advisory Council. There are also six other representatives from the Children's Advisory Council that sits on the Governors Advisory Council as well as other interested parties. Senior managers of DPBHS and DSAMH meet quarterly regarding the management of the CMHS Block Grant and areas of mutual interest in program development, as well as participating together in periodic site visits, conferences and trainings. A memorandum of

understanding (MOUs) has been developed on the management of grants and on transition of youth to adult services.

Primary sources of planning input to DPBHS

- Statewide System of Care Team chaired by providers and staff.
- Interagency collaboration: In addition to the above-referenced collaboration with DSAMH, DPBHS staff participate on the steering committee for the Maternal and Child Health Block Grant, the Developmental Disabilities Council, an interagency committee on the development of school-based behavioral health services, interdivisional working groups on foster care development and training, program development for juvenile sex offenders, etc.
- Provider meetings and surveys: DPBHS holds quarterly meetings with providers of services and conducts an annual survey of provider satisfaction, solicits input regarding service improvement.
- Parent Information Center of Delaware.
- Ongoing needs assessment processes: The information management system is designed to collect ongoing information regarding service gaps. The Utilization Review Committee provides regularly scheduled reports on utilization patterns and their implications for program development. The DPBHS Leadership Committee and DPBHS representatives to various DSCYF working groups, such as Report Card, Information Management, and Safety Council and special projects to provides continuous input into planning processes.
- Research and continuing education: DPBHS has infrastructure and services, research grants, which keep staff members involved with current information and initiatives. All staff members have the opportunity to participate in training, and fulfill continuing education requirements and many have active roles in their professional organizations, providing additional sources of information for planning.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 163 of 186

IV: Narrative Plan

Table 11 List of Advisory Council Members

Page 51 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Anthony Brazen	State Employees	Medicaid	Div of Medicaid & Medical Assistance, 1901 N. Dupont HWY New Castle, DE 19720 PH: 302-255-9620	anthony.brazen@state.de.us
Connie Hughes	Providers	DelARF	100 W. 10th Street, Suite 103 Wilmington, DE 19801 PH: 302-622-9177	CHughes@delarf.org
Andrea Guest	State Employees	Vocational Rehabilitation	4425 N. Market Street Wilmington, DE 19802 PH: 302-761-8275	andrea.guest@state.de.us
Carol Harman	State Employees	Mental Health	Baratt Bldg, Suite 102, 821 Silver Lake Blvd Dover, DE 19904 PH: 302-739-8380	carol.harman@state.de.us
James Lafferty	Individuals in Recovery (from Mental Illness and Addictions)	Mental Health Association	100 West 10th Street, Suite 600 Wilmington, DE 19801 PH: 302-654-6833	JLafferty@mhainde.org
George Meldrum, Jr.	Individuals in Recovery (from Mental Illness and Addictions)	Nemours Health and Prevention Services	Christiana Bldg., Suite 200, 252 Chapman Road Newark, DE 19702 PH: 302-444-9071	Bandit47@Comcast.net

Janet Ray	State Employees	Education	401 Federal Street, Suite 2 Dover, DE 19901 PH: 302-735-4260	jaray@DOE.k12.de.us
Joseph Swiski	State Employees	Criminal Justice	PO Box 818 Dover, DE 19903 PH: 302-744-2670	joseph.swiski@state.de.us
Paula Voshell	State Employees	Housing	18 The Green Dover, DE 19901 PH: 302-739-4263	Paula@destatehousing.com
Chris DiSanto	Providers	Connections, CSP	500 W. 10th Street Wilmington, DE 19801 PH: 302-545-9836	cdisanto@connectionscsp.org
Lynn Fahey	Providers	Brandywine Counseling, Inc.	2713 Lancaster Avenue Wilmington, DE 19805 PH: 302-472-0381	faheyl@yahoo.com
James Larks	Providers	NET Centers	3315 Kirkwood Highway Wilmington, DE 19808 PH: 302-691-0140	jlarks@net-centers.org
Bruce Lorenz	Providers	Thresholds	20505 DuPont Blvd., Unit 1 Georgetown, DE 19947 PH: 302-856-1835	blorenz753@aol.com
Cheryl Biddle	Individuals in Recovery (from Mental Illness and Addictions)		110 Susan Place Dover, DE 19901 PH: 302-734-3027	cherylbiddleindoverdelaware@comcast.net
Sara Fishman	Others (Not State employees or providers)		Community Legal Aid Society, Inc. , 100 W. 10th Street, Suite 801 Wilmington, DE 19801 PH: 302-575-0690	sfishman@declasi.org
Edie McCole	Individuals in Recovery (from Mental Illness and Addictions)		12 Hillside Road Claymont, DE 19703 PH: 302-793-1941	ediemccole@comcast.net
William Rhines	Individuals in Recovery (from Mental Illness and Addictions)		Swanwyck Estates, 130 Dyer Avenue New Castle, DE 19720 PH: 302-571-9056	revwilliam_marierhines@msn.com

Justin Thompson	Individuals in Recovery (from Mental Illness and Addictions)	1201 Donna Marie Way Bear, DE 19701 PH: 302-836-1295	justin.thompson69@yahoo.com
John Akester	Individuals in Recovery (from Mental Illness and Addictions)	4900 Limestone Road Wilmington, DE 19808 PH: 302-239-1798	akester2@aol.com
Anne Deming, PhD	Others (Not State employees or providers)	651 Beaver Falls Place Wilmington, DE 19808 PH: 302-999-1666	anneldeming@aol.com
Steven Hagen	Individuals in Recovery (from Mental Illness and Addictions)	21116 Arrington Drive Selbyville, DE 19975	steven.hagen@hotmail.com
Wesley Jones	Others (Not State employees or providers)	1901 South College Avenue Newark, DE 19702 PH: 302-369-1501	gjonesii@christianacare.org
Elizabeth Pertzoff	Individuals in Recovery (from Mental Illness and Addictions)	100 W. 10th Street, Suite 303 Wilmington, DE 19801 PH: 302-655-3261	Topdog@dcgp.org
Susan Phillips	Others (Not State employees or providers)	414 Evergreen Circle Milford, DE 19963	ss.phillips@verizon.net
Mary Wicks	Individuals in Recovery (from Mental Illness and Addictions)	1208 Sunnyside Rd Smyrna, DE 19977 PH: 302-653-6448	rpmflowers@aol.com
Gary Wirt	Others (Not State employees or providers)	53 The Strand New Castle, DE 19720 PH: 302-225-6260	wirtgl@gbc.edu

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Page 52 of the Application Guidance

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	26	
Individuals in Recovery (from Mental Illness and Addictions)	10	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	0	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	15	57.69%
State Employees	6	
Providers	5	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	11	42.31%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Public Comment on State Plan

The Division published a solicitation for public comment on the 2012-2013 Combined Behavioral Health Assessment and Plan on Tuesday August 16, 2011 and Wednesday August 17, 2011 in the Legal Notices section of two Delaware newspapers that have state-wide readership:

1. The News Journal has a statewide readership base, but the newspaper predominately serves the New Castle County population.
2. The Delaware State News has a statewide readership base, but the newspaper predominately serves Kent and Sussex counties.

The solicitation provided members of the general public with information to access the State Plan via the DHSS/DSAMH website and it provided an opportunity for interested persons to schedule an appointment to review the State Plan in hard-form.

The full solicitation reads:

LEGAL NOTICE

FFY 2012-2013 Combined Behavioral Health Assessment and Plan (CBHAP)

The Division of Substance Abuse and Mental Health, Delaware Health and Social Services has developed a draft-application for the FFY 2012-2013 Combined Behavioral Health Assessment and Plan (CBHAP) The CBHAP Block Grant Application includes the State Plan for community mental heath services for adults and children, adults and children with substance use conditions, prevention services and other related services Individuals are invited to submit written comments and recommendations regarding the application's description of the intended use of the funds. Comments should be addressed to: Director, Division of Substance Abuse and Mental Health, 1901 North DuPont Highway, New Castle, DE, 19720. Faxed Comments may be transmitted to the Director at (302) 255-4427. All comments must be received no later than 4:30 p.m., Tuesday, August 30, 2011, to be considered.

The draft CBGAP application document is available for inspection from Monday, , August 15, 2011 through Tuesday, August 30, 2011 between the hours of 8:00 a.m. and 4:30 p.m. at: The Division of Substance Abuse and Mental Health Central Office, 1901 N. DuPont Highway, Main Building, New Castle, DE (302-255-9415) Please call to schedule an appointment to inspect the application.

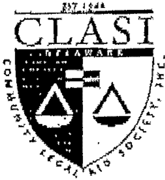
The 2012 – 2013 Combined Behavioral Health Assessment and Plan is also available online at:

Public comments will be incorporated into the FY 2012 – 2013 CBHAP application

In addition to the public notice, members of the State Mental Health Planning Council and the newly implemented CMHSBG Subcommittee to the GAC were provided an

opportunity to review and comment on the State Plan prior to submission. DSAMH also added a SAPTBG Subcommittee to the GAC to provide input into development of the plan and to provide comments.

FAX TRANSMISSION



DISABILITIES LAW PROGRAM OF
Community Legal Aid Society, Inc.
Community Service Building
100 W. 10th Street, Suite 801
Wilmington, DE 19801
302 575-0660 (p) 302 575-0840 (fax)
www.declasi.org

To: Kevin Huckshorn, Director, DSAMH

Fax #: 302-255-4427

From: Sarah Fishman, 302- 575-0660, ext.241

Subject: DLP Comments to FFY 2012 Community Mental Health Services Block Grant Application

Date: 8/29/2011

DOCUMENTS	NUMBER OF PAGES*
Letter	3
Attachments	3

***NOT COUNTING COVER SHEET. IF YOU DO NOT RECEIVE ALL PAGES, PLEASE TELEPHONE US IMMEDIATELY AT 575-0660. THANK YOU.**

The information contained in this facsimile message is confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to the above address via the U.S. Postal Service.

Thank you.

DISABILITIES LAW PROGRAM

COMMUNITY LEGAL AID SOCIETY, INC.

100 W. 10th Street, Suite 801
Wilmington, Delaware 19801
(302) 575-0660 TTY (302) 575-0696 Fax (302) 575-0840
www.declasi.org

August 29, 2011

By Email and Fax to (302) 255-4427
Kevin A. Huckshorn, Director
Division of Substance Abuse and Mental Health
Herman Holloway Campus
1901 N. DuPont Highway
New Castle, DE 19720

Re: Comments and Recommendations on FFY 2012 Community Mental Health Services Block Grant Application

Dear Ms. Huckshorn,

As you are aware, the Disabilities Law Program (DLP) of the Community Legal Society, Inc., is Delaware's Protection and Advocacy agency, charged with advocating for the rights of people with mental and physical disabilities in the State. The DLP provides free legal services on matters involving mental health to many individuals and families in Delaware.

The DLP is providing the following comments in response to DSAMH's invitation regarding the FFY 2012 Community Mental Health Services Block Grant (CMHS-BG). The DLP supports the priorities and services outlined by DSAMH and the Division of Prevention and Behavioral Health Services (DPBHS) and commends the State for its commitment to recovery and consumer-oriented treatment. While the DLP supports DSAMH and DPBHS's overall proposal, the DLP encourages DSAMH and DPBHS to consider the areas highlighted below for increased emphasis and consideration.

1. Address Discrepancies Between DSAMH and DPBHS Eligibility Criteria to Help Facilitate Youth Transition Services. The DLP agrees with the highlighted need in the DSAMH CMHS-BG for improved transition mechanisms and engagement tactics to successfully move youths into the adult behavioral health system. However, the DLP believes that some of the issues faced by youths aging out of the children's system are due to incompatible eligibility criteria between DSAMH and DPBHS. The DLP has represented clients aging out of the child mental health system who fail to qualify for adult mental health services because the diagnoses which qualified them for services through the children's system are not qualifying diagnoses for the adult system. As a result, youths who have been receiving services through DPBHS are determined ineligible for DSAHM when they reach age 18; consequently these young adults are left without mental health treatment and resources.

KENT COUNTY 840 Walker Road, Dover, DE (302) 674-8500
SUSSEX COUNTY 20151 Office Circle, Georgetown, DE (302) 856-0038

2. Improve Implementation of DSAMH and DPBHS Youth Transition Services Standards. Increased coordination is needed between DPBHS and DSAMH to ensure that transition planning begins and is successfully completed within an appropriate time frame. Although the current memorandum of understanding between DPBHS and DSAMH requires transition planning to begin at least 6 months prior to an individual's eighteenth birthday, it has been our experience that this agreement does not allow sufficient time to plan for complex cases and that the current timeline may not always be followed. Further, the current policy is problematic in that it does not provide a concrete time-line within which specific steps must be taken. The DLP suggests that the revised, more prescriptive, DSAMH - DPBHS transition policy be promulgated as a regulation, to allow public comment on the new policy and to promote uniform compliance.

   Additionally, the DLP suggests that DSAMH engage other state agencies that serve individuals with disabilities in the development of transition planning policies and as part of transition team in individual cases. Involvement of state agencies such as the Division of Developmental Disabilities Services, the Division of Services for the Aging and Adults with Physical Disabilities, and the Division of Medicaid and Medical Assistance (DMMA) in the transition planning process will help to ensure that young adults are less likely to be left without services.

3. Providing Training to Parents and Caregivers of Children with Serious Emotional Disturbance. As DSAMH has recognized, the involvement of an individual's support system in the treatment process can be critical. The DLP often represents children with Serious Emotional Disturbances (SED), who come from chaotic homes and their parents or caregivers may be ill-equipped to provide the level and depth of support their children require. DSAMH and DPBHS are encouraged to partner with schools and community providers to offere training and support specifically targeted to the parents and caregivers of children with SED. In particular, the DLP encourages skill development training which addresses effective ways to handle a child's negative behavior; skill development focused on increasing the parent or caregiver's communication, problem-solving, and stress/anger management skills; and educational resources on treatment options and available support services. Additionally, many parents and caregivers of children with SED feel isolated due to the severity of their child's needs, therefore increasing shared communication and support among parents and caregivers is critical.

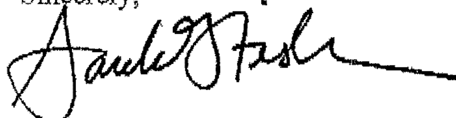
4. Increasing Housing Opportunities for Adults with Serious Mental Illness (SMI) and who have Been Found Guilty of Committing Sex Crimes. The DLP lauds DSAMH's goal of increasing permanent housing opportunities for persons served by the Delaware behavioral health system. However, individuals with SMI who have been found guilty of sex crimes are often those who have the greatest difficulty finding permanent housing. The attached articles highlight barriers to access to supportive housing experienced by sex offenders transitioning from institutional settings. The DLP encourages the State to improve access to supportive housing for persons with SMI who have been found guilty of a sex crime.

5. Improving Services for Children and Adults who are Deaf. In the DLP's comments last year, it raised the concern that there are very few deaf-competent mental health service providers available for individuals with SMI who are deaf. We reiterate that comment this year, and again highlight the need to hire more deaf competent clinicians. The DLP also suggests that DSAMH consider providing incentives for current clinicians to become deaf-competent.

Finally, the DLP encourages DSAMH to release the CMHS-BG application for public comment earlier in the summer. The DLP recognizes the significant time commitment and effort which goes into the creation of the DSAMH CMHS-BG application and it commends DSAMH for its careful consideration of the needs of the population it serves. However, the short time frame the public has to review the application and submit comments significantly curtails the ability of DSAMH to solicit meaningful public input. Moreover, given the short time frame in which the public has to consider and submit comments, there is even less time for DSAHM to fully consider and incorporate those comments into its final application.

Thank you for your consideration of the DLP's comments and suggestions.

Sincerely,



Sarah G. Fishman
Staff Attorney

Enclosures.

Cc: Susan Cycyk, Director, Division of Prevention and Behavioral Health Services (by email)
Jim Lafferty, Executive Director, Mental Health Association (by email)

Police get judge's OK to evict sex offenders near school

12:47 AM, Aug. 20, 2011|

Police were given the go-ahead Friday to evict sex offenders living at an East Side Wilmington house that is allegedly within the state's 500-foot prohibited school zone.

The American Civil Liberties Union of Delaware and attorneys for the Harriet Tubmans Safe House Inc., which shelters newly released inmates so they can re-enter society, had sought a temporary restraining order to prevent sex offenders living at the houses from being forced out. Chancery Court Vice Chancellor John W. Noble's ruling, however, does not throw out the case.

"The ACLU is disappointed that the judge did not grant a temporary restraining order ... until the facts and the legal questions of this case are resolved," said Kathleen MacRae, ACLU Delaware's executive director. "We believe this is an issue of fairness and public safety. It is in the community's best interest to provide appropriate housing, services and jobs for ex-felons, including registered sex offenders when they are released from prison.

"If these men are homeless, no one wins. They suffer and the safety of the community may be at greater risk."

At one point, about 24 people lived at the safe houses. But since Wilmington police informed them of the coming evictions, 13 registered sex offenders have moved out. Three others had remained.

Residents said they knew they would not be able to stay at the house in the 900 block of E. Seventh St. because it is 365 feet from the learning center on the grounds of Old Swedes Church, which is leasing out the rooms. But the men were hoping they would be allowed to stay at the second safe house in the 700 block of Buttonwood St., which is farther from the day care center.

How far the house is from the school is part of the dispute, as Wilmington police claim the house is 493 feet from the school -- or 7 feet short of the 500 feet the law mandates -- and Tubmans' attorneys say the house is 592 feet away.

Advertisement
Protect Your Home with ADT!
ADT AUTHORIZED DEALER
Click Here to Learn More!
Print Powered By FormatDynamics

In their lawsuit, the ACLU questions how police measured the distance between the homes and the daycare center, whether a daycare center qualifies as a "school" under state law and, if it does, the constitutionality of evicting men because the state law does not contain a "grandfather" provision for existing facilities like Tubmans House, which has operated since 2003. The day care center, whose license has been revoked, opened in September.

"I was hoping that we got a stay, because they were safe down here," said Earl W. Woodlen Jr., CEO of Tubmans Safe House. Woodlen, who started the re-entry program after battling drug problems when he was younger, said shelter was found for all but one of the offenders -- 52-year-old Richard Paredes.

"I'm looking for a place but I haven't found anything yet," said Paredes, a former teacher, who also works out of the home as a case manager trying to find jobs and permanent housing for the former offenders.

Paredes, who was convicted of two sexual offenses, has been homeless before because of the stigma and restrictions attached to the crime. Being homeless pushes people to want to give up on life, he said, adding his faith will get him through this.

"I know God will not abandon me," he said. "He will give me a place to go. Having faith is the most importantthing. Because without it, there are a lot of things that people will turn to."

Paredes cannot be living in the house on Monday, or he will be prosecuted.

Delaware Attorney General Beau Biden's office did not respond to questions about where these offenders will live if they are evicted. Biden's office has been consulting with Wilmington officials on the sex offenders' evictions.

Since his election in 2006, Biden has pushed to strengthen the state's laws to protect children from child predators.

Advertisement
Protect Your Home with ADT!
ADT AUTHORIZED DEALER
Click Here to Learn More!
Print Powered By FormatDynamics

This use of sex offender ban is unfairly punitive

11:39 PM, Aug. 15, 2011|

Efforts to stop the eviction of sex offenders living too close to a recently opened Wilmington day care center haven't gone far enough.

Since 2003, the Harriet Tubman Safe House has offered newly released inmates, including sex offenders, a place to stay for free for 30 days. The men can then pay rent to stay on after the 30 days.

In September, the day care center began operating less than 500 feet away, a violation of state law.

As offensive as the tenants' crimes are, they paid their debt to society and earned the right to purse law-abiding livelihoods. Their home predates the day care center by eight years.

This is not to dismiss the fact that even with treatment a high percentage of sex offenders -- pedophiles particularly -- will recommit their crimes.

But a carte blanche banishing of all sex offenders to be on the run every time they have found legally acceptable housing is vindictive, reactionary and no solution.

"Sex offender" is a widely inclusive term.

For this reason, courts have dismissed cases against teenagers on the verge of legal adulthood who have consensual sex with 16-year-old girlfriends. This is the necessary wisdom that should be applied when it comes to pre-existing safe houses.

With no record of criminal or civil violations, these properties deserve to be grandfathered as an appropriate zoning use.

Delaware's ACLU should also seek a mandate requiring municipalities to alert zoning applicants of the location of pre-existing safe houses and a ban on new business licenses that create a violation of state law.

This is fair to all interests, predominantly the safety of children.

Advertisement
Protect Your Home with ADT!
ADT AUTHORIZED DEALER
Click Here to Learn More!

Print Powered By FormatDynamics™

Governor's Advisory Council
to the
Delaware Health and Social Services/Division of Substance Abuse and Mental Health

August 31, 2011

The Honorable Jack Markell
Office of the Governor
Legislative Hall
Dover, Delaware 19901

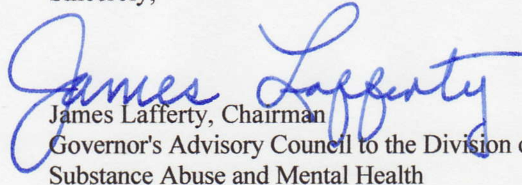
Dear Governor Markell:

Under 29 Delaware Code Sec. 7909, the Governor's Advisory Council to the Division of Substance Abuse and Mental Health serves in an advisory capacity to the Director of the Division of Substance Abuse and Mental Health and considers matters related to alcoholism, drug abuse and any other matters that may be referred to it by the Governor or the Department of Health and Social Services. In addition, the GAC-DSAMH serves as the State Mental Health Planning Council pursuant to the Public Health Service Act, Section 1914. In this capacity, the Council conforms to stipulated membership requirements and certain duties in the development, review and approval of the community mental health plans and implementation reports included in the annual CMHS Block Grant application.

In compliance with the regulations stipulated in P.L. 102-321, the Governor's Advisory Council of the Department of Health and Social Services/Division of Substance Abuse and Mental Health has reviewed the FY 2011 State Plans for Adults with Serious Mental Illness and Children with Serious Emotional Disturbances. In its deliberations, the Council has sought representation from the Child Mental Health Council. The Council approves both of these plans and has no recommendations for modifications to either document. Planning Council members and anyone that wishes to comment on the State Plan have been encouraged to submit their feedback regarding the State Plan via the webBGAS electronic system or via hard copy sent to the attention of the Director of DSAMH. All comments regarding the State Plan have been taken into consideration during the construction of the State Plan. All comments regarding the State Plan have been forwarded to SAMHSA.

The Governor's Advisory Council is pleased to support the efforts of the Division of Substance Abuse and Mental Health and the Division of Child Mental Health Services to develop a comprehensive community support system for the adults with serious mental illness and children with serious emotional disturbances and urges that full consideration and support be given to their respective community mental health plans.

Sincerely,



James Lafferty, Chairman
Governor's Advisory Council to the Division of
Substance Abuse and Mental Health

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

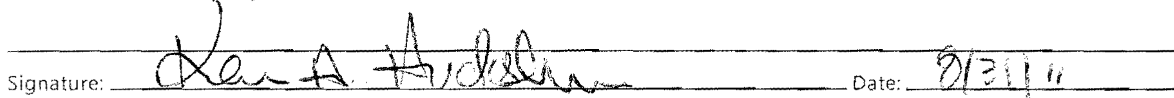
1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
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.

Name: Kevin A. Huckshorn

Title: Director

Organization: DHSS/DSAMH



Signature: ______ Date: 8/31/11

Footnotes:

I: State Information

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 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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

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)

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.

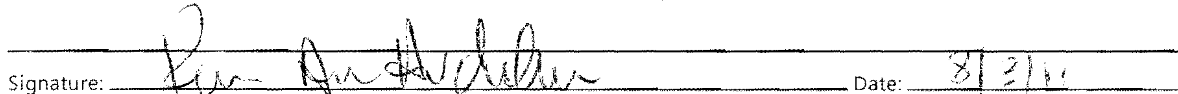
Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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.

Name	Kevin Huckshorn
Title	Director
Organization	DHSS/DSAMH



Signature: ____________ Date: 8/2/11

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

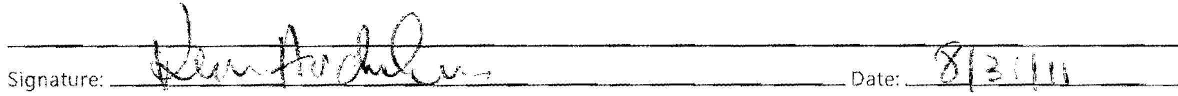
XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Delaware will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as 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.

Name	Kevin Huckshorn
Title	Director
Organization	DHSS/DSAMH



Signature: ______________________ Date: 8/3/11

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Delaware agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[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 (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

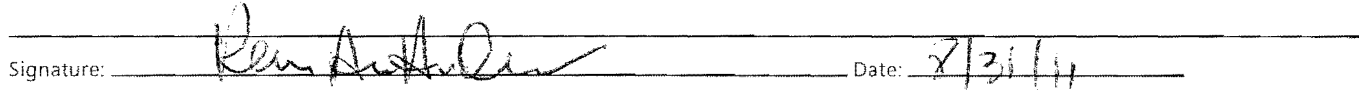
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Kevin A. Huckshorn
Title	Director
Organization	DHSS/DSAMH



Signature: ________ Date: 8/31/11

Footnotes: