

# Delaware

## UNIFORM APPLICATION

### FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020  
(generated on 09/01/2017 12.01.43 PM)

Center for Substance Abuse Prevention  
Division of State Programs

Center for Substance Abuse Treatment  
Division of State and Community Assistance

and

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

# State Information

## State Information

### Plan Year

Start Year 2018

End Year 2019

### State SAPT DUNS Number

Number 134632624

Expiration Date

### I. State Agency to be the SAPT 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 SAPT Grantee of the Block Grant

First Name Clarence

Last Name Watson

Agency Name Delaware Health & Social Services, Division of Substance Abuse and Mental Health

Mailing Address 14 Central Avenue

City New Castle

Zip Code 19720

Telephone 302-255-9398

Fax 302-255-4427

Email Address Clarence.Watson@state.de.us

### State CMHS DUNS Number

Number 1346326240

Expiration Date

### I. State Agency to be the CMHS 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 Admin Building

City New Castle

Zip Code 19720

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

First Name Clarence

Last Name Watson

Agency Name Delaware Health & Social Services, Division of Substance Abuse and Mental Health

Mailing Address 14 Central Avenue

City New Castle

Zip Code 19720

Telephone 302-255-9398

Fax 302-255-4427

Email Address Clarence.Watson@state.de.us

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

From

To

IV. Date Submitted

Submission Date 9/1/2017 12:00:28 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Susan

Last Name Holloway

Telephone 302-255-2714

Fax 302-270-4427

Email Address Susan.Holloway@state.de.us

Footnotes:

# State Information

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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 Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

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

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

## LIST of CERTIFICATIONS

### 1. CERTIFICATION REGARDING LOBBYING

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

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

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

### 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Clarence Watson

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Acting Division Director

Date Signed: \_\_\_\_\_

mm/dd/yyyy

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



Footnotes:



STATE OF DELAWARE  
**OFFICE OF THE GOVERNOR**

TATNALL BUILDING, SECOND FLOOR  
MARTIN LUTHER KING, JR. BOULEVARD SOUTH  
DOVER, DELAWARE 19901

**JOHN CARNEY**  
GOVERNOR

PHONE: 302-744-4101  
FAX: 302-739-2775

August 22, 2017

Ms. Kana Enomoto  
Acting Deputy Assistant Secretary  
Substance Abuse and Mental Health Services Administration  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Enomoto:

As Chief Executive Officer of the State of Delaware, I designate the Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health as the sole administering agency in the State of Delaware for the following federal programs funded through the Substance Abuse and Mental Health Services Administration:

- Community Mental Health Services (CMHS) Block Grant
- Substance Abuse Prevention and Treatment (SAPT) Block Grant
- Projects for Assistance in Transition from Homelessness (PATH) Formula Grant

This designation shall remain in effect until further notice.

I also delegate authority to the Secretary of the Delaware Department of Health and Social Services to certify all required assurances, funding agreements, and certifications for the above referenced programs and to submit the annual applications and plans until such time as this delegation of authority might be rescinded. Please be informed that the Secretary of the Delaware Department of Health and Social Services is Dr. Kara Odom Walker, MD, MPH, MSHS.

Sincerely,

A handwritten signature in blue ink that reads 'John C. Carney'.

John C. Carney  
Governor  
State of Delaware

cc: Kara Odom Walker, Cabinet Secretary, Delaware Department of Health and Social Services.

# State Information

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	<a href="#">42 USC § 300x</a>
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	<a href="#">42 USC § 300x-1</a>
Section 1913	Certain Agreements	<a href="#">42 USC § 300x-2</a>
Section 1914	State Mental Health Planning Council	<a href="#">42 USC § 300x-3</a>
Section 1915	Additional Provisions	<a href="#">42 USC § 300x-4</a>
Section 1916	Restrictions on Use of Payments	<a href="#">42 USC § 300x-5</a>
Section 1917	Application for Grant	<a href="#">42 USC § 300x-6</a>
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Clarence Watson

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Acting Division Director

Date Signed: \_\_\_\_\_

mm/dd/yyyy

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

Footnotes:





STATE OF DELAWARE  
**OFFICE OF THE GOVERNOR**

TATNALL BUILDING, SECOND FLOOR  
MARTIN LUTHER KING, JR. BOULEVARD SOUTH  
DOVER, DELAWARE 19901

**JOHN CARNEY**  
GOVERNOR

PHONE: 302-744-4101  
FAX: 302-739-2775

August 22, 2017

Ms. Kana Enomoto  
Acting Deputy Assistant Secretary  
Substance Abuse and Mental Health Services Administration  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Enomoto:

As Chief Executive Officer of the State of Delaware, I designate the Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health as the sole administering agency in the State of Delaware for the following federal programs funded through the Substance Abuse and Mental Health Services Administration:

- Community Mental Health Services (CMHS) Block Grant
- Substance Abuse Prevention and Treatment (SAPT) Block Grant
- Projects for Assistance in Transition from Homelessness (PATH) Formula Grant

This designation shall remain in effect until further notice.

I also delegate authority to the Secretary of the Delaware Department of Health and Social Services to certify all required assurances, funding agreements, and certifications for the above referenced programs and to submit the annual applications and plans until such time as this delegation of authority might be rescinded. Please be informed that the Secretary of the Delaware Department of Health and Social Services is Dr. Kara Odom Walker, MD, MPH, MSHS.

Sincerely,

A handwritten signature in blue ink that reads "John C. Carney".

John C. Carney  
Governor  
State of Delaware

cc: Kara Odom Walker, Cabinet Secretary, Delaware Department of Health and Social Services.



# State Information

## Disclosure of Lobbying Activities

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

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

---

Name

Title

Organization

---

Signature:

Date:

Footnotes:

Not Applicable. No lobbying activities have taken place

## Planning Steps

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

Narrative Question:

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

Footnotes:

**STEP ONE: Assess the strengths and organizational capacity of the service system to address the specific populations.**

**Organizational Overview**

The Delaware Department of Health and Social Services is the largest agency in state government employing more than 4,000 persons, which affect all State residents through the provision of services through 11 Divisions and 4 programmatic areas. The Department's Divisions provides services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.

The Department's mission and vision statements are simple yet profound:

***Mission Statement:*** *To improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations*

***Vision Statement:*** *"Together we provide quality services as we create a better future for the people of Delaware."*

*The organizational priorities are as follows:*

- Maximize Personal and Family Independence
- Be a self-correcting organization working to retool to keep pace with changing client needs and a changing service delivery environment

*The organizational goals include:*

- DHSS will be customer service focused
- DHSS will be driven by a shared vision
- DHSS will communicate effectively, both internally and externally
- DHSS will live its Beliefs, Principles, and Management Principles
- DHSS will function as an integrated organization, which partners with outside organizations to improve the quality of services provided to our clients

The Department's Division of Substance Abuse and Mental Health (DSAMH) is the single state agency (SSA) for the State of Delaware for mental health and substance abuse prevention and treatment, coordination of state and federal funding, and development of standards for the certification and approval of prevention and treatment programs. The Substance Abuse and Mental Health Services Administration (SAMHSA), provides funding for DSAMH to implement substance abuse prevention and treatment, and mental health services in the State of Delaware.

As the SSA, DSAMH receives and administers funding of the Substance Abuse Block Grant from SAMHSA. DSAMH has been a recipient of the SABG Block Grant since the

Federal Fiscal Year (FFY) 1992. DSAMH utilizes the majority of these funds to support a statewide behavioral health system that provides services such as detoxification, outpatient, and inpatient programs for the children, youth and adult populations. The SABG also includes requirements related to prevention services and maintaining compliance with the prevention requirements of the SABG. DSAMH allocates a minimum of 20% of the total award each year to provide substance abuse prevention programs targeting youth and adults in our state.

***DSAMH's Mission:*** *To promote health and recovery by ensuring that Delawareans have access to quality prevention and treatment for mental health, substance use, and gambling conditions.*

***DSAMH's Vision:*** *Always the Right Time, Always the Right Place, To Get the Right Service.*

The major goals of the Division include:

- The consumer is a partner in service delivery decisions
- Delawareans receive mental health, substance use and gambling prevention and treatment services in a continuum of overall health and wellness
- Disparities in substance use and mental health services are eliminated
- Develop the clinical knowledge and skills of workforce
- Promote excellence in care

Technology is used to access and improve care and to promote shared, real-time, information dissemination, quality and efficiency in management and administration.

### ***DSAMH 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 DSAMH's Central Office. The Central Office has the following responsibilities:

- Implementing Delaware's Health and Social Services policies
- 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 administrative functions and key positions include:**

- DSAMH Director reports directly to the Cabinet-level Secretary for DHSS and oversees all positions and functions in the Division.
- DSAMH Deputy Director, has responsibility for the Office of Consumer Affairs, Provider Relations and Strategic Planning.
- Delaware Psychiatric Center Director oversees the state's sole state psychiatric hospital, DPC;
- Director of Administrative Services has responsibility for MIS, Quality Assurance, and, Licensure and Certification;
- Director of the Fiscal Office has responsibility for the overall fiscal management of the Central Office;
- Director for Planning and Program Development oversees all of DSAMH's grants, policies, and procedures ;
- Director of the Education and Training Office oversees DSAMH's intra-agency and community training programs;
- The Director of Community Mental Health oversees the mental health system including The Eligibility and Enrollment Unit; Mobile Crisis Intervention centers, The PROMISE Assessment Centers, and the array of contracted providers through the state; and,
- The Director of Substance Abuse Services and Gambling Affairs oversees the Treatment Access Service Centers and the array of contracted substance abuse providers and gambling services for the Division.

## **State Behavioral Health Provider System**

The State's behavioral health system for children, youth and adults is currently located within two State agencies, DSAMH and the Division of Prevention and Behavioral Health Services ("DPBHS"). DSAMH service provision is focused on individuals 18 years of age or older, while DPBHS service provision is for children and youth under age 17.

DPBHS is located within the Department of Services for Children, Youth and Their Families ("DSCYF"). DSCYF was established in 1983 by the General Assembly of the State of Delaware, and has the primary responsibility of providing and managing a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, and/or substance abuse. DSCYF services include prevention, early intervention, assessment, treatment, permanency, and after care. DSCYF leads a system of care approach (both community-based and residential) that is child-centered and assures effective, timely and appropriate support for Delaware's children. DPBHS' treatment services are accredited under the Commission on Accreditation of Rehabilitation Facilities ("CARF"). In addition, the contracted and/or state operated treatment providers within the DPBHS network are licensed where appropriate, and most are accredited under one of the nationally recognized accrediting agencies such as CARF, JCAHO, COA or CHAP<sup>1</sup>.

The two Divisions (DPBHS and DSAMH) in the two Departments (DSCYF and DHSS) have developed Memorandums of Understanding<sup>ii</sup> (“MOU”) to formalize the respective roles and responsibilities of each of the divisions. The MOUs are intended to guide the implementation, data collection, and reporting strategies for both entities in alignment with the statutory regulations of the Substance Abuse Prevention and Treatment Block Grant.

There is an ongoing effort by both DSAMH and DPBHS to ensure that the services are reflective of a seamless, single system of care. The administrative structure of the provision of services is in alignment with State legislative mandates.

Although DSAMH works collaboratively with all DHSS Divisions, the primary collaborator within DHSS is the Division of Public Health (DPH) whose mission and vision are most compatible. DPH is a nationally accredited state health agency. The Division of Public Health (DPH) exists to protect and promote the health of all people in Delaware. To gauge effectiveness in meeting this mission, DPH conducts a rigorous effort of data collection and monitoring of health outcomes and continual engagement of strategies to improve health outcomes for Delawareans. Outside DHSS, DSAMH’s closest collaboration is with DPBHS. DPBHS, housed within the Department of Services to Children, Youth and their Families provides ongoing administrative oversight and program management for M/SUD for individuals under the age of 17. Other collaborations are with the Department of Education, which, through statewide school districts, provides students with health related education, which includes SUD and its relationship to MH. The collaboration with the Division of Alcohol, Tobacco Enforcement (DATE) provides enforcement and direct public safety efforts through compliance checks and the impact of alcohol, drugs and driving. Finally, collaboration with the Office of Highway Safety provides public education, data collection and information dissemination.

## **DELAWARE’S BEHAVIORAL HEALTH SYSTEM**

Delaware’s publicly funded, community-based behavioral health system is a comprehensive, culturally competent continuum of care. The system is responsive to the diversity within the State’s populations which are linguistically appropriate; a combination of rural and urban; with a socio-economic base that spans from a range below the federally defined criteria for poverty to economic affluence.

The State’s Behavioral Health system along with its contracted providers, have developed and implemented a person-centered, recovery-oriented system of care for the consumers we serve. Services provided are expected to be trauma-informed and equipped to working with consumers with co-occurring disorders, including those with histories of trauma. These fundamental principles are inherent and expected in each scope of service. Every aspect of working with consumers, including: the role of peers, screening, assessment, treatment planning, service provision, case management, social service and other, must be sensitive to these core principles. Contract monitoring and

performance improvement activities will be geared toward assuring these core principles are in place. It is DSAMH's intentions to design (when not present) and institute performance based contracts operationalizing these and other principles.

The Behavioral Health System operates primarily through contracts with public and private agencies to implement a comprehensive continuum of care, inclusive of primary prevention and treatment services. Treatment services include: outpatient evaluation and counseling; medication-assisted outpatient detoxification and treatment; care management services, including intensive multidisciplinary teams; variable length of stay residential programs; and, residential detoxification services.

## **PREVENTION SERVICES**

DSAMH and DPBHS develop and implement prevention services through the State's four planning regions: New Castle, Kent and Sussex Counties and the City of Wilmington. The current service delivery system is a combination of children, youth and adult services that are responsive to a plethora of factors including but not limited to age, gender, race/ethnicity, culture, sexual orientation, and socio-economics. Communities within the State with high Spanish speaking populations, services and printed materials are linguistically appropriate. Although numerous attempts have been made, there is no substantive relationship with the State's two Native Tribes: Lenape and Nanticoke.

Delaware's current prevention service system focuses on primary prevention (individuals not in need of treatment). DSAMH and DPBHS have adapted the SAMHSA's Strategic Prevention Framework (SPF) within Delaware's substance abuse prevention infrastructure which has attributed to the efficient implementation of primary prevention activities by the State. Services are provided within the parameters of the Institute of Medicine classifications: universal (direct or indirect), selective, and indicated interventions and through prevention strategies: information dissemination, education, alternatives, problem identification and referral, community-based processes and environmental.

## **SHARED MISSION AND VISION**

Going forward to ensure a comprehensive, culturally competent, consistent array of services DSAMH and DPBHS will develop the following guidance documents:

- Strategic Substance Abuse Prevention Plan
- Consistent Program Reporting and Monitoring Protocols
- Consistent Data Collection and Reporting Protocols
- Annual Professional Development Calendar
- Increased Community Coalitions
- Development of a Statewide Prevention Coalition

## **YOUTH PREVENTION**

### ***Division of Prevention & Behavioral Health Services***

The SABG primary prevention services managed by DPBHS are provided through contracts with community coalitions, community-based agencies, universities, and private vendors.

DPBHS allocates SABG prevention funding to 5 community-based agencies to implement evidence-based substance abuse prevention programs and practices.

The following is a description of each organization, the services to be provided, and the target population(s):

***Kent Sussex Community Services (“KSCS”)*** is a non-profit organization providing a wide-range of alcohol and other drug and behavioral health services in sub state planning regions in Kent County since 1970, and in Sussex County since 1995.

KCCS proposes to implement the Prime for Life curriculum to youth and their families, ages 12-17 in the towns/cities of Dover, Smyrna, Milford, Greenwood, Lincoln and Laurel. Prime for Life is an evidence-based motivational prevention, intervention and pre-treatment program specifically designed for people who might make high-risk choices. This includes but is not limited to impaired driving offenders, college students, and young people charged with alcohol and/or drug offenses. It is designed to change drinking and drug use behaviors by changing beliefs, attitudes, risk perceptions, motivations, and the knowledge of how to reduce their risk of alcohol and drug related problems throughout their lives. Because Prime for Life includes both prevention and intervention content, it is also designed in a way that serves universal, selective, and indicated audiences with program delivery options for each. Families that complete the Prime for Life education sessions will have the opportunity to participate in alternative activities such as educational/cultural field trips and events. KSCS will continue to support the activities of the Sussex County Action Prevention Coalition by attending monthly meetings and coalition events. KSCS will also attend health fairs and community events to disseminate substance use prevention materials.

***New Castle Prevention Coalition (NCPC)*** is a coalition of stakeholders that are committed to addressing problems facing the Route 9 community in the sub state planning region of New Castle County, such as underage use and abuse of alcohol, tobacco and other drugs, crime, unemployment and underemployment, elevated high school dropout rates and community estrangement from local educational institutions.

NCPC proposes to implement the Ripple Effects software programs and Life Skills. The *Ripple Effects* whole spectrum prevention program will be used with middle school students. Ripple Effects software programs can be used as curricula for systematic, positive behavioral training in many areas: social-emotional skill building, suspension alternatives, character education, violence prevention, substance abuse prevention, health education, diversity appreciation, pregnancy prevention, AIDS/HIV awareness, bullying, and more. The spine of each program is the seven-key social-emotional skills identified through research as crucial to life success. Ripple Effects has broken these



skills down into bite-size, learnable elements, and combined them in different ways to solve a range of behavioral, health, and social challenges.

The Botvin Life Skills program will be used with high school students. The Botvin *LifeSkills Training* High School program is a highly interactive, skills-based program designed to promote positive health and personal development for high school youth. Based on the highly effective *LifeSkills Training* curriculum, this program helps adolescents navigate the challenges of the high school years and prepares them for the independence and responsibilities that they will encounter as young adults.

The *LifeSkills Training* High School program uses developmentally appropriate, collaborative learning strategies to help students achieve competency in the skills that have been shown to prevent substance use, violence, and other health risk behaviors. NCPC will disseminate substance use prevention materials at activities conducted by the Coalition, community meetings and through video productions developed by program participants and aired on local television stations. NCPC will continue to strengthen and enhance the coalition's infrastructure and capacity to coordinate their efforts across the sub state planning region of New Castle County through the development of strategic and action plans.

***Open Door, Inc.*** serves as the lead and fiscal agency for the ***Southern New Castle County Communities Coalition (SN4C)***. In 2008, the Southern New Castle County Communities Coalition, which focuses on the communities within the Appoquinimink School District, came under the leadership of Open Door, Inc. Open Door Inc. is a private, non-profit organization that provides a comprehensive range of behavioral health services including mental health, substance abuse and psychosocial services throughout Delaware (New Castle, Kent and Sussex Counties). Open Door, Inc. is an affiliate of Holcomb Behavioral Health Systems. The mission of the Southern New Castle County Communities Coalition is to prevent youth substance use and abuse to produce healthy, stable, family oriented communities.

***Southern New Castle County Communities Coalition (SN4C)*** proposes to implement the Prime for Life curriculum to middle and high school students in the sub state planning region of southern New Castle County. Prime for Life is an evidence-based motivational prevention, intervention and pretreatment program specifically designed for people who might be making high-risk choices. This includes but is not limited to impaired driving offenders, college students, and young people charged with alcohol and/or drug offenses. It is designed to change drinking and drug use behaviors by changing beliefs, attitudes, risk perceptions, motivations, and the knowledge of how to reduce their risk of alcohol and drug related problems throughout their lives. Because Prime for Life includes both prevention and intervention content, it is also designed in a way that serves universal, selective, and indicated audiences with program delivery options for each. SN4C will publish and post Stall Stories, which is a monthly poster publication featured in the restrooms of community businesses, organizations and agencies frequented by families and youth. Stall Stories will serve as media messaging to keep community members informed on youth substance abuse trends data from the County and State School Survey results. SN4C will provide families with the Scholastic

over-the-counter (OTC) Medicine Safety Guide on Home Safety Tips for Families. SN4C will also conduct Park Safety Audits an environmental approach to reducing underage drinking in community parks. Park audits seek to improve the perceived safety of the park. In doing so, residents can reclaim the park for its intended use.

**Delaware 4-H, through Delaware Cooperative Extension at the University of Delaware** proposes to implement LifeSkills program to elementary and middle school students in the sub state planning regions of New Castle County, Kent County and Sussex County the LifeSkills Training Elementary School program is a comprehensive, dynamic, and developmentally appropriate substance abuse and violence prevention program designed for upper elementary school students. This highly effective curriculum has been proven to help increase self-esteem, develop healthy attitudes, and improve their knowledge of essential life skills - all of which promote healthy and positive personal development. The LifeSkills Training High School program is a highly interactive, skills-based program designed to promote positive health and personal development for high school youth. Based on the highly effective LifeSkills Training curriculum, this program helps adolescents navigate the challenges of the high school years and prepares them for the independence and responsibilities that they will encounter as young adults. The LifeSkills Training High School program uses developmentally appropriate, collaborative learning strategies to help students achieve competency in the skills that have been shown to prevent substance use, violence, and other health risk behaviors.

**West End Neighborhood House** is a registered 501c3 organization, whose mission is to help individuals achieve self-sufficiency, reach and maintain their maximum potential, and live responsibly and harmoniously in a healthy community and complex world. For over 15 years, West End has participated in prevention coalitions and partnerships and implemented prevention programs.

West End proposes to implement the evidence-based All Stars to middle school students in the sub state planning regions of New Castle County and the City of Wilmington. All Stars is a school-based program for middle school students (11-14 years old) designed to prevent and delay the onset of high-risk behaviors such as drug use, violence, and premature sexual activity. West End will support the efforts of the Delaware Prevention Coalition, a voluntary network of individuals and organizations working together to create safe, healthy, drug-free communities. Through the years, DPC staff and volunteers have committed countless hours providing substance abuse prevention information, organizing community events, building work groups, and connecting the purpose of prevention to the people. Youth Prevention Frontliner groups (ages 13-17) through the Delaware Prevention Coalition will continue to support adult staff in schools and communities to lead and promote student advocacy groups, and educate their peers on the dangers of substance use. The Coalition will collaborate with local officials, community leaders, and members from various sectors of the community to implement alternative activities that foster positive engagement for youth.

The SABG also funds the following prevention resources and supports below:

- The Resource Center located within the Prevention Unit in Wilmington, Delaware, provides substance use prevention resources for youth, parents, schools, and communities. The State has a contract with the Channing Bete Company in Deerfield, Massachusetts to purchase and ship directly to the customer a variety of prevention booklets, self-care handbooks, workbooks, brochures, and pamphlets. The Resource Center provides access to research-based substance abuse prevention, treatment and recovery materials, information, and resources to those working in substance abuse and related fields, community coalitions, local and state agencies, community and faith-based organizations, school districts and the public and others in Delaware. The Resource Center has served more than 65 agencies statewide. The Resource Center is staffed by a Program Analyst funded by the SABG. Contracts will be maintained with the University of Delaware Center for Drugs and Health Studies evaluate prevention services.
- MOSAIX Software, Inc. services will be used to support the data infrastructure of Delaware's prevention system to collect and report NOMS, program level data, and in the future fiscal expenditures.

In FFY 2018-2019, DPBHS anticipates serving over 1,000 youth with SABG funds. A Family Services Program Administrator and Program Analyst funded through the SABG monitors and supports SABG services.

In addition to the SABG, DPBHS also provides prevention and early intervention services through other state and federal funding sources as described below:

- Afterschool and summer evidence-based or promising programs are implemented with 29 community-based agencies to provide opportunities for youth aimed at the prevention of suicide, violence and substance abuse.
- Delaware Fatherhood & Family Coalition (DFFC) is an extension of the Promoting Safe and Stable Families Program and the Responsible Fatherhood Initiative. DFFC is an advocacy coalition with diverse and unified membership, created specifically to give a voice to fathers and the importance of father involvement in the overall well-being of their children. Families and Centers Empowered Together (FACET) is a family support and empowerment program located in 5 child care centers. FACET is designed to strengthen families through educational and life-enhancing /stress relieving activities, and other support services. These activities and support services are chosen by the parents through a Parent Empowerment Council designed to promote their involvement control over the program.
- Youth Suicide Prevention Initiatives are implemented through the Garret Lee Smith (GLS) grant. Professionals are trained in the Assessing and Managing Suicide RISK (AMSR) curriculum. Suicide prevention education is provided to state and school personnel and the public. This effort integrates suicide screening into primary care medicine practices, and working with the Behavioral

Health Consultants in middle schools on risk screening for suicide using a web based tool.

### **Early Intervention Services**

**Promoting Safe and Stable Families** is a family support and preservation program which provides consultation services to families who are “at risk or in crisis” due to one or a combination of stressors that may lead to child maltreatment. The program uses a unique intervention technique that assists parents to become the driving force behind a family planning process where concerns and needs are assessed, informal and formal support systems are identified and developed and plans are created to assist families to meet their goals.

**Intensive Family Consultation** is an intervention services program designed to support families who are experiencing more complex issues in their lives. These multiple complex needs are associated with parent /child conflict, substance abuse, family instability associated with homelessness, single parent stressor and isolation, blended family stressors, unresolved mental health needs, absence of supports and resources, etc. IFC Services uses a team approach to assist the family in creating opportunities to acquire competencies that will permit them to mobilize supports necessary to cope, adapt, and grow in response to life’s many challenges and empower families by giving them the tools needed to care for and protect their children; improve their family functioning; build connections to various support networks within their community; and self-advocate.

### **Delaware Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health)**

aims to promote the wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive, and behavioral aspect of their development. The coordination of child-serving systems and the integration of behavioral and physical health services drive this work to ensure children are thriving in safe, supportive environments and entering school ready to learn.

Delaware Project LAUNCH focuses on neighborhoods with multiple environmental risk factors and gaps in services and supports for youth children, birth to 8 years, and their families. These communities are areas of high poverty have experienced high crime and violence and have few, if any high quality early care and education programs. There are five core prevention and promotion strategies identified by SAMHSA for Project LAUNCH: Screening and assessment in a range of child-serving settings; integration of behavioral health into primary care; mental health consultation in early care and education; enhanced home visiting with a focus on social and emotional well-being; and family strengthening and parent skills training.

**Early Childhood Mental Health Consultation (ECMHC)** is a year-round service provided by licensed mental health consultants who are available to any licensed early learning programs statewide in Delaware. ECMHC is a free service that supports young children’s (infants, toddlers and preschoolers) social and emotional development in early childhood education settings. Through on-site consultation, coaching, modeling and training from clinically licensed Early Childhood Mental Health Consultants, early

educators are obtaining the tools necessary for behavior management in the classroom and supporting the social and emotional development of young children. This service ultimately reduces incidents of disruptive behaviors, builds collaborative relationships and enhances social and emotional skills in children. Additionally, the ECMHC service is one strategy that effectively reduces suspension and expulsion in early learning settings. The service has consistently shown a 98% success rate in avoiding suspensions/expulsions. Additionally, the service has demonstrated that changes in teacher behavior leads to changes in classroom climate and reduction in children's problem behavior and an increase in positive behavior.

**Family Crisis Therapists (FCT)** who provide services to K-5 schools to improve the school environment for children and families. This program addresses issues within the home that affect performance in the classroom. The goal is to enable families to support the social and academic growth and the healthy development of children so they may attain positive outcomes in school. This is a collaborative effort between the Department of Services for Children, Youth and Their Families (DSCYF), Division of Prevention and Behavioral Health Services, the Department of Education (DOE) and participating public school districts. Participation in the program is for children attending Kindergarten through fifth grade and their families. Currently there are 52 FCTs in K-5 schools throughout the state.

**The Behavioral Health Consultation Program** is comprised of Licensed Mental Health Professionals (Behavioral Health Consultants) who work to identify at risk youth and provide brief mental health services to students in middle schools throughout the State of Delaware. The Behavioral Health Consultation Program (BHCP) currently has 30 Licensed Mental Health Clinicians. The goal of the program is to identify students and families who are vulnerable and at-risk. The interventions include but are not limited to: screen identified students for mental and behavioral health related concerns; make referral for primary prevention services and more intensive therapeutic clinical services for the identified students, if needed; provide brief counseling services if needed; expand targeted *intervention* for vulnerable students in designated middle schools via enhanced screening and counseling support from licensed practitioners; and positively impact behavioral *indicators* (e.g., *Attendance, Behavioral Incidents and Suspension, and Developmental Assets*).

### **Adult Prevention Services**

DSAMH currently has prevention services contracts with three community-based providers, which provide services in three of the four planning regions, New Castle County, Kent County and the City of Wilmington. The community contractors use data to identify and implement appropriate universal, selective, and indicative programs throughout the state. The target populations do not include individuals who need treatment or have been diagnosed with a substance abuse disorder. The following is a description of each organization, the services provided, and the target population:

**Brandywine Counseling & Community Services (“BCCS”)** BCCS is a community-based substance abuse treatment and prevention program which describes itself as a,

“resource that transforms the way society responds to how people view the multiple dimensions of prevention and recovery. With the goal to promote hope and empowerment to persons who are not in need of treatment (primary prevention), addiction, mental health and HIV related challenges....” BCCS proposes to implement a statewide prevention campaign that will address substance abuse prevention including alcohol, marijuana, prescription opiate, and heroin risk through the adaptation of Challenging College Alcohol Abuse (evidence-based practice), as well as peer- to-peer interactions and universal prevention messaging. The target populations are considered universal, selective, and/or indicated, based on the risk and needs of the Community. As a state-wide grantee, much of its service provision efforts focus on community processes, information dissemination, and supporting other grantee’s alternative activities. Through these efforts awareness is expected to be increased around the risks and consequences of underage and binge drinking. Their efforts are aimed to help mobilize Delaware to create at least one Environmental Strategy with a focus on catalyzing policy changes through collaborative efforts with other substance abuse prevention providers. **Central Delaware Committee on Drug and Alcohol Abuse (“KSCS”)**

**KSCS was** established in 1970, as a private non-profit corporation and is the parent organization of Kent Sussex Community Services. KSCS addresses the Sussex County Delaware Hispanic youth and young adults ages 12 – 25 as well as others in the community through the CSAP strategies of Information Dissemination and Prevention Education with their monthly delivery of Prime for Life. Prime for Life® is an evidenced-based prevention education and motivational risk reduction program. It is used most with people who have had a legal or policy violation such as impaired driving, possession, or workplace violation, but it is relevant for all. Prime for Life helps foster attitudes, beliefs, and understanding that helps people reduce risk for any type of alcohol or drug problem. Community-based processes are built through the prevention coalitions of KCAPC and SCAPC and documented collaborations with BGC, Wesley, DSU, BCCS<sup>iii</sup> and other entities that host and/or support family/community/business/agency efforts to prevent the onset of alcohol and prescription drug use of youth and young adults ages 12 – 25. KCAPC and SCAPC promotes advocacy skills, monthly coalition meetings and town hall forums.

**Latin American Community Center (“LACC”) LACC**

El Centro Latino was founded in 1969 by a small group of Puerto Rican migrants seeking to address the immediate needs of members of their community as they adapted to life in a new country, and in most cases, to a new language. LACC helps the Wilmington Latino community address primary prevention through 50+ programs, offered daily. Of these programs, three are designed to assist 12-25-year old’s, and their families. They are aligned to work collaboratively in addressing Wilmington Latino families’ prevention-related health disparities. One of the programs offered is called *Prevention Promoters*, and it delivers the *Healthy Families* program initiative aimed to connect Wilmington and New Castle County Latino families to prevention healthcare. The program assists in providing detailed assessments of health needs and the identification of barriers to obtaining preventative based care, with an emphasis on

servicing 12-25-year olds, the *Healthy Families* coordinator makes appropriate referrals to services and care. These two areas are part of the problem identification and referral section within the Block Grant. In addition, the *Prevention Promoters* Prime for Life curriculum is the tool used for prevention education used. *LACC Evening Enrichment* programs provide alternative activities such as swimming, yoga and exercise classes for 12-25-year-olds. These activities are introduced to the families to assist in their lifestyle changes to move towards health and away from substance use and abuse.

The current DSAMH Substance Abuse (SA) Prevention staff includes three contracted employees and a SAMSHA Prevention Fellow. Additional administrative oversight is through the coordinated efforts of the DSAMH Fiscal and Contract Units.

### **Additional Prevention Resources**

#### ***Strategic Prevention Framework State Incentive Grant (SPFSIG)***

In 2009, DSAMH received a SPF SIG from SAMHSA/CSAP. The goal of the SPF SIG grant was to build and strengthen Delaware's substance abuse infrastructure. There were eleven community-based agencies who successfully completed the competitive bid process and were awarded four-year contracts (renewal contingent upon performance and the availability of funding) to implement substance abuse prevention services. The SPF SIG also has two evaluation contracts, one for community assessment and evaluation support, and one for the State Epidemiological Outcomes Workgroup (SEOW), otherwise known as the Delaware Drug and Alcohol Tracking Alliance (DDATA). The SPF SIG continues to work with statewide prevention staff to develop comprehensive prevention efforts and enhance Delaware's prevention infrastructure through training and development.

#### ***Strategic Prevention Enhancement (SPE)***

In 2011, DSAMH received the Strategic Prevention Enhancement (SPE) grant through SAMHSA/CSAP. The grant, originally a one-year award was approved for a no-cost extension for a second year (expiring August 31, 2013). The SPE afforded the state to further focus on assessment, strategic planning, and workforce development efforts. The SPE, in conjunction with the SPF SIG and SAPT Block Grant helped to transform Delaware's prevention system. The recommendations of the SPE to focus on the building of community-based coalitions continues to be a prevention priority.

#### ***Strategic Prevention Framework – Partnerships for Success (SPF-PFS):***

The purpose of Delaware's SPF-PFS (2015-2010) is to design and implement a comprehensive, culturally competent, sustainable, effective, statewide, substance abuse prevention framework across the lifespan creating an infrastructure for planning, managing, and sustaining prevention services. Through the duration of the SPF PFS targeted services will be provided to address divergence in cultural norms, gender, socioeconomic status and geography. As funds are distributed statewide, community grantees will document how their assessment, capacity building, planning, implementation, and evaluation decisions actions are culturally competent and sustainable.

The Delaware SPF-PFS Project is in the process of responding to all of its proposed and related goals that are reflected in the five steps of the Strategic Prevention Framework (Assessment; Capacity Building; Planning; Implementation and Evaluation). Additionally, the Delaware SPF-PFS Project will respond to the related goal of the incorporating cultural competency and creating a foundation for sustainability.

***Strategic Prevention Framework Rx (Prescription Misuse and Abuse 2016 – 2021)***

Delaware has been executing a Strategic Prevention Framework for Prescription Drugs (SPF Rx) to: (1) raise community awareness about prescription drug abuse by educating on the dangers of sharing medications, (2) work with the pharmaceutical and medical community on the risks of overprescribing to young adults and youth, (3) provide enhancements to track opioid overdose reductions via the Delaware Prescription Drug Monitoring Program (PDMP); and, (4) implement PDMP data into community needs assessments and State strategic plans to track program success.

DE SPF Rx will focus on implementing the SPF model of assessing need; designing a revised strategic prevention plan; implementing evidence based prevention education and addressing key problems of and prescription drug misuse across the lifespan, as noted by the Prescription Drug Action Committee (PDAC), the state epidemiological outcome workgroup (SEOW) and the Department of Public Health. DE SPF Rx will use the Strategic Prevention Framework and previous SIG resources to achieve the following objectives:

- Provide ongoing data to inform policy and program decisions;
- Mobilize and build state and community capacity by implementing culturally appropriate/competent prevention programs with the inclusion of experienced multicultural leaders from community and faith-based coalitions;
- Create cultural competence and a structure for infusing appropriate strategies and tactics for serving the targeted communities in the SPF Model;
- Revise the State's Strategic Plan and coordinated community-level plans;
- Implement an appropriate array of evidence-based programs, practices and policies (EBPs) specific to the identified priorities; and,
- Monitor and evaluate the effectiveness of programming and services at state and community levels, and adapt them to enhance performance.

Efforts will focus on mobilizing, building and strengthening community capacity to determine local needs, readiness and means to change with cultural sensitivity integral in all phases of implementation. Services will be statewide with universal programs reaching over 50,000 with selective programs reaching 5,000 and indicated programming reaching at least 10,000 Delawareans annually once the project has been fully implemented.



## BEHAVIORAL HEALTH SERVICES

**Youth Treatment Services (DPBHS)** DPBHS have made significant changes in our behavioral health system for children and youth when System of Care began its focus on child safety and evolved into a comprehensive trauma and behavioral health service system for children and families with an emphasis on community-based practices.

DPBHS is committed to collaboration within our department and state partners including juvenile justice and child protection divisions. Within the broader state system, DPBHS collaborates with the Department of Education and local school districts, and the Department of Health and Social Services and its divisions.

In 2015, DPBHS began to transform its operations of serving children and adolescents requesting behavioral health treatment services beyond the first thirty units of outpatient therapy. These efforts were made to improve practice with the division's mission of supporting a family-driven, youth-guided, trauma-informed system of care.

DPBHS merged its Intake and Acute Care units to create one seamless, family-friendly entry point (Access Unit). This unit brought several functions together to promote consistency in decision-making and increase resource offerings to families. When a family or provider (on behalf of the family) requests treatment services, the Access Unit uses standardized measures such as the Child and Adolescent Service Intensity Instrument (CASII) and the American Society of Addiction Medicine (ASAM) criteria for assessment and evaluation. The use of these standardized tools facilitates objective decision-making to determine eligibility and identify appropriate services. Staff assist families by offering DPBHS programs across the continuum of care. This could include prevention, early intervention, care coordination or treatment services along with supports offered through grants or family peers.

Another function of the DPBHS Access Unit is to provide administrative support to children and families seeking treatment. This includes facilitating short-term hospitalization and crisis services and families wanting outpatient services without wraparound care coordination.

For families needing extra support, DPBHS provides care coordination guided by wraparound principles and philosophies. Wraparound is a process of individualized family-based care planning when children or youth have complex needs. The clinical care coordinators in the Child and Family Care Coordination Unit (CFCC) act as facilitators, helping families navigate the system and service options. Coordinators assist families in building a team and developing a plan that fits the strengths and needs of the child and family. The goal of this approach is to empower caregivers to lead a team and develop a customized and personalized treatment plan. The wraparound model has proven to be an effective method of supporting families and children in the community.

In addition to the care coordination provided through CFCC, DPBHS provides a

*Delaware CARES* program which is a specialized wraparound team that serves both children and youth receiving services from DPBHS and DFS. Thus far, the program has demonstrated positive outcomes maintaining children in family and community settings. DPBHS Specialized Services Unit includes the Consultation and Assessment Services, which provides psychological assessments and consultations, competency evaluations, and consults with the Department staff on specific child and family-centered issues.

DPBHS psychologists provide assessment and counseling services to youth in the Division of Youth Rehabilitation Services (DYRS) facilities. All youth entering DYRS facilities receive behavioral health admission screenings including a review of mental health and substance abuse records and the Massachusetts Youth Screening Instrument (MAYSI) is administered. Crisis evaluations, crisis stabilization, individual, family and group therapy including Trauma Grief Component Therapy for Adolescents (TGCT-A) are provided to youth as indicated. Behavioral health consultation services are offered to enhance safety and security of youth, help youth to be successful in the program, and identify youth who would benefit from additional behavioral health services providing referral and linkage to their families and other child serving systems (including juvenile justice and child welfare). Across all of the DYRS facilities, behavioral health staff conduct risk screenings to comply with the Prison Rape Elimination Act (PREA), and also provide training for staff around basic counseling, suicide awareness and prevention, and effective treatment planning.

*The Family Mental Health Court Diversion Program* addresses the needs of youth whose charges are associated with an underlying mental health and/or substance use diagnosis. The judge, prosecutor, attorney and mental health team (case manager and treatment providers) work with the appropriate service provider to assist youth with developing tools needed to succeed in school and home.

Another role DPBHS performs for the DSCYF is to manage care for Delaware children receiving Medicaid/CHIP. Beginning in July 2016 DPBHS began using a new reimbursement methodology between DPBHS/DSCYF and the Division of Medicaid and Medical Assistance (DMMA/DHSS). DSCYF/DPBHS retained responsibility of administering behavioral health benefit for Children enrolled in Medicaid/CHIP that have exceeded the outpatient benefits included in their Medicaid MCO.

DSCYF will be reimbursed from DMMA on a fee-for-service basis for direct services and is reimbursed for administrative activities related to administering the Medicaid State Plan.

This methodology will allow DPBHS to contract with any willing provider that meets quality criteria established by the division. Which in turn allows for more flexibility and increased choice for the children and families we serve.

DPBHS developed a continuum of services to meet the goal of offering choice and flexibility in treatment services to children and families we serve. Providers offer services statewide with extended hours to make services available for those with

varying needs.

### ***Outpatient Services, Mental Health/Substance Abuse***

Outpatient therapy is an individualized treatment option which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns ranging from behavioral problems to relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the child is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the child's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change. Length of treatment will vary based on the individual's needs.

### ***Therapeutic Support for Families (TSF)***

Therapeutic Support for Families provides psycho-educational, therapeutic and supportive services for parents/caregivers and children who are eligible for services through the Division of Prevention and Behavioral Health Services. TSF services are typically delivered in conjunction with other treatment services, but in some instances, may be the only service provided by the Division of Prevention and Behavioral Health Services. TSF goals will be included in the child and family's treatment plan and will include the projected frequency and length of service along with the specific interventions and activities (with purpose) to be incorporated in the attainment of these goals. TSF services may be provided individually or in family and/or group settings. TSF services are tailored to meet the unique needs of the child and family. These services are delivered by trained, skilled paraprofessionals. Length of stay will vary based on the individual's needs.

### ***Dialectical Behavior Therapy (DBT)***

Dialectical Behavior Therapy (DBT) is an evidence-based outpatient service. It has been empirically validated for adults and the emerging literature shows great promise for treating adolescents. This has been an effective treatment for a variety of conditions such as borderline personality disorder, depression, post-traumatic stress disorder (PTSD), substance abuse, self-injurious behaviors and eating disorders. Treatment is used to aid adolescents in managing problem behaviors (self-harm, self-injury, suicidal planning, gestures, actions, impulsive decision making, and avoidance) and increase adaptive methods to manage stressful life situations. Treatment includes 24/7 phone coaching, 2 group sessions per week, individual, family and parent groups. Average length of treatment is 6 to 12 months.

### ***Multi-Systemic Therapy (MST)***

Multi-Systemic Therapy (MST) is a home-based intensive family and community-based treatment that addresses multiple aspects of serious conduct-related behavior in adolescents. MST typically targets chronic, aggressive youth who are at high risk for out-of-home placement. MST recognizes that many "systems" (family, schools,

neighborhood/community, and peers) play a critical role in a youth's world and impacts their behavior. Each system requires attention when effective change is needed to improve the quality of life for youth and their families. MST strives to promote behavioral changes in the youth's natural environment, using the strengths of each system to facilitate change. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change. Interventions promote responsible behavior among family members and are present-focused, action-oriented and developmentally appropriate. In addition, the interventions target specific, well-defined problems and are designed to require daily or weekly effort by family members. They incorporate strategies that promote treatment generalization and long-term maintenance of therapeutic change. Service is available 24/7 (on call system). Average length of treatment is 3 to 5 months with an average of 2-4 hours of direct service per week.

### ***Family Based Mental Health Services (FBMHS)***

The Family Based Mental Health Services are designed to service children between 3 and 17 years of age who are living with their parents, guardians, or caretakers and have a serious mental illness or emotional disturbance. These children are also at risk for out-of-home placement into residential treatment facilities, psychiatric hospitals or foster placements due their symptomatic behaviors and/or the dysfunction of the family system that contributes to the behaviors. Family Based Mental Health Services (FBMHS) are able to treat these children and adolescents in their homes, communities and schools thus allowing the youth to remain in the home. FBMHS is a team-delivered service rendered in home, community and school settings. It is designed to integrate mental health treatment, the family, family support services, the surrounding system, and casework so that families may continue to care for their children and adolescents with a serious mental illness or emotional disturbance in their home. These children and adolescents experience depression, anxiety, chronic acting out behaviors, aggression, social, coping and skill deficits, drug and alcohol abuse, and school truancy. These children are frequently described as "hard to manage" by their parents. Often times, their personality traits and their parents' management skills are frequently in conflict with each other which lead to a youth/family's involvement with multiple systems. Services are available 24 hours per day and 7 days a week via an on-call therapist from the FBMHS program. Average length of treatment is 32 weeks.

### ***Functional Family Therapy (FFT)***

Functional Family Therapy (FFT) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for, or who manifest, antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in or outpatient settings and at times of transition, from a residential placement. FFT incorporates specific intervention phases which include engagement, motivation, assessment, behavior change and generalization. FFT is designed to improve within-

family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior. Parenting skills, youth compliance, and the complete range of behaviors (cognitive, emotional, and behavioral) domains are targeted for change based on the specific risk and protective factor profile of each family. FFT provides approximately 2.5-3 hours of service weekly which includes face to face and collateral contact, travel, case planning. Average length of treatment is 3 to 4 months.

### ***Day Treatment, Mental Health***

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for children or adolescents with moderate to severe behavioral health disorders who are unable to fulfill the functional requirements without this level of intensive service. The program is available as clinically appropriate and is open approximately 250 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the youth's natural environment. Average length of stay is 1 to 3 months.

### ***Partial Hospital Program (PHP)/Day Hospital***

Day Hospital is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable to fulfill the functional requirements of his/her developmental stage without this level of intensive service. This level of care provides support and psychiatric services five days per week to clients living at home or in other residential settings. Average length of stay is 1 to 2 weeks.

### ***Inpatient Hospital***

Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored, and treatment interventions can be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services. Average length of stay is 3 to 10 days.

### ***Rehabilitative Residential Treatment (RRT)***

Rehabilitative Residential Treatment (RRT) provides a 24 hour, supervised, non-hospital based residential living arrangement with intensive therapeutic services for children and adolescents. Youth requiring RRT are diagnosed with varying Behavioral Health (Mental Health, Substance Use and Co-occurring) disorders and may present as a risk to themselves or others, require intense supervision, have difficulty self-regulating their behaviors and have not benefited from community based treatment services. Average length of stay is no more than 6 months, which includes a period of community reintegration and transition.

### ***Psychiatric Residential Treatment Facility (PRTF)***

A Psychiatric Residential Treatment Facility (PRTF) provides comprehensive rehabilitative services to assist and support youth, with behavioral health (Mental Health, Substance Use and Co-occurring) disorders, in the development of positive personal and interpersonal skills, daily living skills, and behavior management skills; to improve functioning and meet the youth's developmental needs; and to enable youth to identify, adjust, and manage symptoms. PRTF level of care is designed for high-risk youth that have been diagnosed and present with complex conditions that require extended treatment in a structured setting in order to more adequately treat their psychiatric and psychosocial needs. PRTF's are staffed 24 hours a day, 7 days a week, and provide treatment under the daily supervision of a physician and provide a high level of nursing and/or specialized staff to meet the diverse needs of the target population. PRTF services are delivered in secure or non-secure settings. PRTF's are required to provide educational services for the youth residing in their facility. Average length of stay is 3-6 months. Children in residential treatment facilities achieve maximum benefit from the service within the first 6 months of treatment. It is expected average LOS to be 3-6 months, however, the length of stay varies depending on the youth's individual diagnosis and treatment needs.

### ***Residential Transition Service***

Residential Transition Services (RTS) are ancillary services provided in preparation for a child's return home from a residential facility and continue, with the same provider, after the child has transitioned back to the home. Services are designed to work with the family and child prior to discharge. The service will identify natural and community supports and plan for these resources to be utilized to promote positive transitions home. Average length of service is 3 to 4 months.

### ***Transition Support Service (TSS)***

Transitional Bed Service (TBS) services provide supervised, supported care, including overnight, for youth with emotional disturbance or behavioral health issues. Transition Support Service may provide: short-term stabilization; a safe, structured environment for youth awaiting placement. Youth utilizing these services must be active with DPBHS and the use of the service must support a positive transition to an appropriate longer-term service or placement. The use of this service can significantly reduce stress in the family, enhance the family's ability to keep their child/youth at home in the community, and prevent or delay the use of more restrictive behavioral health services for the child. The use of a Transition Support Services may be planned in advance or be offered as an option in emergent situations; and, should **not** to be used in lieu of a crisis residential service, inpatient care or residential treatment. These beds are not designed to provide 1:1 supervision and should not be considered for youth requiring this level of observation. Average length of service is 1 to 3 days.

### ***Mobile Response and Stabilization Services***

Mobile Response and Stabilization Services staff receive crisis calls directly from the published crisis number and respond in-person to crises as appropriate. Mobile Response and Stabilization Services begin with the first face-to-face contact response

with a child/youth experiencing a mental health emergency involving up to three contacts (face to face interactions) within a 72 hour period. Stabilization services can continue for up to 30 days. Mobile Response and Stabilization Services are community based (home, school) intensive (an unlimited number of contacts per week, with 24-hour availability), short term therapeutic intervention to assist the child and their family to improve coping mechanisms, identify and address the issues that precipitated the crisis, and plan in conjunction with DPBHS for further treatment if necessary. Average length of service is 2 to 4 weeks.

### ***Crisis Residential Service***

Crisis Residential Services provide a temporary supervised setting which provide safety, supervision and treatment and for a child in a crisis situation. Average length of stay is 1 to 3 days.

### ***Community Outreach, Referral and Early Intervention (CORE)***

Delaware is using the MHBG 10% Set-Aside funds to build a sustainable statewide program for identifying and engaging youth and young adults experiencing first episode psychosis. The program, entitled Community Outreach, Referral and Early Intervention (Delaware CORE) is based on the outreach and service model developed by the University of Maine Medical Center called the Portland Identification and Early Referral (PIER) program. PIER is similar to other CSC models with the exception that it places emphasis on linking families up through group education and networking. Most of Delaware's program participants are enrolled in groups that practice collective problem solving. These groups demonstrate to families with lived experienced with first episode of psychosis (FEP) that they are often their own best resource for solving the day-to-day challenges they encounter.

The MHBG set aside covers some of the cost of treating FEPs while funding from the Substance Abuse and Mental Health Services Administration covers the remainder including costs for treating youth and young adults considered to be at high risk for experiencing a first episode. Thus far, Delaware's CORE teams (i.e., eight clinicians) have served 62 families across the state. The program offers a broad array of services including psychiatric consultation, occupational evaluation and therapy, supportive services for school or work, and inter-family group meetings to promote networking and support. The program's principal challenge at the present is developing a strategy for sustaining the program's financial viability in the light of those services (including outreach, peer-support, and supported education and vocation) that are not reimbursed by public or private insurance. In the short-term, the program is looking at a fee-for-service model while program administrators explore the option of negotiating a bundled service rate.

### ***Adult Treatment Services***

The three counties in Delaware do not provide funding for public human services in the state. Responsibility for public mental health services has been 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 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:

Clinical MOU that deals with transition of youth from the Juvenile Mental Health System to the Adult Mental Health System.

MOU that establishes mutual responsibility for reporting via the Community Mental Health Block Grant Application and the Implementation Report.

With the SAPT/CMHC Block Grant funds and a combination of other federal grants, state funding and Medicaid funds, DSAMH and DPBHS support comprehensive behavioral health services for the insured and under-insured citizens of Delaware. DSAMH also provides operational support for the state's sole state hospital, the Delaware Psychiatric Center (DPC).

### ***DSAMH Disaster Planning***

DSAMH has partnered with Division of Public Health for the integration of behavioral health supports in the Delaware All Hazards Disaster Plan.

DSAMH has trained crisis volunteers as well as Medical Reserve Corps (MRC) volunteers to provide emergent, behavioral health supports in natural or man-made disaster events. This cadre of trained volunteers called *DE BEST* will deploy in the event of large or small-scale disasters to provide free emotional support outreach services and referral options to persons affected by a disaster.

The purpose behind this team is to support the emotional well-being of survivors and to increase resiliency while decreasing the likelihood of chronic mental health concerns following the event. The need to enhance state mental health disaster plans has become apparent to all involved as disaster and emergency planning has evolved.

### ***Joint Law Enforcement Collaboration***

In May 2014 DSAMH instituted the Crisis Intervention Team (CIT), an approach that was developed through a partnership with Memphis Police, the University of Memphis, the National Alliance on Mental Illness, and other community stakeholders. The CIT is a 40-hour week long training class specifically tailored to training first responders, and specifically law enforcement professionals. It provides various core curriculum components including: Introduction to Mental Illness and Psychiatric Medications, Family & Consumer Perspective, De-Escalation Techniques, Negotiations for the First Responder, Risk Assessment and Suicide Intervention, Excited Delirium, Cognitive and Developmental Disabilities, Children's Mental Health Issues, and other important



modules. There are experiential learning opportunities such as an auditory hallucination component and scenarios to demonstrate the skills learned in the classroom environment. Training is ongoing through a partnership between the Division of Substance Abuse and Mental Health (DSAMH) and the National Alliance on Mental Illness (NAMI). The next class will be held in October 2017.

### ***Law Enforcement Ride-Along***

Many states have looked to implement programs that partner social workers riding with law enforcement officers in an attempt to de-escalate confrontations between individuals suffering with a mental illness and the police. Although Delaware was not able to fully implement this program, DSAMH was able to get Crisis Intervention Team (CIT) training in place and has partnered with state law enforcement agencies to participate in a 'ride-along' program where a social worker rides along with a law enforcement officer during a shift. Although contrary to a true CIT model, Delaware has been successful in diverting individuals into treatment versus jails with the implementation of this hybrid program. In situations where individuals may need additional help, the social workers may be able to get the individuals directly into treatment programs, rather than forcing individuals to wait in an emergency-room bed.

### ***Delaware Psychiatric Center***

The Delaware Psychiatric Center (DPC) is a 24-hour inpatient state psychiatric hospital with 200 licensed beds and 122 operational beds. DPC is owned and operated by the State of Delaware, Department of Human and Social Services, Division of Substance Abuse and mental Health. DPC operates six (5) client units and a Recovery Academy which functions as a centralized treatment model.

DPC provides psychiatric services through two programs, general adult and forensic behavioral health services. The Kent/Sussex building houses 4 units that accept clients on a voluntary status or a civil involuntary status. The Jane E Mitchell (JEM) building houses one (1) forensic unit. The JEM Unit receives clients from the Department of Corrections.

#### ***Kent 2 and Kent 3 Units***

The Kent 2 and 3 units (K2 and K3) serve as general acute psychiatry units for DPC. These two acute units are comprised of a total of 40 acute care beds. Emphasis is on symptom reduction, skills development, and building support networks.

#### ***Sussex 2 Unit***

The Sussex 2 (S2) unit is a 20-bed unit focused on adults who may have age related and/or ambulatory issues. The emphasis for this unit is to help clients achieve as a higher level of adaptive functioning to facilitate discharge to a community-based level of care. This tends to be a more medically vulnerable population although this is not a medical or geriatric unit. When appropriate, clients with acute care needs can be admitted to this unit.

### *Sussex 1 Unit*

The Sussex 1 (S1) unit is a 20-bed unit serving male only clients. Male clients are typically assigned to this unit if they have been socially inappropriate or overly aggressive, with or without provocation, towards other clients, particularly female clients. Treatment plans are focused on improving interpersonal skills and reducing aggressive and/or impulsive behavior. When appropriate, clients with acute care needs can be admitted to this unit.

### *Jane E Mitchell Unit*

The Jane E Mitchell Unit (JEM or Mitchell) is a 42 bed, secure treatment unit designed to serve those who are criminally court committed. The referrals to this treatment program come from the Delaware Department of Corrections (DOC) and the clients on this unit are formally considered a part of the DOC population.

### *Active Treatment Programming*

The Recovery Academy is a centralized treatment unit where most of the therapeutic treatment occurs. Clients of the Kent/Sussex units are expected to engage in therapeutic and recreational groups at the Recovery Academy.

### *Medication Stabilization and Management*

Each unit is staffed with a Psychiatrist who is trained in the use of Psychopharmacology as a treatment intervention to assist clients in achieving greater stabilization. Specifically, Psychopharmacology is used to assist clients with stabilizing their symptoms so they can return to a level of functioning that will enable them to live successfully in the community.

### *Peer Support Services*

Peer support Services are provided by persons hired at DPC to provide peer support to clients admitted to the hospital. Peer Support Specialists are staff members who have received mental health services for a mental illness themselves. They are there to share their own stories, to empower clients to be their own advocate, and to help the client recovery so that they can return to the community as soon as they are ready.

The Delaware Psychiatric Center's average daily census was 113 clients for State Fiscal Year 2017.

### ***Crisis Services***

DSAMH manages the Mobile Crisis Intervention Services (MCIS) unit directly. MCIS manages and provides Delaware's only 24-hour substance abuse and psychiatric crisis hotline for individuals over the age of 18.

Trained psychiatric social workers are available to provide crisis intervention and support via phone with the ability to mobilize in the community to perform comprehensive mental health, suicide and substance abuse assessments and assist with voluntary or involuntary hospitalization or other emergency based referrals for treatment.

MCIS has access to psychiatric services for evaluation and medication assessment and provides ongoing, short-term supportive counseling services until clients are transitioned to a community-based provider for long-term behavioral health treatment.

In addition to providing individual behavioral health services, MCIS provides trainings on mental health education, suicide awareness, de-escalation techniques and the role of MCIS to law enforcement agencies, public health units, nursing programs and any other community entities. MCIS also plays a role in the State of Delaware's overall disaster preparedness and response plan.

The Division also contracts with RI International for care management services through the *Restart Program*. Restart provides recovery based, short-term Targeted Care Management (TCM) and engagement services for individuals 18 years of age and older with significant mental health and/or substance use challenges. The goal of Restart is to prevent, when possible, hospitalization and higher levels of care by rapidly assessing person's needs and engaging in a voluntary recovery opportunity, and connecting people to community services and supports. Currently there are two Restart locations in Delaware: Ellendale and Wilmington, with the primary initiative being to increase availability of community-based, recovery-oriented behavioral health services without regard to income or insurance status. Restart accepts referrals 7 days a week from hospital emergency departments, law enforcement agencies, mobile crisis teams and community agencies.

*Recovery Response Centers ("RRC")* located in Ellendale and Newark offer a facility-based, 23-hour assessment and evaluation program for adults suffering from substance use or psychiatric crisis. This service is contracted by the state to a provider, Recovery Innovations.

The goal of RRC is to prevent, when possible, unnecessary psychiatric hospitalizations. RRC staff consisting of nurses, mental health professionals, peer support specialists and psychiatric staff are available 24 hours per day to assess walk-ins, police referrals or anyone experiencing a psychiatric crisis. RRC staff offer quick engagement and evaluation by trained behavioral health professionals in a recovery-based environment to assist individuals in determining the best path forward for treatment. Being co-located with RRC's, the Restart teams in both the Ellendale and Newark facilities, assist the RRC in connecting individuals in crisis to a community-based care management team with a warm handoff for improved continuity of care and access to needed services.

### ***Eligibility and Enrollment Unit ("EEU")***

The DSAMH EEU is the gatekeeper for the state's public mental health system. The goal of the EEU is to gather information about mental health consumers to refer them to the level of care that is the most appropriate as determined by best practice assessment tools and the individuals themselves.

### *Assessment and Evaluation*

The EEU uses the ASAM PPC- 2 for placement in the most appropriate level of intensity and based on a comprehensive assessment. Information on the ASAM PPC-2R is 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-occurring 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 began the use of The Delaware 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 bio-psychosocial completed by the provider. It includes diagnosis based on DSM V criteria. The results of the assessment help decide about appropriate intensity of care focused on ASAM PPC-2R.

### *Psychiatric Hospital Placement*

The EEU receives calls from General Medical Center Emergency Departments, Crisis Centers, and other sources to find appropriate placement for psychiatric hospital beds for adults who are held under 24-hour observation, have Medicaid, as well as those who do not have insurance.

### *Utilization Review*

The EEU conducts utilization review for those placed in a private psychiatric hospital for whom DSAMH is the payer. These would primarily be for those who do not have insurance or who have Medicaid.

### *PROMISE Referral and Approval*

The EEU is the first point of contact for referrals to the PROMISE program array of community-based services (see PROMISE description directly below the EEU section). When a referral meets initial criteria for PROMISE, the information is forwarded to a county specific PROMISE Assessment Center (PAC). The PAC then assigns a care manager to further evaluate the level of care needed and make recommendations for community based services. The care manager evaluation and recommendations are then sent back to the EU who makes a final determination for approval.

## ***Community Support Program Structure for Adults***

**PROMISE** (Promoting Optimal Mental Health for Individuals through Supports and Empowerment)

PROMISE is a joint venture between the Division of Medicaid and Medical Assistance (DMMA) and DSAMH. It is an outcome of the Affordable Care Act, revisions to the FY14 State Plan Amendment (SPA), and the USDOJ Settlement Agreement. PROMISE's goal is to provide community supports to facilitate enhanced engagement within the community for persons with serious and persistent mental illness. The partnership between the two divisions led to the development of a comprehensive Medicaid waiver that would allow the state to leverage federal funding (Medicaid dollars) with state funding. The enhanced Medicaid benefit package is being coordinated by DSAMH through the fee-for-service program in compliance with home and community-based standards (1115 Demonstration Waiver) and assurances that the services meet the standards of the signed Olmstead agreement.

The goals are to improve clinical and recovery outcomes for individuals with behavioral health needs and reduce the growth in costs through a reduction in unnecessary institutional care through care coordination, including initiatives to increase network capacity to deliver community-based, recovery-oriented services and supports.

Specifically, the Medicaid funding has provided:

- Federal reimbursement for crisis intervention, substance use disorder (SUD) treatment and treatment by other licensed practitioners; and,
- Home and community-based services for individuals meeting established diagnostic and functional criteria.

*PROMISE Program Goals:*

- Provide behavioral health (BH) supports in a community-based setting.
- Assist individuals with BH needs to work in a competitive work environment.
- Provide individually tailored services for individuals with BH needs.
- Leverage limited State dollars to better meet the needs of the target population
- Ensure that individuals with BH needs live in the community in integrated housing and with the appropriate services and supports.

*Expected Outcomes of PROMISE:*

- PROMISE will continue to modernize and improve the delivery of mental health and substance use services.
- Recovery-oriented services will be continued to be delivered according to a written person-centered plan of care, called a Recovery Plan, developed through a process led by the individual, including people s/he has chosen to participate.

The person-centered planning process must identify the individual's physical and mental health support needs, strengths, preferences and desired outcomes. For individuals receiving other Medicaid services, PROMISE will provide a coordinated approach to services.

*Eligible individuals will be:*

- Over the age of 18 years;

- Diagnosed with a mental illness, co-occurring and substance use disorders;
- Identified as having either moderate or severe functioning on the Delaware specific American Society for Addiction Medicine (ASAM) assessment tool that evaluates both mental health and SUD conditions; and,
- The individual may also be found to continue to need at least one service or support to live/work independently.

*Assertive Community Treatment (ACT)*, which is based on the evidence-based Program of Assertive Community Treatment model. A Delaware *ACT Team* is comprised of a group of ten (10) staff members, and there are a total of 16 ACT teams. Each ACT team serves up to 100 individuals and thus has a maximum staff to client ratio of 1:10. The sixteen (16) teams serve clients in New Castle County, three teams provide services in Kent County and two teams serve Sussex County. The core members of the team are the primary care manager, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each client. The team has continuous responsibility to be knowledgeable about the client's life, circumstances, goals and desires; to collaborate with the client to develop and write the recovery plan; to offer options and choices in the recovery plan; to ensure that immediate changes are made as needs change; and, to advocate for the client.

The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for outcomes for people that they serve. ACT services are provided predominantly in the community. The services are person-centered and customized to each client. Each member of the team, including the person receiving services, is accountable to work together to ensure that the service and treatment goals are met. Services are delivered in a continuous framework, for as long as the individual meets the DSAMH defined criteria for inclusion in these programs. Services are trauma-informed and will avoid coercion or paternalistic approaches. *The primary ACT program goals include:*

- To lessen or eliminate critical health and safety issues, that each individual client might experience, toward preventing or mitigating these signs, symptoms, and/or social issues that could lead to crisis situations and the need for re-hospitalization;
- To assist the individual in achieving their maximum recovery potential from the effects of institutionalization, their mental condition and co-occurring substance use conditions;
- To improve the overall medical and physical health of the individual;
- To meet basic human needs and enhance quality of life;
- To improve the client's opportunity to be successful in social and employment roles and activities;
- To increase community tenure in a setting and home of that client's choice; and,
- To partner with families and/or significant other(s) in supporting the individual's recovery, if these people are available.

*ICM (Intensive Care Management) Team* is a group of ten (10) ICM staff members who together have a range of clinical and rehabilitation skills and expertise. The ICM team members are assigned by the team leader and the psychiatric prescriber to work collaboratively with a client and his/her family and/or natural supports in the community by the time of the first client assessment and subsequent person-directed recovery planning meeting. The ICM team serves up to 250 clients in Kent and Sussex County, and 125 clients in New Castle County, and thus has a maximum staff to client ratio of 1:20. The core members of the team are the primary care manager, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each client. The team has continuous responsibility to be knowledgeable about the client's life, circumstances, goals; to collaborate with the client to develop and write the recovery plan; to offer options and choices in the recovery plan; to ensure that immediate changes are made as needs change; and, to advocate for the client.

The primary and mandatory Intensive Care Management (ICM) program goals include:

- To lessen or eliminate critical health and safety issues, that each individual client might experience, toward preventing or mitigating these signs, symptoms, and/or social issues that could lead to crisis situations and the need for re-hospitalization;
- To assist the individual in achieving their maximum recovery potential from the effects of institutionalization, their mental condition and co-occurring substance use conditions;
- To improve the overall medical and physical health of the individual;
- To meet basic human needs and enhance quality of life;
- To improve the client's opportunity to be successful in social and employment roles and activities;
- To increase community tenure in a setting and home of that client's choice; and,
- To partner with families and/or significant other in supporting the client's recovery, if these people are available.

*The Targeted Care Management (TCM)* program provides services and supports to adult individuals who have a serious mental illness and/or co-occurring substance use condition and who are not well connected to community based services or are poorly served by services they are receiving. It is primarily an advocacy program, successfully linking individuals to behavioral health services that can assist the individual in their recovery. More specifically, the TCM provides:

- The provision of early intervention activities to assure that individual clients who end up in inpatient psychiatric facilities receive the services they need immediately to prevent further use of such deep end services if these are not needed;

- Rapid engagement of individuals wherever the individual is located including emergency departments, psychiatric hospitals, homeless shelters, etc.;
- Assessment of the individuals' immediate needs and assistance in meeting them.

TCM services are person-centered, trauma-informed and individualized. Once a client is referred, a targeted care manager will complete a full assessment of the individual to determine: intensity of care needed, status of entitlements and application of entitlements, housing needs, medical needs, employment and educational needs, community support needs, legal status and obligations and other areas of living that impact a client's overall success with independence in the community. The TCM will conduct assessments wherever needed.

TCM acts as a liaison with providers in DSAMH's continuum of care and within the community to provide appropriate linkage to services and follow up for as long as needed. All services are planned and carried out with full participation of the client, the client's family and other supports when appropriate. TCM remains engaged with the client until a warm handoff to another provider is completed or the TCM has successfully met the needs of the client including facilitating immediate access to crisis apartments that have capacity to provide short-term emergency housing.

*Comprehensive Behavioral Health Outpatient Treatment (CBHOT):*

DSAMH funds twenty-one (21) outpatient programs that provide comprehensive mental health, alcohol, and other drug treatment services. Outpatient services include services to clients in the criminal justice system and individuals living in the community. Services offered by CBHOT programs include: individual, group and family counseling, psychiatric treatment, medications, case management, assistance with acquiring entitlements, and working with vocational rehabilitation and employment issues. All outpatient programs contracting with DSAMH are required to be able to meet the needs of individuals with co-occurring mental health and substance use disorders. Programs offer an array of services including IOP and PHP<sup>IV</sup>.

*Peer Run Services*

There are four peer run drop-in programs operating in Delaware which provide community-based supportive and recovery services. The programs are located in and serve clients in New Castle County, serving clients Wilmington, Kent County, and Sussex County.

**Community Based Residential Services**

*Group Homes*

As part of its continuum of care, DSAMH contracts for residential group homes to serve those who require extensive medical, activities of daily living ("ADL"), and/or instrumental activities of daily living ("IADL") supports. In Delaware, a group home must be licensed by the State of Delaware's Division of Long Term Care Residents Protection. Community-based Residential Alternatives (excluding Assisted Living) offer a cost-effective, community-based alternative to Nursing Facility care for persons with



behavioral health needs. Community-based Residential services are supportive and health-related Residential services provided to beneficiaries in settings licensed by the State. Residential services are necessary, as specified in the Recovery Plan, to enable the beneficiary to remain integrated in the community and ensure the health, welfare, and safety of the beneficiary. Community-based Residential services include Personal Care and Supportive services (Homemaker, Chore, Attendant services, and Meal Preparation) that are furnished to beneficiaries who reside in home-like, non-institutional, integrated settings. In addition, 24-hour on-site response capability to meet scheduled and unscheduled or unpredictable beneficiary needs and to provide supervision and safety. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law).

The services include assisting beneficiaries in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, these services may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors, as well as habilitative services to instruct beneficiaries in accessing and using community resources such as transportation, translation, and communication assistance related to a habilitative outcome, and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self-advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included. This service are provided to meet the beneficiary's needs as determined by an assessment performed in accordance with DHSS requirements and as outlined in the beneficiary's Recovery Plan.

ADLs include tasks related to self-care and physical movement .IADLs are the activities not directly related to functional activities; rather, they are assistance with an additional set of more complex life functions necessary for maintaining a person's immediate environment and living independently in the community. IADLs self-sufficiency; daily living; financial management; employment and medication management skills.

#### *Supported Apartment Program (SAP)*

The Supervised Apartment Program (SAP) is a state-wide apartment program for persons who are working toward the goal of living independently and who need some additional daytime, evening, overnight and/or weekend supervision. The SAP is available to the client if s/he needs supervised services. The staffing responsibilities should be sufficient to ensure: onsite supervision, assurance of client safety, coordination of care with the community provider and assisting the community provider with supports for the client when the community provider is unable to provide these in an emergency. Clients in SAP's are also assigned to either ACT or ICM teams to ensure their bio/psycho/social needs are met. SAP services include:

- The participation in the development of a strengths based and rehabilitation focused collaborative treatment plan with the Assertive Community Treatment

(ACT) and Intensive Case Management (ICM) providers. (The collaborative treatment plan is developed in collaboration with the client, the ACT/ICM Team and RI.);

- The documentation of participation of the ACT/ICM Team, client and RI;
- The maintenance of current ACT/ICM Crisis Plan on-site, to be utilized in the mitigation of on-sight crisis;
- The communication and documentation of crisis situations to the 24 hours on-call ACT/ICM Team for clinical intervention as well as sharing the information with the Housing Service Provider and DSAMH;
- The reporting of client issues at the weekly meetings with the Housing Service Provider and DSAMH;
- The provision of transportation services for clients for who are participating in organized group activities (i.e., Circle of Friends activities); and,
- The enhancement of the housing services provided by the ACT/ICM Teams such as observation of and additional skill development in the areas of housekeeping, food shopping and preparation and other ADL's for home maintenance.

### Crisis Apartments

As a component of the PROMISE program, crisis beds are available to clients during periods of crisis. This program is available in two locations, one in New Castle County and one in Kent County (rural). Each location has 4 beds for a total of 8 beds. The program is not only peer specialist supported but also peer run by Recovery Innovations, Inc.

### Services to Rural Populations

Publicly funded mental health services for adults provided by the Division are offered either directly or via contractual arrangements through four state-operated PROMISE Centers. It is worth noting that DSAMH does not differentiate services based on geographic location. All services provided to individuals served by the Division are available without location bias.

According to the U.S. Census for 2010, "rural" is defined as places of less than 50,000 population and those outside of areas of 2,500 or more. By the Census definition, New Castle County is entirely urbanized. All of Kent and Sussex Counties are rural, except for the City of Dover, located in Kent County. The Division funds several mental health services, including (2) PROMISE Centers; (2) PEER-Operated community centers; supervised apartment program, group homes, as well as many programs providing comprehensive behavior health outpatient services.

DSAMH has been taking steps to increase the availability and accessibility of behavioral health services for rural populations. Strategic initiatives that have been realized are:

- Increased emphasis on tele-medicine, psychiatry emphasized have resulted in increased number of DSAMH contracted providers in rural areas using this resource. This not only addresses issues associated with distance, but also with issues associated with prescriber shortages in both rural and urban areas. While

it has been stated that DSAMH does not limit access to services based on where a person lives, to increase accessibility, DSAMH has expanded contracted providers throughout the state, more significantly in rural Kent and Sussex Counties. This expansion has resulted in increased services and locations in these two counties in the following ways:

- An increase to 7 CBHOT locations for outpatient services in Sussex County
- An increase to 6 CBHOT locations in Kent County
- An increase from 2 to 20 for medication assisted treatment locations state-wide (note: not these are DSAMH contracted providers)
- Establishment of 5 ACT teams and 2 ICMS teams with locations in both Sussex and Kent counties
- Increased residential services, Group Homes, Supported Apartment Programs and Crisis apartments in all three counties.
- As part of the PROMISE implementation, increased Medicaid funded non-medical and medical transport options.
- As part of the PROMISE implementation, established Representative Payee services for the whole state.
- Established a 16-bed co-occurring residential treatment program (SUD and MH) in Sussex County

#### Withdrawal Management Services, including Ambulatory (Detox)

DSAMH contracts with two (2) providers for withdrawal management programs. One program is in New Castle County and the second is in Kent County. Each program offers the following:

- ASAM Level 2-WM Ambulatory Withdrawal Management with Extended Onsite Monitoring; (23-hour observation – 12 beds; Ambulatory Detox – 30 slots)
- ASAM Level 3.2\_WM Clinically Managed Residential Withdrawal Management – 8 beds
- ASAM Level 3.7 – WM Medically Monitored Inpatient Withdrawal Management – 8 beds

Core services include 24-hour physician, psychosocial services, medical services, and linkages to substance abuse treatment facilities. Both programs provide Methadone, Suboxone to assist with withdraw symptoms and Vivitrol (Naltexone) a once a month injection that when used in conjunction with treatment can help reduce or eliminate the craving for alcohol in individuals with alcohol dependence. Both facilities will provide other forms of medicated assisted withdraw management for individuals addicted to alcohol and benzodiazapines.

As part of its internal quality improvement measures, DSAMH collects data on referral information including referrals to admissions for young adults with Opioid addiction. DSAMH believes that by adding AMDETOX as an outpatient option the less restrictive setting will be more attractive to the target population of young adults. It uses Buprenorphine for medical management of the detoxification process.

### Medication Assisted Recovery

DSAMH funds three (3) providers who offer medication assisted treatment services at eight (8) 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) provides methadone maintenance in New Castle County. Kent Sussex Counseling Services (KSCS) provide methadone maintenance in both Kent and Sussex Counties. Connections CSP provides methadone maintenance in New Castle County, Kent County and Sussex County. The addition of methadone maintenance treatment provided by Connections CSP has allowed DSAMH to double the number of methadone maintenance sites throughout the state. The three (3) programs currently prescribe Suboxone (Buprenorphine) and Vivitrol (Naltrexone) for alcohol dependence. Ambulatory detoxification is required for the transition to outpatient services.

### Residential Services

DSAMH contracts for ASAM 3.3 Clinically Managed Population Specific High Intensity Residential Treatment Programs:

- Gateway is contracted to provide 47 beds for males located in Smyrna, DE. This program provides services to a mix of community and criminal justice referred clients.
- Psychotherapeutic Services is contracted to provide 16 beds for females located in Dover, DE.
- Psychotherapeutic Services is contracted to provide 10 beds for males located in Dover, DE.
- Connections is contracted to provide 16 beds for females located in Wilmington, DE
- Gaudenzia is contracted to provide 16 beds for co-occurring clients located in Ellendale, DE
- Gaudenzia is contracted to provide 32 beds for young adults. While alcohol or any drug can be treated, admission preference is given to those with Opioid addiction. This program treats both males and females

### ***Comprehensive Behavioral Health Outpatient Treatment Programs (CBHOT)***

DSAMH funds twenty-one (21) outpatient programs that provide comprehensive mental health, alcohol, and other drug treatment services. Outpatient services include services to clients in the criminal justice system and individuals living in the community clients. Services offered by OP programs include: individual, group and family counseling, psychiatric treatment, medications, case management, assistance with acquiring entitlements, and working with vocational rehabilitation on employment issues. All outpatient programs contracting with DSAMH are required to be able to meet the needs of individuals with co-occurring mental health and substance use disorders. Programs offer an array of services including IOP and PHP.

### Sober Living Residences

DSAMH currently funds 120 Sober Living beds throughout the State of Delaware, and 20 beds specifically designed for women and their dependent children. These programs meet National Association of Recovery Residences (NARR) standards. Core services include safe, sober, and drug free residences, 24-hour staffing, intake and assessment, orientation, coordinating behavioral health and medical health care, education, pre-vocational and vocational training, employment, recreation, self-help meeting, continuing care, housing, financial management, nutrition, urinalysis, and conflict resolution.

The addition of the Sober Living residences supports DSAMH's belief that a "housing first" model to recovery enhances treatment experiences by offering safe, drug free environments for individuals in recovery. Sober living residences will include a woman and children's residence and support individuals in all levels of the treatment continuum.

### Oxford Houses

DSAMH contracts with Oxford House International to provide a network of over sixty Oxford Houses, 200+ beds. This represents an increase of more than (Twenty) 20 beds since 2013. State general funds are also used 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.

### Treatment Access Center (TASC)

TASC is the primary liaison between the 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 works closely with the EEU to ensure that treatment placement occurs in a timely manner.

### Drug Diversion Programs

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. In 2013, a DUI specialty Court pilot was introduced in the Delaware Court of Common Pleas for first-time DUI offenders with high risk markers for substance abuse and dependence. Diversion efforts mirror the Drug Diversion program funded by DSAMH in Superior Court and Court of Common Pleas.

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. DUI Court programs last nine (9) to eleven (11) months with an emphasis on abstinence.

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.

#### *HERO HELP*

*Hero Help is a collaboration between The New Castle County Police Department (NCCPD), The Delaware Department of Justice (DOJ) and The Delaware Division of Substance Abuse and Mental Health (DSAMH).* This collaborative initiative links qualifying adults who encounter police to drug and/or alcohol addiction treatment in lieu of an immediate arrest for their illegal behavior(s). If a law enforcement officer suspects substance abuse upon initial contact with an individual, therapeutic options are discussed and the individual may indicate their willingness to engage in treatment. The goal of the HERO HELP program is to create an opportunity to engage individuals in treatment and *not* to rely on arrest action/ the criminal justice system solely to combat addiction and the commensurate criminal activity. Instead, the HERO HELP Program authorizes police, through the DOJ, to suspend arrest and provides an avenue for those seeking treatment to overcome their addiction. The program also links individuals with a case manager to guide them through the recovery process (TASC). Individuals can choose from inpatient, IOP or any other outpatient treatment or they may choose to disengage completely and criminal charges may be reinstated.

HERO HELP is available to adults who are Delaware residents, have self-identified as suffering from a substance abuse related disorder and are voluntarily willing to engage in a treatment program as clinically indicated. There must be an express interest to *fully* participate in treatment and individuals will undergo a screening process, a review of current and past criminal charges and complete an intake process with a substance abuse counselor (NET Detox). Additionally, the individual must sign a formal

agreement indicating their willingness to agree to the terms of the program – family, friends or loved ones cannot volunteer an individual to participate in this program.

#### Project Renewal

DSAMH contracts with BCCS to provide services to homeless in Sussex County. Based on an intensive case management model, 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 Gambling Problems (DCGP)

DSAMH realizes that there is a high rate of gambling among clients with drug and or alcohol conditions. Due to this fact DSAMH, through DCGP, 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 individual scores 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

DSAMH continues to partner with the Department of Public Health (DPH) on Delaware's Needle Exchange Program. The concept of Needle Exchange Programs comes from the public health concept of harm reduction. By providing clean needles to intravenous drug users it reduces their chances of acquiring chronic health conditions such as hepatitis or HIV. These programs provide treatment services as well.

### **SYSTEM ENHANCEMENTS**

In 2018, Delaware's Substance Abuse Treatment System will continue to undergo a transformation in operating procedures. Following SAMHSA's philosophy, DSAMH adapted the approach that "Behavioral Health is essential to overall health; That prevention (for many of these conditions) works; Treatment is effective; and People Recover. Delaware's approach will continue to push the use of evidence-based and promising practices throughout the system. Integration of both mental health and substance use disorder services is important so that the State has no wrong door and people seeking services can get them wherever they land.

In addition, the integration of primary care services for many clients of DSAMH with Mental Health (MH) and Substance Use Disorders (SUD) disorders is another major goal. All people with serious mental health disabilities are vulnerable to several serious physical problems that have led to national research findings that people with serious mental health concerns die over 25 years earlier than the general population.

DSAMH is currently imbedding in all our provider contracts the expectation that services and supports will be accessible and seek to engage that person in treatment recommendations. As such, going forward, DSAMH will not have tolerance for

wait lists, or inaccessibility to care. The best treatment for persons with alcohol, Opioid dependence, or addiction is often the use of intensive outpatient ambulatory services. The national research shows that the use of Naltrexone, Methadone, and Buprenorphine can be very effective; however, while effective, there may still be issues with diversion. DSAMH is working with DMMA to address these issues. To increase effectiveness of the services Delaware provides DSAMH needs to maintain people in their homes, in their jobs and in treatment.

### **DEVELOPMENTS IN DELAWARE’S BEHAVIORAL HEALTH INFRASTRUCTURE**

In 2009, then Governor Jack Markell significantly improved Delaware’s Behavioral Health Infrastructure through an increased focus on prevention which positioned the State to be in better alignment with the Substance Abuse and Mental Health Services Administration (SAMHSA) movement to put prevention at the forefront of health care services. As a result of his focus, then Governor Markell reorganized state agencies to include prevention mandates within their infrastructure, resulting in expanded services and improved service delivery for Delawareans.

Consequential to Governor Markell’s mandates, the Delaware Department of Health and Social Services (DHSS), Division of Public Health requested the assistance of the Centers for Disease Control and Prevention (CDC) in conducting an epidemiological study of this cluster of youth suicides in Kent and Sussex counties to determine the frequency of fatal and nonfatal suicidal behaviors in the first quarter of 2012, examine risk factors, and make recommendations about potential strategies that might be used by community and state leaders to prevent future suicides. The objectives of the investigation were to: 1) characterize the fatal and non-fatal suicidal behaviors among youth occurring between January 1, 2012 and May 4, 2012 (when the CDC visit would conclude), in Kent and Sussex counties, Delaware; 2) describe trends in fatal and non-fatal youth suicidal behaviors over the past 4 years (2008 - 2012) in these counties to determine the degree to which the current suicide deaths demonstrate an increase over prior years; 3) identify, where possible, individual, family and community risk and protective factors; and 4) identify relevant prevention strategies for youth suicide. (The full report can be found:

[http://dhss.delaware.gov/admin/files/de\\_cdc\\_final\\_report\\_21913.pdf](http://dhss.delaware.gov/admin/files/de_cdc_final_report_21913.pdf)).

After extensive data collection and analysis, in November 2015, the Delaware Department of Health and Social Services (DHSS) released an epidemiological study conducted by the Centers for Disease Control and Prevention (CDC), which examined youth firearm violence in the city of Wilmington, Delaware. As recommended by the study, the Department convened an advisory council composed of key community stakeholders to provide recommendations on proposed evidence-based, integrated services to be provided to youth who are considered at high risk of committing violence. The Council included representatives from the New Castle County school districts; community-based organizations; faith communities; Delaware Divisions of Public Health, Prevention and Behavioral Health and Youth Rehabilitative Services; United Way of Delaware; City of Wilmington Mayor’s Office; and the Wilmington City Council, as well as community advocates. The Council performed an extensive literature review



to become familiar with the evidence-based and promising practices in Delaware and elsewhere being used to prevent youth violence and promote positive youth development. The Council also assessed the current array of services available to youth living in high-risk neighborhoods in Wilmington through broad engagement of youth, families, community organizations, and other key community stakeholders. The Council also drew upon its knowledge of the youth of Wilmington. The Council developed recommendations on the network of services that can and should be strengthened to prevent youth violence and help youth make good choices, be resilient, and grow up to be physically and mentally healthy members of their communities. The six recommendations were foster violence-free environments and promote positive opportunities and connections to trusted adults; intervene with youth and families at the first sign of risk; restore youth who have gone down the wrong path; protect children and youth from violence in the community; integrate services; and address policy issues that have unintended adverse consequences for youth. (The full report can be found at: [http://dhss.delaware.gov/admin/files/de\\_cdc\\_final\\_report\\_21913.pdf](http://dhss.delaware.gov/admin/files/de_cdc_final_report_21913.pdf)).

In alignment with the behavioral health improvements commenced by Governor Markell, Delaware's current Governor John Carney, signed Executive Order 9 (May 8, 2017) which reestablished the Family Services Cabinet Council to develop a statewide family strategy to assure that public and private initiatives are coordinated and focused to provide the support and assistance required for the success of families in today's society. The mission of the Council shall be to design new service alternatives for school and community-based family-centered services, and otherwise act as a catalyst for public-private partnerships to reduce service fragmentation and make it easier for families to get supportive services. The Council is tasked, but not limited to, developing recommendations for implementing innovative tools and strategies for addressing breaking the school-to-prison pipeline; early childhood education; increasing affordable housing; substance abuse and treatment; prison re-entry issues and its collateral effects; the violence epidemic in neighborhoods; and job training. The Council, in conjunction with the Government Efficiency and Accountability Review Board ("GEAR"), shall also make recommendations regarding the appropriate responsibilities of all interagency and departmental boards, commissions, committees and other State governmental entities involved in the delivery or coordination of services to families, with the goal of maximizing their effectiveness by eliminating overlap and clarifying their respective missions. The Council shall review and, where appropriate, propose modifications of existing public programs and other initiatives to target present and proposed resources, including general funds, Federal funds, and other sources, so as to provide the most effective assistance to families. The Council shall work with its constituent agencies to coordinate their respective budget priorities and requests to best advance the statewide family strategy. The Council shall coordinate the State's efforts to secure Federal grants related to the support of families before such grant proposals are submitted for approval by the Delaware State Clearinghouse and shall advise the Clearinghouse and the agencies involved regarding issues related to coordination and consistency with the statewide family strategy. The Council shall be composed of the Governor, the Secretary of the Department of Services for Children, Youth, and Their Families, the Secretary of the Department of Health and Social Services, the Secretary

of the Department of Education, the Secretary of the Department of Labor, the Secretary of the Department of Safety and Homeland Security, the Director of the Delaware State Housing Authority, the Director of the Office of Management and Budget, the Commissioner of the Department of Correction, and such others as the Governor shall invite. All members will make data and other resources available from their respective organizations as needed to achieve the goals of the Council. Administrative support for the Council shall be provided by existing staff within each of the member State government agencies and from the Office of the Governor.

Governor John Carney also signed into law Senate Bill 111 and House Bill 220 (August 17, 2017) – bipartisan legislation aimed at curbing the addiction epidemic Delaware faces and improving resources for those struggling with mental illness. Senate Bill 111 creates the Behavioral Health Consortium; an advisory body comprised of community advocates, law enforcement, healthcare professionals, and state leaders that will assess and outline an integrated plan for action to address prevention, treatment, and recovery for mental health, substance use, and co-occurring disorders. House Bill 220 creates the Addiction Action Committee and has the specific charge of making recommendations on a strategic approach to address and monitor the addiction crisis. Lt. Governor Hall-Long has been the leading force behind the two pieces of legislation and has been tapped by Governor Carney to Chair the Consortium and lead Delaware’s efforts on improving behavioral health services.

The Department of Health and Social Services (DHSS) launched an updated and significantly improved version of Delaware’s centralized online resource for addiction prevention, intervention, treatment and recovery information, [HelpIsHereDE.com](http://HelpIsHereDE.com). The website is designed to assist people struggling with addiction, their families, the community, and medical providers. The new version of “Help is Here” is easier to navigate, can be translated into four languages (Spanish, Haitian Creole, French, and Chinese), is more mobile-device friendly, and offers updated information for the community and medical providers. Its expanded video section features new and highly personal testimonials from individuals in long-term recovery, parents who have lost adult children to overdoses, a treatment provider, and a police officer.

## **SYSTEM ENHANCEMENTS**

The Behavioral Health System in Delaware, which encompasses both mental health and substance use disorders (SUDs), has evolved and continues to be transformed. Much of this transformation is due to the stewardship of the leadership of the Division of Health and Social Services, the Department of Substance Abuse and Mental Health (“DSAMH”) and the Division of Public Health as well as the commitment of the Delaware legislative bodies to supporting increased treatment alternatives to incarceration, improved psychiatric crisis system, as well as enhanced local community collaboration.

Delaware has come to recognize the unique needs of individuals with complex behavioral health issues. These individuals experience a range of other risk factors, including unemployment, homelessness, and co-occurring health issues. Delaware also appreciates the need for specialized services for individuals with intellectual disabilities, new mothers with depression, and military trauma affected veterans and their families.

Delaware recognizes the need to further leverage technological innovations to allow people to have greater access to the information and care they need. Delaware state agencies and community organizations continue to also move toward research-based assessment tools and services that enable us do a better job defining and coordinating services.

In spite of these advancements, the behavioral health system continues to experience challenges, thereby requiring further transformation in its organizational system including its operating processes and procedures, workforce development and use of better technologies specifically with the goal of becoming more data-driven. Following SAMHSA's philosophy, DSAMH has adapted the approach that "Behavioral Health is essential to overall health that prevention (for many of these conditions) works, Treatment is effective, and People Recover". Delaware's approach will continue to push the use of evidence-based and innovative promising practices throughout the system. Integration of both mental health and substance use disorder services is important so that the State has no "wrong door" and people seeking services can get them wherever they land.

In addition, the integration of primary care services for many clients of DSAMH with Mental Health (MH) and Substance Use Disorders (SUD) disorders is another major goal. All people with serious mental health disabilities are vulnerable to several serious physical problems that have led to national research findings that people with serious mental health concerns die over 25 years earlier than the general population.

DSAMH is currently imbedding in all our provider contracts the expectation that services and supports will be accessible and seek to engage clients in treatment recommendations. As such, going forward, DSAMH will not have tolerance for wait lists, or inaccessibility to care. The best treatment for persons with alcohol, Opioid dependence, or addiction is often the use of intensive outpatient ambulatory services. The national research shows that the use of Naltrexone, Methadone, and Buprenorphine can be very effective; however, while effective, there may still be issues with diversion. DSAMH is working with DMMA to address these issues. To increase effectiveness of the services Delaware provides DSAMH needs to maintain people in their homes, in their jobs and in treatment.

DSAMH is continuously reviewing ways to improve service delivery. Key observations of the system designed and implemented by DSAMH because of the USDOJ Settlement in 2011, are as follows:

*While DSAMH has implemented many significant evidence-based programs throughout the state (i.e., ACT, ICM, TCM, etc.) these programs tend to exist as stand-alone components rather than as systems with multiple levels of care. In addition, DSAMH has not yet taken on the task of studying a medical home approach for mental health and substance use disorder clients. Due to the speed with which*

*DSAMH had to implement these programs, ACT became the de-facto model for most of mental health clients regardless of their specific needs or diagnostic categories. Related to number 2 above, DSAMH has yet to implement a robust Dialectical Therapy (DBT) component as a treatment option for certain mental health clients. Supported Employment (SE) for clients with severe mental illness is an evidenced based practice that should be in place for the mental health clients. In fact, SE has been a model that DSAMH has struggled to fully implement considering other critical program implementations. Timely access to CBHOT services tends to be problematic in that it often can take 3 to 10 weeks for clients to access appointments for medication prescribers.*

As DSAMH moves forward, certain strategic initiatives have emerged as priorities. Keeping in mind that the above stated issues are still lacking in sufficient data to fully understand their scope, DSAMH will include data collection as a preliminary first step in addressing these issues:

- Design a treatment provider approach that builds different levels of care into the same organization. The Community Mental Health Center, a comprehensive service approach to serving populations that require the ability to access varying levels of care according to their current needs is a model that DSAMH will explore. A model such as this, would reduce stand-alone programs, such ACT, ICM, TCM, Crisis Services etc., and organize them into centers where a client can access any level of care needed based on an assessment of needs. This approach would serve to begin integration of services and levels of care into one organization that creates greater flexibility and efficiency in meeting the complex needs of a group of clients.
- A natural next step for this approach would be the exploration of developing the concept of a Health Home. A health home—such as a Medicaid health home, as defined in Section 2703 of the Affordable Care Act—offers coordinated care to people with multiple chronic health conditions, including mental and substance use disorders. Health home services complement traditional medical, behavioral, and other services. Health homes address whole person care coordination needs—including substance use disorders—either through direct services or partnerships. (Referenced from: <https://www.samhsa.gov/integrated-health-solutions/build-practices/care-approaches/health-homes>).
- Explore designing a DBT program for adults served by the PROMISE program (1115 Medicaid Waiver). Development of this evidenced based practice will ensure clients are offered services that are individualized for their specific needs. As mentioned, currently, many of these clients are assigned to ACT or ICM teams that struggle to meet the needs that DBT would address.
- Review and explore implementation of SAMSHA’s Supported Employment evidenced based model for person with severe mental illness. There is a need to strengthen employment supports in both the ACT programs as well as for stand-alone Employment Contracts for those served outside of ACT. Delaware is

committed to furthering its efforts to achieve increased outcomes associated with employment for the clients we serve.

- Develop access standards for contracted provider services. Standards would include requirements for DSAMH contracted providers to admit clients into their programs. The initial emphasis for this initiative would focus on access to CBHOT programs.

This is a time of tremendous change in behavioral health, and the extent of these significant changes for Delaware are uncertain. However, Delaware is committed to pursuing broad transformative efforts to meet the fluid landscape of behavioral health needs of its diverse population.

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<sup>i</sup> See Appendix (?) for List of Acronyms

<sup>ii</sup> See Appendix (?) for the Attached MOU

<sup>iii</sup> See Appendix (?) for List of Acronyms

<sup>iv</sup> See Appendix (?) for List of Acronyms

## Planning Steps

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

Narrative Question:

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

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

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

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

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

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

Footnotes:

## Step Two Narrative:

**Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps in populations relevant to each block grant within the state's behavioral health system, especially for those required populations**

Delaware is a small, but diverse state, located in the Northeast Corridor 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, as of July 2016, has a population of 71,442. This represents 13% of New Castle County's 556,987 total population. Kent County has 174,827 residents or 18% and Sussex County has 23% of the State's population at 220,251 residents. Combined, Kent and Sussex counties contain 66 percent of the State's land area but only 41% 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.

Delaware is divided into four sub-state planning areas by SAMHSA: the city of Wilmington, the remainder of New Castle County, Kent County and Sussex County. Delaware's State Epidemiological Outcomes Workgroup (SEOW) sponsored through the SPF-PFS award has also used these sub-state planning areas for the purpose of the development and analysis of its annual State (and sub-state) Epidemiological Profiles.

Based on the US 2016 Census population data, Delaware has 952,065. Seventy-eight and a half percent (747,371) of the population are individuals ages 18 and over, and 21.5% (204,694) of the population are children and youth (age 0 - 17). African-Americans (non-Hispanic) comprise 22.6% and individuals of Hispanic origin comprise 9.2% of the total state population.

From 2010-2016, Delaware saw a 6% population growth. By 2025, Delaware is expected to have 1,014,667 residents. In October 2016, the Delaware Population Consortium Population Projection Series reflects 114,020 youth in the 0 – 9-year-old age group with that number expected to be 115,881 in 2025. The 10 – 19-year-old population is listed as 119,674 with that number expected to be 118,559 in 2025. The Delaware Population Consortium Population Projection Series 2016 data show Delaware's 20-64 year olds to be 563,089 and by 2025 to be estimated at 568,188. The 65 and older population 2016 population was listed as 164,901 and is expected to jump to 212,039 by 2025. That is 47,138 more seniors residing in the state over the next eight years. Delaware's 2016 Veteran population includes 75,081 veterans with approximately 17% under the age of 30.

Census 2016 median household income in Delaware was \$ 60,509. Delaware's major businesses include banking and financial services and healthcare and pharmaceutical industries. The single largest employer was the State of Delaware, with over 13,000 employees. In December 2016, Governor Markell's 2016 State of the State Address, State of Delaware Diversity and Inclusion Study prepared by the Ivy Planning Group noted that about 30 percent of the current State workforce will be eligible for retirement by 2019, according to the Civil Service Commission. That is the largest share of employees projected to retire and exit the workforce since 2009. Also, noteworthy is the data that indicates that almost 50 percent of public school students were students of color. These demographic trends and Delaware's growing multicultural communities, make the needs of not only youth and young adults, but also minorities, veterans and the elderly even more compelling as the data suggests these populations are most in need of resources.

DSAMH and DPBHS rely on various sources of information in order to identify needs and establish planning and programmatic priorities. Through the use of local program and assessment data, as well as national survey results such as the National Household Survey on Drug Use and Health (NSDUH), and other sources, they have identified several priority populations for which substance abuse and mental health services are focused. These include some of the following: youth at risk of substance abuse disorders; LGBTQ individuals; persons ages 12 and older needing, but not receiving services for treatment for alcohol and illicit drug use; injecting drug users; pregnant women and women with dependent children in need of treatment services; Veterans; and the aging population in the State.

The unmet service needs and critical gaps within the current system are lack of: (1) needs assessment that are reflective of the communities to be served; (2) coordinated services that are family focused; (3) culturally competent services which address racial, ethnic, and sexual minorities; linguistic barriers; rituals and traditions which are often barriers to accessing services; geographic location and sexual orientation. Although substance abuse prevention services infrastructure has advanced significantly in the last eight years, these are still critical unmet service gaps, as identified in the 2017 Delaware Epidemiological Report.

Delaware Substance Abuse and Mental health (DSAMH) and Delaware Prevention and Behavioral Health Services (DPBHS) collaborated with the Center for Drug and Health Studies (CDHS) as the lead on State Epidemiological Outcomes. CDHS is located at the University of Delaware and was founded in 1991 as the Center for Drug and Alcohol Studies (CDAS) per the outgrowth of funding opportunities initiated by the National Institute on Drug Abuse (NIDA). In 2007-2008, with SAMHSA support, DSAMH and CDHS collaborated to establish the Delaware State Epidemiological Outcomes Workgroup (DE-SEOW). The SEOW was subsequently funded through previous Strategic Prevention Framework-State Incentive Grant (SPF-SIG), and continues through funding from Strategic Prevention Framework-Partnerships for Success Grant (SPF-PFS).

Prevention and Behavioral Health (DPBHS) is the division within the Delaware Department of Services for Children, Youth and their Families that provides prevention



and behavioral healthcare services for youth through age 18, as well as providing some services to families. DSAMH picks up at age 18 and continues through the life span in providing prevention services. Their efforts, and those of the SEOW serve Delaware families through data driven prevention and early intervention programs that promote safe and healthy children, nurture families, and provide services to adults and communities through the lifespan. DPBHS and DSAMH prevention services promote resiliency and well-being. Service options have varying intensity levels in order better meet the needs of children, youth, families, and adults. DPBHS and DSAMH are committed to provide prevention services within a child-centered and family-driven system of care framework aligned within SAMHSA's Strategic Prevention Framework. We understand that today's youth and families and adults often experience stress that can lead to early substance use and abuse. Therefore, we strive to deliver services in an informed manner that respects each individual's journey through their lifespan.

The Delaware SEOW is a collaborative representative body of State agencies, community organizations, statewide non-profits, Universities, and Federal partners. With a membership of over 25 Delaware different agencies and entities ranging from State agencies (*e.g., Delaware Department of Education, Delaware of State Office of Controlled Substances, Department of Health and Social Services, Department of Services for Children, Youth and their Families, Department of Justice, etc.*) to local nonprofits, health focused entities and community focused agencies (*e.g., DEMCO, La Esperanza, Open Door, Inc., atTack Addiction, Delaware Coalition Against Domestic Violence, Christiana Care Health Systems, Nemours Health and Prevention Services, Mental Health Association of Delaware*), the SEOW consistently produces data-driven products and makes them available through multiple communications channels, including web-based (including social media), electronic dissemination directly to state agencies and e-mail distribution networks. The SEOW facilitators also share hard copies of relevant products at meetings and conferences as appropriate and conduct webinar trainings. Data products vary in topic and length, but the most vital and comprehensive product is the annual State Epidemiological Profile, which is created annually with the goal of being used to facilitate strategic, data-driven prevention planning, policy and programming.

The 2017 Epidemiological Profile contains substance use data from over 17 data sources and includes over 120 different data tables across 11 different chapters. Chapters cover the major substances of concern (alcohol, marijuana, opioids, tobacco, etc.) as well as cross-cutting issues that may impact substance use and prevention, such as mental health, adverse childhood experiences, and protective factors. Based upon feedback from SEOW members, the 2017 report also addresses potential action steps and policy considerations to promote and support prevention efforts. (See: <https://www.cdhs.udel.edu/contentsubsite/Documents/2017%20Epi%20Report/2017%20Delaware%20Epidemiological%20Report.pdf>).

Thus, the SEOW continues to function under its established threefold mission: (1) To create and implement a systematic process for gathering, reviewing, analyzing and integrating data that will delineate a comprehensive and accurate picture of state

substance related consumption patterns and consequences; (2) To inform and guide substance abuse prevention policy, program development and evaluation in the State; and, (3) To disseminate information to State and community agencies, to targeted decision-makers, and to the Delaware public.

Specific archival activities implemented through the DE SEOW include, but are not limited to decision-makers to facilitate planning, monitoring and evaluation of prevention efforts.

Delaware's Prevention System has provided archival data activities implemented through the DE SEOW, and these efforts continue to identify gaps in needs assessment data as well as service delivery. The collection and assembling of data from state and national sources includes information on consequences of substance use as defined by the membership of the group, quantifiable relationships of specified substances to those consequences, and identified risk and protective factors associated with the pathways; data sources include youth surveys, vital statistics, law enforcement databases, health databases and other related sources. In keeping with prior work, the SEOW continues to provide input to other specific committees and task forces in the state to address ongoing and/or current issues (e.g., Cultural Competence, Identification of Evidence-based Practices, SBIRT Task force, Early Warning Network for identifying and reporting on drug crises (heroin overdoses) and emerging drug problems (e.g., youth prescription misuse).

The SEOW's analysis and synthesis of data to illustrate consumption patterns and consequences and their impact on Delaware's health and culture are used to identify and provide specific prevention targets and to facilitate the development of an achievable, effective prevention plan; that can be monitored over time for progress. These activities are required for the development of a true strategic prevention framework for Delaware.

Besides these data sources for which the SEOW has direct access, the SEOW directly partners with and has representation with other state groups focused on data collection and dissemination in areas related to the goals of the SABG. These include Kids Count Delaware, the Delaware Violent Death Reporting System, the Prescription Drug Action Council, the Delaware Suicide Prevention Coalition, the Delaware Coalition Against Domestic Violence, the Wilmington Coalition Against Violence, the Delaware Health Care Innovation Board, the IMPACT Tobacco Coalition, the DSCYF Advisory Committee, several groups of Delaware's State Innovation Model award including the Healthy Neighborhoods Data Committee, and a number of neighborhood coalitions. Of note, these organizations and groups cross over different state Departments and Divisions and community groups in all 3 of Delaware's counties, providing direct access for the SEOW to data gatherers and policymakers

### **Prevention Service System Gaps**

These reported service gaps are a mirror reflection of the previously identified gaps that are being addressed. DSAMH's previous narrative indicated the following: (1) the need for needs assessments that are reflective of the communities to be served; (2) the lack

of coordinated services that are family focused services; (3) the need for culturally competent services which address racial and ethnic minorities; linguistic barriers; rituals and traditions which are often barriers to accessing services; geographic location and sexual orientation.

A semi-structured qualitative survey of current prevention contractors on unmet needs and critical gaps, yielded the following areas to be addressed:

1. Needs assessment that are reflective of the communities to be served
  - a. a qualified workforce; and,
  - b. inconsistency in definitions of service categories
2. The lack of coordinated services that are family focused services
  - c. lack of coordination and collaboration with other State agencies, local providers and community organizations;
  - d. the current two-tiered system that implies lack of continuity of service provision;
  - e. lack of clarity in policies and procedures regarding the delivery of substance abuse prevention services; and,
  - f. lack of integration of prevention and treatment services.
3. Culturally competent services which address racial, ethnic and sexual minorities; linguistic barriers; rituals and traditions which are often barriers to accessing services; geographic location and sexual orientation
  - a. Availability of culturally competent evidence-based programs/practices;

These reported gaps in services are a mirror reflection of the gaps identified in previous plans with additional specificity. To address these gaps, the SEOW produces monthly one-page “DDATAGrams” that focus on specific topics addressed within that 30 day period, annual hot spot mapping, semiannual gap reports that identify gaps in data (knowledge) or gaps in services and respond to data requests and questions posed by the State and the SEOW partners. Examples of these data requests include disparities in prescription drug use. These datagrams assist in addressing the specific and overall gaps reported.

At present, DSAMH can provide: (1) some accurate data on adults in Delaware by sub-state planning area; (2) provide prior year data on youth, however, there are minimal data available on adults and more specifically high risk adults; (3) better assess the accuracy of decisions based on extrapolated data reducing the probability of error in reporting; (4) provide additional information for the persons who would qualify for primary prevention services; (5) create sustainability options for prevention services beyond federal funding. Again, more improvement with data integration is needed for prevention activities at the community level. “If you don’t measure it, it has not been done.” Contractors are being asked to update sustainability plans annually, with specific benchmarks and strategies that will help cope with decrease in federal funding. Plans include an increase in more environmental strategies and the development of concomitant stable state funding for services.

Delaware, like all states, is presented with challenges when trying to address substance use through primary prevention activities. Currently, there is no statewide mechanism or entity to coordinate or discuss community led prevention efforts. Previous efforts to coordinate information sharing as well as collaboration, even with State supported funding, have not been sustained, and some communities continue to be marginalized in their efforts when addressing similar issues in similar geographic areas. Creating statewide environmental change that will be sustainable post funding, although of necessity, has received a greater focus. However, creating environmental change is more realistically achievable if there are shared and agreed upon substance use prevention priorities across different state agencies and funding sources.

Finally, building upon the work of the first iterations of the SEOW in prior SPF funding cycles, the Delaware SEOW facilitators have increased their efforts to raise their visibility to generate and to share data through facilitation of its relevance by County. This improves data functioning and enhances the potential for sustainability. Recently, the SEOW conducted a webinar, with support from the CAPT, to promote how the SEOW can and should be accessed in Delaware as resources for identifying and interpreting data for assessments, planning, and evaluation of prevention-focused effort. Delaware SEOW facilitators also spearheaded, again with the CAPT, a regional SEOW peer-sharing workgroup to discuss best practices among SEOWs in regards to promoting data usage in products and prevention planning.

In partnership, DPBHS and DSAMH are ensuring that all SEOW data are captured in a manner that can be utilized to predict needs from infancy through the life course. From knowledge of the individual level data, community partners are sought that can best deliver culturally competent services, programming and information for self-ownership of prevention behaviors by both individuals and communities. From there, we are able to provide technical assistance at the State level and seek assistance from the Federal level to ensure State efforts are aligned with those of SAMHSA. This allows us to make significant strides in addressing prevention issues using data as the back drop for all decisions.

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Footnotes:

## **Planning Steps**

### **Quality and Data Collection Readiness**

#### **Adult Behavioral Health System**

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 continues to meet on a regular basis to monitor and 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.

#### **Unique Client Level Data**

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.

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 identifier of the parent organization are based on the national provider identification systems maintained by CMHS and CSAT.

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.

### **Unique Information Technology Systems**

**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 it 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.

#### **Efforts to Assist Providers with EHRs**

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 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 providers. This speeds the transmission of data and increases security.

During SFY17, DSAMH began Phase 1 of implementing an Electronic Health Records system. CORE Solutions has developed a system for Delaware which will collect relevant assessment data and assist with 3<sup>rd</sup> party billing practices. CORE Solutions will enhance Delaware's data collection systems and the implementation of information technologies. We are currently using the EHR for our PROMISE Care Management Program and our Mobile Crisis Unit. We are beginning Phase 2 which is our "Payor" module which will accept electronic billing claims for MH and SUD clients. This will improve our ability to capture real time service utilization for each client. This will expand our data reporting capabilities and we will be able to utilize that data to develop performance outcome measures. We will be able to see, in real time, the complete individual services provided to each consumer which will increase our monitoring/compliance activities to ensure evidence based practices are being followed. This will also increase our ability to have timely submission of our client demographic data as it will be submitted prior to claims for payment.

### ***Substance Abuse Prevention***

Delaware is currently on the cutting edge in creating a unified, comprehensive system for the development, delivery, evaluation and replication of substance abuse prevention services. As previously discussed the reality of a two tiered system of service development and delivery is responsible for the perception of a lack of readiness, which impacts quality.

DSMAH and DPBHS have consistently collected data which has been used to develop a prevention service delivery system. While "no harm" can be documented, the duality or "siloes" appearance of the system creates the potential for fragmentation and lack of quality in service delivery. It is virtually impossible to provide sustainable results when the system are incompatible and often competing in nature.

In response to the 2016 SAMHSA Core review, it was clearly and repeatedly stated that it was imperative to work toward a unified prevention service delivery system that would mirror, but maintain the uniqueness of each agency's target population and mission. The efforts to respond to this recommendation have resulted in the adoption of the IMPACT system of program data collection using the MOSAIX software.

Each agency completed an informal assessment of its current data collection efforts and shared that while both DSAMH and DBPHS were required to collect the same data, the collection, analysis and reporting were vastly different. Key informants indicated that one system would more effectively utilize staff time, while benefitting the agencies in being responsive to unmet or critical needs. As of January, 2017, DSAMH and DPBHS will be using the IMPACT system.

The transition for DSAMH providers was smooth in, given the IMPACT system followed the five steps of the Strategic Prevention Framework has been the basis of service development and delivery since 2010.

### **Description of Current System:**

Currently the State's approach to quality and data collection is achieved through a contract with MOSAIX Software Inc. The IMPACT<sup>SAPT</sup> is a multi-level grants management system that is designed to ensure that States receiving SABG prevention dollars are collecting accurate and timely data needed to meet federal block grant reporting requirements.

IMPACT was created with the understanding that grants management is an organizationally driven process. After all, organizations receive and manage multiple grants simultaneously. While the reporting requirements may vary, there are some fundamental functions that are needed across the organization. Working closely with clients through this process, allows MOSAIX to configure IMPACT to an organization's workflow. The remainder of this document will focus on the application of IMPACT for the management of grants by those organizations involved with the management of substance abuse prevention.

IMPACT provides options as to how the State can configure IMPACT to manage Provider's grant programs. Since each state can change the terminology for their implementation, this guide will not address those changes, and will utilize the generic Model IMPACT.

IMPACT uses a series of integrated quantitative evaluation modules that are designed to individualize how a program measures progress toward system and individual program goals and objectives over time and then report the actual results in relation to the services and activities that were provided to your communities. Additionally, IMPACT includes an extensive library of reports that can be used by the State, Region, or Community or Provider level to manage its organization.

The benefit of the combined system includes:

- Allows for organizations to retrieve data entered throughout the IMPACT system
- Reports show the relationship between planning efforts with the services that are delivered
- Reports show the relationship between planning efforts with the services that are delivered
- A number of filtering options are available allowing organizations to customize how they view their data
- Managing organizations can access data for all organizations that they manage
- Provides plug and play Block Grant Reporting to ensure State is always compliant with the Block Grant

IMPACT also provides a unique capability in its fully integrated funds management system (IMPACTFM). IMPACTFM allows you to plan and track the spending of your prevention funds. For the first time, it's possible to track your process, outcome, and financial information all in one system and to be able to answer questions such as "How much did we spend on prescription drug misuse prevention last year."

The State can improve the quality of data and reporting by using IMPACTFM to report on Primary Prevention Planned Expenditures and Non-Direct Services/System Development expenditures required for SABG reporting.

In addition to the implementation of the IMPACT system, DSAMH will be working to secure external evaluation services, which would be compatible with the current evaluation contract managed by DBPHS.

### **State Programmatic Challenges:**

Currently the DSAMH has not fully implemented the IMPACT system for program reporting. All community contractors have received training in the use of the instrument and have accessed technical assistance to ensure accuracy in data reporting. The development of program work plans which will serve as a guide for reporting are in the initial stages of development.

The decision to require all SABG prevention providers to utilize a common data collection instrument is in alignment with ensuring that the Delaware substance abuse prevention system, while physically located in two Departments, speak and act in accord of one voice to ensure a consistent, competent delivery of services. The strategic approach to data collection and reporting helps to meet the State's reported unmet needs of: consistency in data collection and reporting; it supports the data contained in the State's Epidemiological Profile and it is a key element for sustainability.

It is anticipated that the State's substance abuse prevention providers will be fully functioning at the beginning of the new fiscal year, October 1, 2017.

The State is fully aware that its readiness and implementation have not been a coordinated effort, however, the proposed data collection system improvements is responsive to the SAMSHA Core Review Recommendations, but also to developing a sustainable system of prevention services.

### **Child Behavioral Health System**

### **Unique Client Level Data**

DPBHS is currently Providing TEDS (Treatment Episode Data Set) Substance abuse data and have completed and submitted the Client Level Reporting Data set as well. Moving forward DPBHS will be providing the TEDS Substance Abuse, TEDS Mental Health, and Client Level Reporting data set from our FACTS II system. The creation of those data sets is part of the system output design specifications of our FACTS II system, and collection of the data is integral to the system.

### **Unique Information Technology Systems**

The Department of Services for Children Youth and their Families has a comprehensive integrated system which serves all of the clients across our department; The Family and Child Tracking System (FACTS). Within FACTS is a Behavioral and Mental Health section for the Division of Prevention and Behavioral Health Services (DPBHS). Clients are identified with a Unique 1-7 Digit Personal Identification Number (PID) which stays with the client throughout their entire treatment history with DPBHS. The system stores demographic, information as well as complete service history by date based service episode which is identified with a unique case identifier. DPBHS captures admission and discharge dates, assessments, treatment plans, specific service information, contact information, case treatment notes, provider treatment records, billing records and client educational information. The DPBHS 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 DPBHS system includes national provider identifiers. DPBHS also has an interface with other state systems and participate in client data exchanges as appropriate and allowed under confidentiality requirements.

### **Efforts to Assist Providers with EHRs**

The State of Delaware has a private organization called the Delaware Health Information Network DHIN which is working towards developing an EHR exchange throughout the State of Delaware. It is up to individual providers to create or license their own EHR and participate in the DHIN. Currently most providers who write Prescriptions use the DHIN and most all Delaware Pharmacies are participating. DPBHS supports the Use of Electronic Health records but currently has not technology licensed for that application, nor do we provide funding or assistance to our providers in that regard. DPBHS plans to make diligent efforts going forward to co-operate with, and participate in all electronic health record initiatives as funding and technology allow. DPBHS will work with DSAMH to discuss funding the Electronic Health record Initiative and its deployment to our provider network.



# Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1  
 Priority Area: Opiate Prevention and Early Intervention  
 Priority Type: SAP, MHS  
 Population(s): PP

Goal of the priority area:

Across the US today, health, crime, and social problems stemming from prescription opiates, heroin and illegal opioids (e.g., carfentanyl and other opiate-based new psychoactive substances) are wreaking havoc among large segments of the population. Delaware is squarely in the middle of these threats. It ranks among the top 25% most problematic states in the nation with regard to opiate-related fatalities. The Prescription Behavior Surveillance System's (2016) recently reported drug overdoses in Delaware have increased to about 21 deaths per 100,000 residents and that deaths attributed to prescribed opiate medicines comprised about 42% of all deaths in 2014, while heroin accounted for 29%. While the age-adjusted drug-poisoning death rate for the United States was 14.6 deaths per 100,000 population in 2013, Delaware exceeded this national average at 19.1 per 100,000 population, ranking 11th nationally (see Rudd, Seth and Scholl 2016). This is a national problem but particularly acute in Delaware. The goal is to stem the increases in consumption and consequences and then to reduce the incidence of new use of opiates and opiate-related problems. To do this requires that the SABG efforts be coordinated with the other existing and newly funded efforts in the state to address the crisis (BJA, CDC, NIJ, ONDCP). There needs to be a multi-faceted prevention, intervention, and treatment effort to the opiate epidemic in the state, like the effort that was accomplished with tobacco. Only by coordinating prevention with the other efforts will the state be able to succeed.

Objective:

Introduce evidence base programs and practices that provide prevention-focused strengths and assets to at-risk youth and adults to reduce initiation of use and to intervene with experimenters before use becomes abuse or dependence. For youth these are primarily primary prevention programming; for adults EB early intervention programs are also needed. Also to integrate these prescription opiate prevention efforts with the other treatment, criminal justice, and environmental efforts now underway in the state to make a coordinated initiative against the scourge of prescription opiates.

Strategies to attain the objective:

New Program areas needed for treatment and criminal justice have been outlined by new county and state task forces seeking to address the opiate issue. However, programs for primary prevention and secondary prevention have not been strong components of these recommendations. DSAMH and DPBHS prevention specialists need to be at the table in the statewide initiative. They can provide access to SAPG support for Evidence-based opiate prevention programming for both youth (primary prevention) and adults (secondary prevention and early intervention). They can also provide input on environmental prevention strategies to coordinate with environmental efforts by the treatment and law enforcement partners.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Delaware PDMP, DSAMH and DPBHS treatment data bases, DPH Vital records, the new Delaware Violent Death Reporting System (CDC), DELJIS, and other criminal justice databases. Delaware School Survey and Delaware YRBS data for youth, Delaware BRFSS and NSDUH for young adults and adults -- reports on opiate use, abuse and dependence.
Baseline Measurement:	2016 measures of problem prescribing patterns from the DE PDMP, as well as criminal justice and overdose data from 2016.
First-year target/outcome measurement:	10% reduction in patterns of prescriber misuse and patient misuse of prescriptions using PDMP and other data from 2018 to compare to 2016 baseline data (2017 data will be examined, but since new SABG programs will not have been fully implemented by then, it is too proximate to be used as a formal outcome benchmark). These data will come from ongoing analyses of data collected as part of the SPF Rx grant initiative from SAMHSA.
Second-year target/outcome measurement:	An additional 5% reduction in PDMP/Overdose reports related to misuse, again as measures are available from the SPF Rx initiative and the PDMP data for 2019.
Data Source:	

Use of Records data from the Prescription records of the Delaware PDMP, US Census data on demographics and other neighborhood characteristics (e.g., poverty, education), data on drug-related arrests and convictions from DELJIS, and overdose deaths from the DE Division of Forensic Science. Survey data on youth and adult Prescription opiate use and abuse will come from the DSS survey annual data and YRBS survey bi-annual data of middle and high school students in DE and the NSDUH state level data for Delaware.

Description of Data:

DE PDMP provides information on all Prescribed opiates by patient and provider and in collaboration with the other Prescription Opiate initiatives continuing and beginning in the State, as described in Indicator 1 above.  
Biannual YRBS surveys of middle school and high school students via YRBS; annual census of 8th, and 11th graders using survey questions modelled on Monitoring the Future and the NSDUH. The surveys provides good measures of frequency and consumption of Prescription opiates as well as other substances. This includes DSM approximations of abuse and dependence on opiates using an algorithm modified from the NSDUH for youth data available only in the DSS.

Data issues/caveats that affect outcome measures::

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Indicator #: 2  
Indicator: To develop and sustain a qualified, prevention workforce  
Baseline Measurement: Provider verification of prevention staff (certified and non-certified)  
First-year target/outcome measurement: 10% increase in the number of Certified Prevention Specialists. Increased number of prevention relevant professional development  
Second-year target/outcome measurement: Additional 10% increase in the number of new Certified Prevention Specialists. 5% maintenance of current Certified Prevention Specialists

Data Source:

Delaware Certification Board; provider job description; training participant rosters

Description of Data:

Delaware Certification Board maintains an active, publically accessible list of current certified professionals. The Board certification list indicates date of initial certification. Certification must be renewed every two years. Data will allow DSAMH and DPBHS to determine needed training and professional development to ensure stability of workforce

Data issues/caveats that affect outcome measures::

Funding sources must require certification to help ensure a qualified workforce. Hiring practices must be deliberate in the requirement of prevention experience and obtaining of prevention credential. Providers must support training through work release time and financial support. Culturally competent and ongoing training must be readily available. Professional development must be linguistically appropriate.

Indicator #: 3  
Indicator: Create a culturally competent continuum of care which addresses the diverse (language, sexual orientation, geographic location and life experiences) needs of the respective populations  
Baseline Measurement: Community needs assessment to determine cultural demographics, inclusive of language  
First-year target/outcome measurement: 50% of all prevention training, technical assistance will be developed, delivered and evaluated using the standards prescribed by SAMHSA (Culturally and Linguistically Appropriate Services) CLAS standards and TIP 59 Improving Cultural Competence (SAMHSA 2015)  
Second-year target/outcome measurement: 50% of all prevention training, technical assistance will be developed, delivered and evaluated using the standards prescribed by SAMHSA (Culturally and Linguistically Appropriate Services) CLAS standards and TIP 59 Improving Cultural Competence (SAMHSA 2015)

Data Source:

Utilization of current census data to determine cultural and ethnic diversity; 2017 State Epidemiological Profile; SAMSHA Tip 59



Description of Data:

SAMSHA has developed cultural competence standards for service development, delivery and evaluation. The CLAS standards serve as a guideline for assessment of needs and protocols for development of services. CLAS standards must be included in all SAMSHA funded grants and cooperative agreements.

Treatment Improvement Protocols (TIP) series has developed a guide for the development, delivery and evaluation of culturally competence programs and services

Data issues/caveats that affect outcome measures::

Availability of indigenous leaders and professionals to provide input on service development, delivery and evaluation of prevention services. Accessibility of services in areas with significant concentrations of persons whose native language is not English. Immigration and documentation for populations which are highly mobile. Traditions, customs and rituals often limit external resources to be accessed

Indicator #: 4

Indicator: Create a data driven continuum of care that is sustainable beyond federal funding

Baseline Measurement: Current chart of funding sources that indicates levels of funding; duration of funding; requirements for renewal and strategy for maintenance of funding base. The chart would be used internally to help guide provider resource development

First-year target/outcome measurement: 5% increase in non-federal resources to maintain prevention programming. The increase would provide data to strengthen Sustainability Plan and equalize funding resources.

Second-year target/outcome measurement: 5% increase in non-federal resources to maintain prevention programming. The increase would provide data to strengthen Sustainability Plan and equalize funding resources.

Data Source:

Self reporting of baseline resources and increase in resource development. Program specific data generated through State Epidemiological Profiles. Ongoing local needs assessment which describe and forecast trends and/or patterns which impact service development.

Description of Data:

Though continual needs assessment, data collection, analysis and reporting programmatic and fiscal decisions can be made to sustain prevention efforts. The transition of the SEOW mandates would continue through integration into the State's Behavioral Health committees, workgroups, task forces

Data issues/caveats that affect outcome measures::

The primary issue that will impact this outcome's success is the availability of resources. Providers must position themselves to be diversified, but maintain integrity of mission and purpose. Qualified workforce to assist in resource development. Restrictions placed on the provider through organizational policies or procedures. Strategic and ongoing data collection efforts which serve as the basis for program decision making

Indicator #: 5

Indicator: Inventory of current utilization of EBP by prevention providers

Baseline Measurement: 2016 implementation of Evidence-Based Programs/Practices by prevention providers

First-year target/outcome measurement: 25% increase in identification and utilization of EBP for service delivery

Second-year target/outcome measurement: 25% increase in identification and utilization of EBP for service delivery

Data Source:

National Registry of Evidence-based Programs and Practices (NREPP)

Description of Data:

NREPP is a searchable, online registry of substance abuse and mental health interventions sponsored by SAMSHA. The purpose of NREPP is to help the public learn more about evidence-based intervention that are available for implementation. The Registry is a publically accessible site which includes a description of available EBPs; standards for inclusion and requirements for adaptation and replication or utilization.

Data issues/caveats that affect outcome measures::

EBP not available for target population. Process for developing promising practice in lieu for practices not available

Priority #: 2  
Priority Area: Alcohol Abuse prevention and early intervention  
Priority Type: SAP, MHS  
Population(s): PP

Goal of the priority area:

To reduce the incidence and prevalence and early onset of alcohol abuse, utilizing effective early intervention strategies as reported through national and State data.

Objective:

Continue to reduce incidence and consequences of youth alcohol use and reintroduce a coordinated effort to address alcohol abuse among adults.

Strategies to attain the objective:

Continue existing successful programs (mostly youth) and institute new evidence based prevention programming (EBPP, new focus on adult programs needed) on state, substate and community level that addresses the issue of alcohol abuse in an age appropriate manner for each of youth, young adults, and older adults. Programs from NREPP and other registries will be given preference.

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Delaware School Survey and Delaware YRBS data for youth, Delaware BRFSS and NSDUH for young adults and adults -- reports on alcohol use and abuse  
Baseline Measurement: 2016 measures from DSS, YRBS, BRFSS, and NSDUH as reported in State Epidemiological Profile  
First-year target/outcome measurement: 10% reduction in frequency, consumption, and consequence indicators as seen in 2018 surveys  
Second-year target/outcome measurement: Additional 5% reduction in frequency, consumption and consequence measures in 2019 survey data.

Data Source:

SAMSHA sponsored annual Delaware School Survey, bi-annual Youth Risk Behavior Survey data.

Description of Data:

Biannual YRBS surveys of middle school and high school students via YRBS; annual census of 5th, 8th, and 11th graders using survey questions modelled on Monitoring the Future and the NSDUH. Surveys provide good measures of frequency and consumption of alcohol and other substances. Also measures to approximate DSM criteria of abuse and dependence.

Data issues/caveats that affect outcome measures::

School data sample sizes are large, amounting to a census in some cases, so that good county, sub state, and even community level estimates can be obtained on an annual basis. But school data are only representative of children in school, so some particularly at risk high school students who have dropped out are not included.

Indicator #: 2  
Indicator: Reduce Alcohol Related Traffic Incidents

Baseline Measurement: 2016 measures from OHS and DSS, as reported in State Epidemiological Profile

First-year target/outcome measurement: 10% reduction in alcohol-related traffic incidents and reports of drinking and driving as seen in 2018 OHS data and DSS surveys of high school students, and NSDUH reports for Adults in 2018 survey data.

Second-year target/outcome measurement: Additional 5% reduction in alcohol-related traffic incidents and reports of drinking and driving as seen in 2019 OHS data and DSS surveys of high school students, and NSDUH reports for Adults in 2019 survey data

Data Source:

Office of Highway Safety statistics, SAMSHA sponsored annual Delaware School Survey, and state level NSDUH data for adults

Description of Data:

Office of Highway Safety statistics on Single Vehicle Crashes, alcohol related motor vehicle morbidity and mortality, and repeat offenders. Annual DSS census of 8th and 11th grade student's surveys provides good annual self-report measures on drinking and driving and on riding with a drinking driver. Also measures to approximate DSM criteria of abuse and dependence. Similar information for young adults and adults comes from the NSDUH state survey.

Data issues/caveats that affect outcome measures::

SVCs are a common measure, but still an approximation for alcohol involved motor vehicle incidents. School data sample sizes are large, amounting to a census in some cases, so that good county, sub state, and even community level estimates can be obtained on an annual basis. But school data are only representative of children in school, so some particularly at risk high school students who have dropped out are not included.

Indicator #: 3

Indicator: To develop and sustain a qualified, prevention workforce

Baseline Measurement: Provider verification of prevention staff (certified and non certified)

First-year target/outcome measurement: 10% increase in the number of Certified Prevention Specialists. Increased number of prevention relevant professional development

Second-year target/outcome measurement: Additional 10% increase in the number of new Certified Prevention Specialists. 5% maintenance of current Certified Prevention Specialists

Data Source:

Delaware Certification Board; provider job description; training participant rosters

Description of Data:

Delaware Certification Board maintains an active, publicly accessible list of current certified professionals. The Board certification list indicates date of initial certification. Certification must be renewed every two years. Data will allow DSAMH and DPBHS to determine needed training and professional development to ensure stability of workforce.

Data issues/caveats that affect outcome measures::

Funding sources must require certification to help ensure a qualified workforce. Hiring practices must be deliberate in the requirement of prevention experience and obtaining of prevention credential. Providers must support training through work release time and financial support. Culturally competent and ongoing training must be readily available. Professional development must be linguistically appropriate.

Indicator #: 4

Indicator: Create a culturally competent continuum of care which addresses the diverse (language, sexual orientation, geographic location and life experiences) needs of the respective populations

Baseline Measurement: Community needs assessment to determine cultural demographics, inclusive of language

First-year target/outcome measurement: 50% of all prevention training, technical assistance will be developed, delivered and evaluated using the standards prescribed by SAMHSA (Culturally and Linguistically

Second-year target/outcome measurement: 50% of all prevention training, technical assistance will be developed, delivered and evaluated using the standards prescribed by SAMHSA (Culturally and Linguistically Appropriate Services) CLAS standards and TIP 59 Improving Cultural Competence (SAMHSA 2015)

Data Source:

Utilization of current census data to determine cultural and ethnic diversity; 2017 State Epidemiological Profile; SAMSHA Tip 59 Improving Cultural Competence; CAPT Online Training courses

Description of Data:

SAMSHA has developed cultural competence standards for service development, delivery and evaluation. The CLAS standards serve as a guideline for assessment of needs and protocols for development of services. CLAS standards must be included in all SAMSHA funded grants and cooperative agreements.

Treatment Improvement Protocols (TIP) series has developed a guide for the development, delivery and evaluation of culturally competence programs and services

Data issues/caveats that affect outcome measures::

Availability of indigenous leaders and professionals to provide input on service development, delivery and evaluation of prevention services. Accessibility of services in areas with significant concentrations of persons whose native language is not English. Immigration and documentation for populations which are highly mobile. Traditions, customs and rituals often limit external resources to be accessed

Indicator #: 5  
Indicator: Create a data driven continuum of care that is sustainable beyond federal funding  
Baseline Measurement: Current chart of funding sources that indicates levels of funding; duration of funding; requirements for renewal and strategy for maintenance of funding base. The chart would be used internally to help guide provider resource development  
First-year target/outcome measurement: 5% increase in non-federal resources to maintain prevention programming. The increase would provide data to strengthen Sustainability Plan and equalize funding resources.  
Second-year target/outcome measurement: 5% increase in non-federal resources to maintain prevention programming. The increase would provide data to strengthen Sustainability Plan and equalize funding resources.

Data Source:

Self-reporting of baseline resources and increase in resource development. Program specific data generated through State Epidemiological Profiles. Ongoing local needs assessment which describe and forecast trends and/or patterns which impact service development.

Description of Data:

Though continual needs assessment, data collection, analysis and reporting programmatic and fiscal decisions can be made to sustain prevention efforts. The transition of the SEOW mandates would continue through integration into the State's Behavioral Health committees, workgroups, task forces

Data issues/caveats that affect outcome measures::

The primary issue that will impact this outcome's success is the availability of resources. Providers must position themselves to be diversified, but maintain integrity of mission and purpose. Qualified workforce to assist in resource development. Restrictions placed on the provider through organizational policies or procedures. Strategic and ongoing data collection efforts which serve as the basis for program decision making

Indicator #: 6  
Indicator: Identification and Implementation of EBPs/Promising Programs  
Baseline Measurement: 2016 implementation of Evidence-Based Programs/Practices by prevention providers  
First-year target/outcome measurement: 25% increase in identification and utilization of EBP for service delivery

Second-year target/outcome measurement: 25% increase in identification and utilization of EBP for service delivery

Data Source:

National Registry of Evidence-based Programs and Practices (NREPP)

Description of Data:

NREPP is a searchable, online registry of substance abuse and mental health interventions sponsored by SAMSHA. The purpose of NREPP is to help the public learn more about evidence-based intervention that are available for implementation. The Registry is a publically accessible site which includes a description of available EBPs; standards for inclusion and requirements for adaptation and replication or utilization.

Data issues/caveats that affect outcome measures::

EBP not available for target population. Process for developing promising practice in lieu for practices not available

Priority #: 3

Priority Area: Person-Centered Service Delivery System

Priority Type: SAT, MHS

Population(s): SMI, PWWDC, PWID, EIS/HIV

Goal of the priority area:

Promote participation by people with mental health and substance abuse disorders in shared decision making person centered planning, direction of their services and supports to reach their recovery goals.

Objective:

Increase participation of consumers process

Strategies to attain the objective:

Consumers throughout the State of Delaware's behavioral health system will become the focus of a service system that is designed to provide personcentered services throughout by teaching 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. 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

#### Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of consumers receiving community-based services who actively participate

Baseline Measurement: 90%

First-year target/outcome measurement: 95%

Second-year target/outcome measurement: 98%

Data Source:

DSAMH Consumer Satisfaction Survey, QPR surveys, Recovery Care Plan reviews

Description of Data:

Increase by 5% the number of consumers who respond positively to questions on the Consumer Satisfaction Survey regarding their role in setting goals and treatment strategies  
Numerator: # of surveys marked "agree" on specific items  
Denominator: Total valid responses on consumer satisfaction item

Data issues/caveats that affect outcome measures::

Consumers are sometimes hesitant to complete surveys

Indicator #: 2  
Indicator: Percentage of consumers reporting positively regarding outcomes.  
Baseline Measurement: 75%  
First-year target/outcome measurement: 76%  
Second-year target/outcome measurement: 77%

Data Source:

DSAMH Consumer Satisfaction Survey; QPR's, PROMISE Care Management Monitoring of Recovery Care Plans

Description of Data:

Increase by 1% the number of consumers who respond positively to questions on the Consumer Satisfaction Survey regarding their treatment outcomes.

Data issues/caveats that affect outcome measures::

Consumers are sometimes hesitant to respond

Priority #: 4  
Priority Area: Mental Health Early Intervention and Treatment Services  
Priority Type: MHS  
Population(s): SMI, SED

Goal of the priority area:

Promote hope, recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.

Objective:

Strategies to attain the objective:

Consumers throughout Delaware's behavioral health system receive services in a manner that promotes hope, recovery, resiliency and community integration as components to their recovery planning process that is created through a person-centered approach that promotes client participation in the development, implementation and execution of the plan.

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Increased access to services  
Baseline Measurement: 2017 reported wait times to access psychiatrist services  
First-year target/outcome measurement: Provide accessible services within 7 days of referral  
Second-year target/outcome measurement: Provide immediate access

Data Source:

Consumer Satisfaction Surveys, Psychiatry Resident Rotational Service Data, Telemedicine billing claims, Loan Forgiveness Program Utilization

Description of Data:

data will be collected for all aspects of above and will be utilized to determine accessibility of services

Data issues/caveats that affect outcome measures::

delay in capturing data

Indicator #: 2  
Indicator: Reduced Utilization of Psychiatric Inpatient Beds  
Baseline Measurement: 2017 Inpatient Bed Utilization Report  
First-year target/outcome measurement: 5%  
Second-year target/outcome measurement: 10%

Data Source:

Data collected from crisis walk in programs, mobile crisis, emergency room wait reports

Description of Data:

a wide variety of data points will be utilized to measure efforts leading to the reduction of inpatient psychiatric beds

Data issues/caveats that affect outcome measures::

voluntary admissions vs involuntary admissions

Priority #: 5  
Priority Area: Substance Abuse Treatment  
Priority Type: SAT  
Population(s): PWWDC, PWID

Goal of the priority area:

Increase access to substance abuse treatment services

Objective:

Increase programming that focus on the immediate availability of services and engages consumers in recovery

Strategies to attain the objective:

Education, information dissemination, outreach, engagement strategies

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Housing/Residential Treatment Options to Pregnant Women and Women with Dependent Children  
Baseline Measurement: 2017 Utilization of beds in Residential Treatment Programs/Number of Sober Living Beds  
First-year target/outcome measurement: Increase utilization by 5%  
Second-year target/outcome measurement: Increase utilization by 5%

Data Source:

CRF data, billing data,

Description of Data:

Number of Pregnant Women and Women with Dependent Children served in DSAMH programs

Data issues/caveats that affect outcome measures::

Indicator: Reduce Number of Opioid Overdoses

Baseline Measurement: 2016 - 2017 OD statistics

First-year target/outcome measurement: reduce by 20%

Second-year target/outcome measurement: reduce by 20%

Data Source:

Naloxone administration data, death reports, incident reports

Description of Data:

wide variety of data is available to compute the number of OD's and the number of incidents of naloxone administration events

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of people receiving treatment in Medication Assisted Treatment Programs

Baseline Measurement: Number of people receiving MAT services through DSAMH contracts in SFY17

First-year target/outcome measurement: Increase number of admissions for MAT services by 10%

Second-year target/outcome measurement: Increase number of admissions for MAT services by 20%

Data Source:

Number of MAT prescribers, CRF data for admissions, billing data for MAT services

Description of Data:

Number of participants in substance abuse treatment for illicit drug use (number of IVDUs) receiving substance abuse treatment and/or recovery services. Efforts are currently underway to increase the amount of physician time available for MAT services to increase access and decrease wait times. This is expected to increase the number of admissions

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Increase Utilization of Residential Treatment Beds

Baseline Measurement: 2017 Average Daily Census

First-year target/outcome measurement: Increase utilization of residential treatment beds by 20%

Second-year target/outcome measurement: Increase utilization of residential treatment beds by 20%

Data Source:

daily census reports, CRF data, billing data

Description of Data:

data outlines the utilization of residential treatment beds available in the DSAMH service delivery system

Data issues/caveats that affect outcome measures::

Footnotes:



# Planning Tables

Table 2 State Agency Planned Expenditures [SA]

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

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$4,700,746		\$250,000	\$0	\$30,562,400	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$300,000		\$0	\$0	\$562,400	\$0	\$0
b. All Other	\$4,400,746		\$250,000	\$0	\$30,000,000	\$0	\$0
2. Primary Prevention	\$1,570,272		\$0	\$4,782,000	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$158,466	\$0	\$0
4. Early Intervention Services for HIV	\$348,389		\$0	\$0	\$1,393,560	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$348,389		\$0	\$0	\$0	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$6,967,796	\$0	\$250,000	\$4,782,000	\$32,114,426	\$0	\$0

\* Prevention other than primary prevention

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

Footnotes:

# Planning Tables

Table 2 State Agency Planned Expenditures [MH]

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

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$1,374,120	\$250,000	\$0	\$0	\$0	\$0
8. Mental Health Primary*		\$0	\$46,000	\$0	\$0	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$161,013	\$0	\$1,000,000	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$75,000	\$0	\$0	\$0	\$0	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$1,610,133	\$296,000	\$1,000,000	\$0	\$0	\$0

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

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

Footnotes:

# Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

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

Please provide an explanation for any data cells for which the stats does not have a data source.  
 in process - will be submitted via a revision

Footnotes:

# Planning Tables

Table 4 SABG Planned Expenditures

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

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$4,700,744
2 . Primary Substance Abuse Prevention	\$1,570,274
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV*	\$348,389
5 . Administration (SSA Level Only)	\$348,389
6. Total	\$6,967,796

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

do so.

Footnotes:

# Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

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

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	\$150,317
	Selective	\$16,618
	Indicated	\$2,933
	Unspecified	
	Total	\$169,868
Education	Universal	\$185,024
	Selective	\$132,085
	Indicated	\$16,230
	Unspecified	
	Total	\$333,339
Alternatives	Universal	\$249,899
	Selective	\$50,275
	Indicated	\$13,650
	Unspecified	
	Total	\$313,824
Problem Identification and Referral	Universal	\$36,535
	Selective	\$15,215
	Indicated	
	Unspecified	
	Total	\$51,750

Community-Based Process	Universal	\$262,530
	Selective	\$2,500
	Indicated	\$1,544
	Unspecified	
	Total	\$266,574
Environmental	Universal	\$73,650
	Selective	\$34,213
	Indicated	\$4,887
	Unspecified	
	Total	\$112,750
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Other	Universal	\$47,380
	Selective	\$40,620
	Indicated	
	Unspecified	
	Total	\$88,000
Total Prevention Expenditures		\$1,336,105
Total SABG Award*		\$6,967,796
Planned Primary Prevention Percentage		19.18 %

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

Footnotes:





# Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

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

Activity	FY 2018 SA Block Grant Award
Universal Direct	\$968,801
Universal Indirect	
Selective	\$312,846
Indicated	\$54,459
Column Total	\$1,336,106
Total SABG Award*	\$6,967,796
Planned Primary Prevention Percentage	19.18 %

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

Footnotes:

# Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

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

Footnotes:

# Planning Tables

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

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

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems			\$61,792	
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment			\$44,850	
4. Planning Council Activities (MHBG required, SABG optional)				
5. Quality Assurance and Improvement				
6. Research and Evaluation			\$112,500	
7. Training and Education			\$15,000	
8. Total	\$0	\$0	\$234,142	\$0

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

Footnotes:

# Environmental Factors and Plan

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

### Narrative Question

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#### 1. The Health Care System, Parity and Integration

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

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

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

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>33</sup> Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>34</sup> and ACOs<sup>35</sup> may be important strategies used by SMHAs and SSAs to foster integrated care.

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

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

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

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

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

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

<sup>25</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:1027123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52777

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

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

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

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

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

<sup>31</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, [http://www.nami.org/Content/NavigationMenu/State\\_Advocacy/About\\_the\\_Issue/Integration\\_MH\\_And\\_Primary\\_Care\\_2011.pdf](http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf); Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

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

<sup>33</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

<sup>34</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>35</sup> New financing models, [http://www.samhsa.gov/co-occurring/topics/primary-care/financing\\_final.aspx](http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx)

<sup>36</sup> Waivers, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

<sup>37</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>38</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>39</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

<sup>40</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>41</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>42</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

<sup>43</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

<sup>44</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.
  1. This has been identified as a priority need for DSAMH to address. DSAMH intends to explore a Community Behavioral Health Clinic Model using the Excellence in Mental Health Act (S. 2525/H.R. 4567) passed in 2014. In this model, the state oversees the creation of Behavioral Health Clinics that provide comprehensive mental health and Substance Abuse co-occurring services. As progress on this evolves, these centers will be well positioned to begin integrating physical health. In part, the ACT contains provisions for Certified Community Behavioral Health Clinics to engage in partnerships with a variety of health system partners, from primary care to hospitals, VA centers, and more. The emphasis on these partnerships reflects the need for health care organizations to work together to demonstrate concrete health outcomes and high-value care.
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.
  2. DSAM's contracts with the Comprehensive Behavioral Health Outpatient Treatment providers requires the provision of substance use, mental health, and co-occurring disorders treatment. DSAMH contracts with a provider to specialize in residential services for co-occurring disorders.
3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? j n Yes j n No

and Medicaid? j n Yes j n No
4. Who is responsible for monitoring access to M/SUD services by the QHP?

This is part of the assessment during intake and ongoing care coordination with the MCO.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  Yes  No
6. Do the behavioral health providers screen and refer for:
- a) Prevention and wellness education  Yes  No
  - b) Health risks such as
    - i) heart disease  Yes  No
    - ii) hypertension  Yes  No
    - viii) high cholesterol  Yes  No
    - ix) diabetes  Yes  No
  - c) Recovery supports  Yes  No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  Yes  No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  Yes  No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?  
DSAMH is a participant in the Medicaid analysis and implementation of MH/SA parity for Medicaid recipients. DSAMH is considered a consultant to the State of Delaware Insurance Commission regarding issues of parity for private insurers. We are still finding a large number of private insurers that do not provide substance abuse services or have extremely large deductibles which result in many clients not seeking treatment for substance abuse.
10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

We would be very interesting in receiving TA to improve our efforts and to potential implement a Community Behavioral Health Clinic Model using the Excellence in Mental Health Act (S. 2525/H.R. 4567) passed in 2014

Footnotes:



# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

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

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

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

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>50</sup>. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations<sup>51</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

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<sup>45</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

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

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

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

<sup>49</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

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

<sup>51</sup> [http://www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

Please respond to the following items:

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

Please indicate areas of technical assistance needed related to this section

We would be interested in TA to develop a workforce training plan relative to this area

Footnotes:

# Environmental Factors and Plan

## 3. Innovation in Purchasing Decisions - Requested

### Narrative Question

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

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

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

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General<sup>52</sup>, The New Freedom Commission on Mental Health<sup>53</sup>, the IOM<sup>54</sup>, and the NQF<sup>55</sup>. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>56</sup> SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

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

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

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

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

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

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

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

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

<sup>56</sup> <http://psychiatryonline.org/>

<sup>57</sup> <http://store.samhsa.gov>

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

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Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

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

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

DSAMH is very interested in implementing value based purchasing into its procurement methodology. We are extremely interested in obtaining TA to reach this goal.

Footnotes:

## Environmental Factors and Plan

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

#### Narrative Question

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

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

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

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

Please respond to the following items:

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

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

Delaware CORE staff facilitate statewide outreach efforts according to a community mapping plan developed with our clinical training partner, The PIER Training Institute in Portland, ME. The primary target for outreach was schools, where school staff are most likely to identify symptoms of ESMI, followed by the medical community. Outreach may include literature distribution (available in English and Spanish) during meetings or community events, as well as formal presentations in larger settings. Presentations at Grand Rounds within medical facilities have also taken place. Presentations include case examples and a brief assessment tool for clinicians to use when determining if a referral is appropriate. In addition, multiple versions of brochures have been or are being developed for various audiences. Outreach discussions include a description of the CORE program along with admission criteria, referral instructions, and explanations of what participants can expect from the program.

The CORE program has a multidisciplinary team that provides clinical care, psychiatric support, occupational therapy evaluation and support, and support by an education/vocational specialist. Early phases of the program include individual psychoeducation with the participant to provide the youth with an understanding of what is happening, reduce stigma and shame, and to prepare them for the multi-family groups attended by them and their chosen caregiver(s). All clinicians have been certified to use the Structured Interview for Psychosis-Risk Syndromes (SIPS), developed at the Yale School of Medicine and co-authored by Dr. Barbara Walsh, CORE's training partner. This assessment tool determines if a client's symptoms fall in the realm of early psychosis. In addition to the team approach, several members of the team are in the process of becoming certified in Cognitive Behavioral Therapy for psychosis (CBTp). This provides individual support for the identified symptoms. CORE is hoping to make this training available to community partners in FFY 2018 to assist in sustaining support for ESMI.

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

Delaware's FEP service is based on a treatment model developed at the Maine Medical Center called the Portland identification and Early Referral (PIER) program. PIER is grounded in a biosocial understanding of psychosis (i.e., psychosis is caused by the interaction of biological vulnerability and stressful social conditions), and much of its therapeutic weight rests on the keystone of the multifamily group. Support for the multifamily group dates back to research conducted in hospitals in the 1980s and 1990s showing that people with schizophrenia experience greater clinical improvement when they and their families are randomized to multifamily as opposed to single family therapy. Research suggests that multifamily groups may offer a greater diversity of peers from which to choose, identify, problem solve and share resources. Also, being in therapy with families struggling "in the same boat" may promote family-to-family learning, either directly (e.g., one mother advises another) or indirectly (e.g., one mother observes another). Finally, the multifamily group can provide needed support and understanding for the isolated caregiver that is solely responsible for the care of a disabled relative.

Most families referred to Delaware's PIER program receive services in the following order: (a) prescreen, (b) assessment, (c) "joining sessions" in the home to introduce the social worker, team and program, (d) family psychoeducation meetings to learn about serious mental illness and staying healthy, and finally (e) a multifamily group that provides ongoing support and opportunities for collective problem solving. Psychiatric consultation, occupational therapy and supported education and employment are also available on an as-need basis. Typical lengths-of-stay in Delaware CORE run from 6 months to 2 years.

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

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

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

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

Delaware's FEP service is based on a treatment model developed at the Maine Medical Center called the Portland identification and Early Referral (PIER) program. PIER is grounded in a biosocial understanding of psychosis (i.e., psychosis is caused by the interaction of biological vulnerability and stressful social conditions), and much of its therapeutic weight rests on the keystone of the multifamily group. Support for the multifamily group dates back to research conducted in hospitals in the 1980s and 1990s showing that people with schizophrenia experience greater clinical improvement when they and their families are randomized to multifamily as opposed to single family therapy. Research suggests that multifamily groups may offer a greater diversity of peers from which to choose, identify, problem solve and share resources. Also, being in therapy with families struggling "in the same boat" may promote family-to-family learning, either directly (e.g., one mother advises another) or indirectly (e.g., one mother observes another). Finally, the multifamily group can provide needed support and understanding for the isolated caregiver that is solely responsible for the care of a disabled relative.

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

CORE is working with a new end date of 2018 because the President's current budget does not include the fifth year of funding originally awarded; therefore, this response does not include FFY 2019. Planned activities for FFY 2018 include an ongoing provision of services to clients with early psychosis including ongoing outreach, assessment, admission into treatment, and the development and implementation of a sustainability plan beyond the term of the SAMHSA grant. New outreach plans include the development of online training modules or webinars focused on various audiences that can be access beyond the term of the grant in an effort to sustain community education. Materials will be finalized in collaboration with two steering committees developed to ensure culturally sensitive materials for the Latino and interfaith communities.

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

Using grant funds from SAMHSA Grant No. 1H79SM061931 , the state contracts with the University of Delaware to re-interview program participants every 6 months while they remain in treatment, again at discharge, and once more 6 months post discharge. The battery of questionnaires includes the National Outcomes Measures Survey (NOMS), the Mental Illness Research, Education and Clinical Center (MIRECC) functional scales, and Self-Stigma of Mental Illness Scale--Short Form (SSMIS-SF). The state has recently added the Lehman Quality of Life Scale and the Colorado Symptom Index through its participation in the MHBG 10% Set Aside Study.

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

- Schizophreniform Disorder,
- Schizophrenia,
- Schizoaffective Disorder,

- Major Depression/Bipolar Disorder with psychotic features,
- PTSD with psychotic features

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

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

Footnotes:

## Environmental Factors and Plan

### 5. Person Centered Planning (PCP) - Required MHBG

#### Narrative Question

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

1. Does your state have policies related to person centered planning? j n Yes j n No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication. Care managers are assigned to consumers to develop their recovery care plan. Caregivers are included in the development of the recovery care plan and the plan includes all aspects relative to the client's recovery goals including treatment, socialization, crisis planning, natural supports, transportation needs, etc.
4. Describe the person-centered planning process in your state. Care managers are assigned to consumers to develop their recovery care plan. Caregivers are included in the development of the recovery care plan and the plan includes all aspects relative to the client's recovery goals including treatment, socialization, crisis planning, natural supports, transportation needs, etc.  
Does the state have any activities related to this section that you would like to highlight?  
  
Please indicate areas of technical assistance needed related to this section.

Footnotes:



# Environmental Factors and Plan

## 6. Self-Direction - Requested

### Narrative Question

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

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

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

Please respond to the following items:

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

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

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

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

Footnotes:

# Environmental Factors and Plan

## 7. Program Integrity - Required

### Narrative Question

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

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

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

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Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?  Yes  No

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

*Please indicate areas of technical assistance needed to this section*

Footnotes:

# Environmental Factors and Plan

## 8. Tribes - Requested

### Narrative Question

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

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

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

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

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

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Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?  
N/A - Delaware does not have any federally recognized tribes.
2. What specific concerns were raised during the consultation session(s) noted above?  
N/A  
Does the state have any activities related to this section that you would like to highlight?

*Please indicate areas of technical assistance needed to this section*

Footnotes:

# Environmental Factors and Plan

## 9. Primary Prevention - Required SABG

### Narrative Question

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

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

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

Please respond to the following items

### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No

- Data on consequences of substance using behaviors
- Substance-using behaviors
- Intervening variables (including risk and protective factors)
- Others (please list)

Socio-economic status; geographic locations; vulnerable populations

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- Children (under age 12)
- Youth (ages 12-17)
- Young adults/college age (ages 18-26)
- Adults (ages 27-54)
- Older adults (age 55 and above)
- Cultural/ethnic minorities
- Sexual/gender minorities
- Rural communities

Others (please list)

Moving towards collecting more sexual/gender specific data

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

Archival indicators (Please list)

Delaware uses archival data from all of the sources checked below. These include both federal sources with DE specific data and DE School Surveys which are supported in part by the SABG.

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

Survey Monkey and Mosaix

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?

Yes  No

If yes, (please explain)

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

Currently the state uses the federal formula of a minimum allocation for prevention activities.

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

Please indicate areas of technical assistance needed related to this section

## Narrative Question

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

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

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

## Capacity Building

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

If yes, please describe

Professionals receiving prevention funding are required to be certified.

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

If yes, please describe mechanism used

The Division has a statewide training system which is available to grant funded providers. Additional discretionary grants for prevention have been used to funding training and technical assistance to providers. TA is also available via SAMHSA.

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

If yes, please describe mechanism used

The evaluation team for SPF-PFS adapted a community readiness survey which includes SABG contractors.

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

Please indicate areas of technical assistance needed related to this section

## Narrative Question

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

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## Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  Yes  No  
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  Yes  No  N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
  - a)  Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
  - b)  Timelines
  - c)  Roles and responsibilities
  - d)  Process indicators
  - e)  Outcome indicators
  - f)  Cultural competence component
  - g)  Sustainability component
  - h)  Other (please list):
  - i)  Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  Yes  No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  Yes  No  
If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based  
N/A  
Does the state have any activities related to this section that you would like to highlight?

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





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

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## Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)
  
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:  
Resource clearinghouse, media campaigns, brochures, health fairs, help is here website
  - b) Education:  
Prime for Life; Botvin Life Skills; Smart Moves, All Stars, Ripple Effects
  - c) Alternatives:  
Teen Summit, Safe Havens
  - d) Problem Identification and Referral:
  - e) Community-Based Processes:  
Prevention Promoters Delaware Prevention Coalition, New Castle Prevention Coalition and Southern New Castle Prevention Coalition

f) Environmental:

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

If yes, please describe

Ongoing monitoring, approval of EBP, fiscal review monthly, submission of monthly program activity reports

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

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

## Narrative Question

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

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

## Evaluation

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

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

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

- a)  Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b)  Includes evaluation information from sub-recipients
- c)  Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d)  Establishes a process for providing timely evaluation information to stakeholders
- e)  Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f)  Other (please list:)

No formalized evaluation plan in place. Evaluate services of sub-recipients/community programs.

- g)  Not applicable/no prevention evaluation plan

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

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

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

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

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

Footnotes:

# Environmental Factors and Plan

## 10. Statutory Criterion for MHBG - Required MHBG

### Narrative Question

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#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

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Please respond to the following items

#### Criterion 1

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

1. Delaware's publicly funded, community-based behavioral health system is a comprehensive, culturally competent continuum of care. The State's Behavioral Health system along with its contracted providers, have developed and implemented a person-centered, recovery-oriented system of care for the consumers we serve. Services provided are expected to be trauma-informed and equipped to working with clients with co-occurring disorders, including those with histories of trauma. These fundamental principles are inherent and expected in each scope of service Delaware's priorities have included the development, support and expansion of services for individuals with mental illness, including those with co-occurring mental and substance abuse orders included but not limited to recovery education, housing, suicide awareness, referral services, medication management, and counseling services.

The DSAMH Eligibility and Enrollment Unit (EEU) is the gatekeeper for the state's public mental health system. The goal of the EEU is to gather information about mental health consumers to refer them to the level of care that is the most appropriate as determined by best practice assessment tools and the individuals themselves. The EEU uses the ASAM PPC- 2 for placement in the most appropriate level of intensity and based on a comprehensive assessment.

Trained psychiatric social workers are available to provide crisis intervention and support via phone with the ability to mobilize in the community to perform comprehensive mental health, suicide and substance abuse assessments and assist with voluntary or involuntary hospitalization or other emergency based referrals for treatment. Through the Mobile Crisis Intervention Services (MCIS), the state also provides ongoing, short-term supportive counseling services until clients are transitioned to a community-based provider for long-term behavioral health treatment.

DSAHM also contracted with providers to reduce and/or eliminate hospitalizations:

- RI International for care management services through the Restart Program. Restart provides recovery based, short-term Targeted Care Management (TCM) and engagement services for individuals 18 years of age and older with significant mental health and/or substance use challenges. The goal of Restart is to prevent, when possible, hospitalization and higher levels of care by rapidly assessing person's needs and engaging in a voluntary recovery opportunity, and connecting people to community services and supports.
- Recovery Response Centers ("RRC") located in Ellendale and Newark offer a facility-based, 23-hour assessment and evaluation program for adults suffering from substance use or psychiatric crisis. This service is contracted by the state to a provider, Recovery Innovations. The goal of RRC is to prevent, when possible, unnecessary psychiatric hospitalizations. RRC staff consisting of nurses, mental health professionals, peer support specialists and psychiatric staff are available 24 hours per day to assess walk-ins, police referrals or anyone experiencing a psychiatric crisis. RRC staff offer quick engagement and evaluation by trained behavioral health professionals in a recovery-based environment to assist individuals in determining the best path forward for treatment. Being co-located with RRC's, the Restart teams in both the Ellendale and Newark facilities, assist the RRC in connecting individuals in crisis to a community-based care management team with a warm handoff for improved continuity of care and access to needed services.
- PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) is a joint venture between the Division of Medicaid and Medical Assistance (DMMA) and DSAMH. It is an outcome of the Affordable Care Act, revisions to the FY14 State Plan Amendment (SPA), and the USDOJ Settlement Agreement. PROMISE's goal is to provide community supports to facilitate enhanced engagement within the community for persons with serious and persistent mental illness. The goals are to improve clinical and recovery outcomes for individuals with behavioral health needs and reduce the growth in costs through a reduction in unnecessary institutional care through care coordination, including initiatives to increase network capacity to deliver community-based, recovery-oriented services and supports.

- Assertive Community Treatment (ACT), which is based on the evidence-based Program of Assertive Community Treatment model. A Delaware ACT Team is comprised of a group of ten (10) staff members, and there are a total of 16 ACT teams. Each ACT team serves up to 100 individuals and thus has a maximum staff to client ratio of 1:10. The sixteen (16) teams serve clients in New Castle County, three teams provide services in Kent County and two teams serve Sussex County. The core members of the team are the primary care manager, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each client. Services are delivered in a continuous framework, for as long as the individual meets the DSAMH defined criteria for inclusion in these programs. Services are trauma-informed and will avoid coercion or paternalistic approaches.
- ICM (Intensive Care Management) Team is a group of ten (10) ICM staff members who together have a range of clinical and rehabilitation skills and expertise. The ICM team members are assigned by the team leader and the psychiatric prescriber to work collaboratively with a client and his/her family and/or natural supports in the community by the time of the first client assessment and subsequent person-directed recovery planning meeting. The ICM team serves up to 250 clients in Kent and Sussex County, and 125 clients in New Castle County, and thus has a maximum staff to client ratio of 1:20. The core members of the team are the primary care manager, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each client.
- Comprehensive Behavioral Health Outpatient Treatment (CBHOT): DSAMH funds twenty-one (21) outpatient programs that provide comprehensive mental health, alcohol, and other drug treatment services. Outpatient services include services to clients in the criminal justice system and individuals living in the community. Services offered by CBHOT programs include: individual, group and family counseling, psychiatric treatment, medications, case management, assistance with acquiring entitlements, and working with vocational rehabilitation and employment issues. All outpatient programs contracting with DSAMH are required to be able to meet the needs of individuals with co-occurring mental health and substance use disorders. Programs offer an array of services including IOP and PHP.
- Peer Run Services: There are four peer run drop-in programs operating in Delaware which provide community-based supportive and recovery services. The programs are located in and serve clients in New Castle County, serving clients Wilmington, Kent County, and Sussex County.
- Supported Apartment Program (SAP) The Supervised Apartment Program (SAP) is a state-wide apartment program for persons who are working toward the goal of living independently and who need some additional daytime, evening, overnight and/or weekend supervision. The SAP is available to the client if s/he needs supervised services. The staffing responsibilities should be sufficient to ensure: onsite supervision, assurance of client safety, coordination of care with the community provider and assisting the community provider with supports for the client when the community provider is unable to provide these in an emergency. Clients in SAP's are also assigned to either ACT or ICM teams to ensure their bio/psycho/social needs are met.
- Medication Assisted Recovery: DSAMH funds three (3) providers who offer medication assisted treatment services at eight (8) 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) provides methadone maintenance in New Castle County. Kent Sussex Counseling Services (KSCS) provide methadone maintenance in both Kent and Sussex Counties. Connections CSP provides methadone maintenance in New Castle County, Kent County and Sussex County. The addition of methadone maintenance treatment provided by Connections CSP has allowed DSAMH to double the number of methadone maintenance sites throughout the state. The three (3) programs currently prescribe Suboxone (Buprenorphine) and Vivitrol (Naltrexone) for alcohol dependence. Ambulatory detoxification is required for the transition to outpatient services.
- Comprehensive Behavioral Health Outpatient Treatment Programs (CBHOT): DSAMH funds twenty-one (21) outpatient programs that provide comprehensive mental health, alcohol, and other drug treatment services. Outpatient services include services to clients in the criminal justice system and individuals living in the community clients. Services offered by OP programs include: individual, group and family counseling, psychiatric treatment, medications, case management, assistance with acquiring entitlements, and working with vocational rehabilitation on employment issues. All outpatient programs contracting with DSAMH are required to be able to meet the needs of individuals with co-occurring mental health and substance use disorders. Programs offer an array of services including IOP and PHP.
- Project Renewal: DSAMH contracts with BCCS to provide services to homeless in Sussex County. Based on an intensive case management model, 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 Gambling Problems (DCGP): DSAMH realizes that there is a high rate of gambling among clients with drug and or alcohol conditions. Due to this fact DSAMH, through DCGP, 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 individual scores 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: DSAMH continues to partner with the Department of Public Health (DPH) on Delaware's Needle Exchange Program. The concept of Needle Exchange Programs comes from the public health concept of harm reduction. By providing clean needles to intravenous drug users it reduces their chances of acquiring chronic health conditions such as

hepatitis or HIV. These programs provide treatment services as well.

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

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

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

3. Describe your state's case management services

DSAHM provides and contracts with providers for case management services to support individuals with a diagnosis of mental illness, substance use, and/or co-occurring disorders, and who have committed, have a history of commitment, or are in danger of commitment to a state psychiatric hospital, or private residential facility or correctional facility.

The State's Behavioral Health system along with its contracted providers, have developed and implemented a person-centered, recovery-oriented system of care for the consumers we serve. Services provided are expected to be trauma-informed and equipped to working with consumers with co-occurring disorders, including those with histories of trauma. These fundamental principles are inherent and expected in each scope of service. Every aspect of working with consumers, including: the role of peers, screening, assessment, treatment planning, service provision, case management, social service and other, must be sensitive to these core principles. Contract monitoring and performance improvement activities will be geared toward assuring these core principles are in place. It is DSAMH's intentions to design (when not present) and institute performance based contracts operationalizing these and other principles.

The Behavioral Health System operates primarily through contracts with public and private agencies to implement a comprehensive continuum of care, inclusive of primary prevention and treatment services. Treatment services include: outpatient evaluation and counseling; medication-assisted outpatient detoxification and treatment; care management services, including intensive multidisciplinary teams; variable length of stay residential programs; and, residential detoxification services. For example:

- Comprehensive Behavioral Health Outpatient Treatment (CBHOT): Staff provides services through a multidisciplinary case management approach.
- TASC is the primary liaison between the 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.
- 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.
- Project Renewal: DSAMH contracts with BCCS to provide services to homeless in Sussex County. Based on an intensive case management model, 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.

Engagement and integration of community supports are necessary for individuals to achieve and sustain recovery in the community. By establishing integrated networks and support, individuals can live a meaningful life.

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

The Division also contracts with RI International for care management services through the Restart Program. Restart provides recovery based, short-term Targeted Care Management (TCM) and engagement services for individuals 18 years of age and older with significant mental health and/or substance use challenges. The goal of Restart is to prevent, when possible, hospitalization



and higher levels of care by rapidly assessing person's needs and engaging in a voluntary recovery opportunity, and connecting people to community services and supports.

Recovery Response Centers ("RRC") located in Ellendale and Newark offer a facility-based, 23-hour assessment and evaluation program for adults suffering from substance use or psychiatric crisis. This service is contracted by the state to a provider, Recovery Innovations. The goal of RRC is to prevent, when possible, unnecessary psychiatric hospitalizations. RRC staff consisting of nurses, mental health professionals, peer support specialists and psychiatric staff are available 24 hours per day to assess walk-ins, police referrals or anyone experiencing a psychiatric crisis. RRC staff offer quick engagement and evaluation by trained behavioral health professionals in a recovery-based environment to assist individuals in determining the best path forward for treatment.

Comprehensive Behavioral Health Outpatient Treatment (CBHOT):

DSAMH funds twenty-one (21) outpatient programs that provide comprehensive mental health, alcohol, and other drug treatment services. Outpatient services include services to clients in the criminal justice system and individuals living in the community.

The above-referenced programs are examples of the activities that have been implemented and enhanced to serve individuals at risk for admission to or have been discharged from a hospital.

Narrative Question

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	27,000	
2. Children with SED		11%-13%

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

Narrative Question

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Criterion 3: Children's Services

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

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Criterion 3

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

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

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

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

Criterion 4

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

Publicly funded mental health services for adults provided by the Division are offered either directly or via contractual arrangements through four state-operated PROMISE Centers. It is worth noting that DSAMH does not differentiate services based on geographic location. All services provided to individuals served by the Division are available without location bias.

According to the U.S. Census for 2010, "rural" is defined as places of less than 50,000 population and those outside of areas of 2,500 or more. By the Census definition, New Castle County is entirely urbanized. All of Kent and Sussex Counties are rural, except for the City of Dover, located in Kent County. The Division funds several mental health services, including (2) PROMISE Centers; (2) PEER-Operated community centers; supervised apartment program, group homes, as well as many programs providing comprehensive behavior health outpatient services.

DSAMH has been taking steps to increase the availability and accessibility of behavioral health services for rural populations.

Strategic initiatives that have been realized are:

- Increased emphasis on tele-medicine, psychiatry emphasized have resulted in increased number of DSAMH contracted providers in rural areas using this resource. This not only addresses issues associated with distance, but also with issues associated with prescriber shortages in both rural and urban areas. While it has been stated that DSAMH does not limit access to services based on where a person lives, to increase accessibility, DSAMH has expanded contracted providers throughout the state, more significantly in rural Kent and Sussex Counties. This expansion has resulted in increased services and locations in these two counties in the following ways:

? An increase to 7 CBHOT locations for outpatient services in Sussex County

? An increase to 6 CBHOT locations in Kent County

? An increase from 2 to 20 for medication assisted treatment locations state-wide (note: not these are DSAMH contracted providers)

? Establishment of 5 ACT teams and 2 ICMS teams with locations in both Sussex and Kent counties

? Increased residential services, Group Homes, Supported Apartment Programs and Crisis apartments in all three counties.

? As part of the PROMISE implementation, increased Medicaid funded non-medical and medical transport options.

? As part of the PROMISE implementation, established Representative Payee services for the whole state.

? Established a 16-bed co-occurring residential treatment program (SUD and MH) in Sussex County

? Project Renewal

DSAMH contracts with BCCS to provide services to homeless in Sussex County. Based on an intensive case management model, 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.

Projects for Assistance in Transition from Homelessness (PATH): Delaware's PATH Formula Grant program is administered by DSAMH and is an integral part of Delaware's comprehensive community-based system of care for adults with mental illness. The PATH Program focuses on primary outreach services to persons with serious persistent mental illness (SPMI) or co-occurring substance use issues experiencing homelessness with the aim of engaging them and linking them with the mainstream treatment and support services. Persons enrolled in the PATH Program are provided counseling, psychiatric treatment, healthcare, housing, economic services, and the clients will be linked to an appropriate program in the community mental health system for ongoing treatment, rehabilitation, and support. DSAMH contracts with the Rick Vanstory Center, a peer run organization, to provide its PATH services.

The goal of PATH is to improve access to existing community services and supports by those individuals who, because of the nature of their disability and/or past experiences with the system, remain reluctant or unable to engage in the treatment and supports that they need and can benefit from. The focus of PATH supported services is directed to emphasize the provision of primary outreach services, and the enrollment and engagement of adults with SPMI or a co-occurring mental illness and substance abuse disorder experiencing homelessness, in appropriate community treatment programs and services. Adults with SPMI or co-occurring substance use issues experiencing homelessness with the aim of engaging them and linking them with the mainstream treatment and support services.

Case Management will include:

- Developing a person centered plan for the provision of community mental health services.
- Providing assistance in obtaining and coordinating social and support services including those relating to daily living, personal finance planning and management, transportation services, habilitation and rehabilitation services, prevocational and vocational services, and housing.
- Linking to DSAMH assessment services in order to connect individuals to state funded services and appropriate levels of care.

The program will assist individuals in accessing entitlements, emergency food, educational supports such as GED programs, and relevant vocational programs, supports and employment. In addition, the program will assist the individual with a full range of

housing services and supports including access to temporary shelter, housing-related entitlements/subsidies, security deposits, assistance in obtaining permanent/semi-permanent housing such as an apartment, a home, etc. The program design is culturally competent and includes the use of staff with the necessary language skills required for the target population; staff conversant and trained in culturally appropriate service delivery, and a means of continually assessing the competency of the program design and delivery.

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

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 DSAMH's Central Office. The Central Office has the following responsibilities:

- Implementing Delaware's Health and Social Services policies
- 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 administrative functions and key positions include:

- DSAMH Director reports directly to the Cabinet-level Secretary for DHSS and oversees all positions and functions in the Division.
- DSAMH Deputy Director, has responsibility for the Office of Consumer Affairs, Provider Relations and Strategic Planning.
- Delaware Psychiatric Center Director oversees the state's sole state psychiatric hospital, DPC;
- Director of Administrative Services has responsibility for MIS, Quality Assurance, and, Licensure and Certification;
- Director of the Fiscal Office has responsibility for the overall fiscal management of the Central Office;
- Director for Planning and Program Development oversees all of DSAMH's grants, policies, and procedures;
- Director of the Education and Training Office oversees DSAMH's intra-agency and community training programs;
- The Director of Community Mental Health oversees the mental health system including The Eligibility and Enrollment Unit; Mobile Crisis Intervention centers, The PROMISE Assessment Centers, and the array of contracted providers through the state; and,
- The Director of Substance Abuse Services and Gambling Affairs oversees the Treatment Access Service Centers and the array of contracted substance abuse providers and gambling services for the Division.

The State's behavioral health system for children, youth and adults is currently located within two State agencies, DSAMH and the Division of Prevention and Behavioral Health Services ("DPBHS"). DSAMH service provision is focused on individuals 18 years of age or older, while DPBHS service provision is for children and youth under age 17.

DPBHS is located within the Department of Services for Children, Youth and Their Families ("DSCYF"). DSCYF was established in 1983 by the General Assembly of the State of Delaware, and has the primary responsibility of providing and managing a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, and/or substance abuse. DSCYF services include prevention, early intervention, assessment, treatment, permanency, and after care. DSCYF leads a system of care approach (both community-based and residential) that is child-centered and assures effective, timely and appropriate support for Delaware's children. DPBHS' treatment services are accredited under the Commission on Accreditation of Rehabilitation Facilities ("CARF"). In addition, the contracted and/or state operated treatment providers within the DPBHS network are licensed where appropriate, and most are accredited under one of the nationally recognized accrediting agencies such as CARF, JCAHO, COA or CHAP .

The two Divisions (DPBHS and DSAMH) in the two Departments (DSCYF and DHSS) have developed Memorandums of Understanding ("MOU") to formalize the respective roles and responsibilities of each of the divisions. The MOUs are intended to guide the implementation, data collection, and reporting strategies for both entities in alignment with the statutory regulations of the Substance Abuse Prevention and Treatment Block Grant.

There is an ongoing effort by both DSAMH and DPBHS to ensure that the services are reflective of a seamless, single system of care. The administrative structure of the provision of services is in alignment with State legislative mandates.

Although DSAMH works collaboratively with all DHSS Divisions, the primary collaborator within DHSS is the Division of Public Health (DPH) whose mission and vision are most compatible. DPH is a nationally accredited state health agency. The Division of Public Health (DPH) exists to protect and promote the health of all people in Delaware. To gauge effectiveness in meeting this mission, DPH conducts a rigorous effort of data collection and monitoring of health outcomes and continual engagement of strategies to improve health outcomes for Delawareans. Outside DHSS, DSAMH's closest collaboration is with DPBHS. DPBHS, housed within the Department of Services to Children, Youth and their Families provides ongoing administrative oversight and program management for M/SUD for individuals under the age of 17. Other collaborations are with the Department of Education, which, through statewide school districts, provides students with health related education, which includes SUD and its relationship to MH. The collaboration with the Division of Alcohol, Tobacco Enforcement (DATE) provides enforcement and direct public safety efforts through compliance checks and the impact of alcohol, drugs and driving. Finally, collaboration with the Office of Highway Safety provides public education, data collection and information dissemination.

DSAMH Disaster Planning

DSAMH has partnered with Division of Public Health for the integration of behavioral health supports in the Delaware All Hazards Disaster Plan. DSAMH has trained crisis volunteers as well as Medical Reserve Corps (MRC) volunteers to provide emergent, behavioral health supports in natural or man-made disaster events. This cadre of trained volunteers called DE BEST will deploy in the event of large or small-scale disasters to provide free emotional support outreach services and referral options to persons affected by a disaster.

The purpose behind this team is to support the emotional well-being of survivors and to increase resiliency while decreasing the likelihood of chronic mental health concerns following the event. The need to enhance state mental health disaster plans has become apparent to all involved as disaster and emergency planning has evolved.

In addition to providing individual behavioral health services, MCIS provides trainings on mental health education, suicide awareness, de-escalation techniques and the role of MCIS to law enforcement agencies, public health units, nursing programs and any other community entities MCIS also plays a role in the State of Delaware's overall disaster preparedness and response plan.

Footnotes:



# Environmental Factors and Plan

## 11. Substance Use Disorder Treatment - Required SABG

### Narrative Question

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

### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- |                                 |  |
|---------------------------------|--|
| i) Screening                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ii) Education                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iii) Brief Intervention         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iv) Assessment                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| v) Detox (inpatient/social)     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| vi) Outpatient                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| vii) Intensive Outpatient       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| viii) Inpatient/Residential     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ix) Aftercare: Recovery support | <input type="checkbox"/> Yes <input type="checkbox"/> No |

b) Are you considering any of the following:

- |   |  |
|---|--|
| Targeted services for veterans          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Expansion of services for:              |  |
| (1) Adolescents                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (2) Other Adults                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (3) Medication-Assisted Treatment (MAT) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## Criterion 2

## Criterion 3

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

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

We routinely monitor our programs to verify that PWWDC have immediate access to services and are not placed on any wait lists. We are proactively working with the Division of Public Health and their Healthy Moms/Healthy Baby initiative.

## Criterion 4,5&amp;6

## Persons Who Inject Drugs (PWID)

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

## Tuberculosis (TB)

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

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

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

## Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide j n Yes j n No

individuals with hypodermic needles or syringes(42 U.S.C.A§ 300x-31(a)(1)F)?

- 2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  Yes  No
- 3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  Yes  No

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

## Criterion 8,9&10

### Syringe System Needs

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

### Service Coordination

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

### Charitable Choice

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

### Referrals

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

- c) Identify workforce needs to expand service capabilities j n Yes j n No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background j n Yes j n No

**Patient Records**

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

**Independent Peer Review**

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

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

At this time, treatment providers funded with block grant are accredited and that has been accepted as meeting the independent peer review requirement. We are, however, exploring additional review/evaluation opportunities to continue to improve the services and outcomes of treatment.

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

If YES, please identify the accreditation organization(s)

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

## Criterion 7&amp;11

## Group Homes

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

## Professional Development

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

## Waivers

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

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

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



Footnotes:

## Environmental Factors and Plan

### 12. Quality Improvement Plan- Requested

#### Narrative Question

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

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Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

Yes  No

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

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

Footnotes:

## Environmental Factors and Plan

### 13. Trauma - Requested

#### Narrative Question

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Trauma<sup>60</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

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

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

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>61</sup> paper.

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

<sup>61</sup> *Ibid*

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#### Please respond to the following items

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

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

Footnotes:

# Environmental Factors and Plan

## 14. Criminal and Juvenile Justice - Requested

### Narrative Question

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

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

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

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

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

<sup>63</sup> <http://csqjusticecenter.org/mental-health/>

Please respond to the following items

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

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

Footnotes:

## Environmental Factors and Plan

### 15. Medication Assisted Treatment - Requested

#### Narrative Question

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

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

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

Please respond to the following items:

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

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

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

Footnotes:

## Environmental Factors and Plan

### 16. Crisis Services - Requested

#### Narrative Question

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

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

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

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

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

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

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Please respond to the following items:

1. Crisis Prevention and Early Intervention

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

2. Crisis Intervention/Stabilization

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

3. Post Crisis Intervention/Support

- a)  WRAP Post-Crisis
- b)  Peer Support/Peer Bridges

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

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

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

Footnotes:

# Environmental Factors and Plan

## 17. Recovery - Required

### Narrative Question

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

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

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

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



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

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

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Please respond to the following:

1. Does the state support recovery through any of the following:
  - a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? j n Yes j n No
  - b) Required peer accreditation or certification? j n Yes j n No
  - c) Block grant funding of recovery support services. j n Yes j n No
  - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  
Consumer Satisfaction Survey, Quality Process Review are both utilized in all aspects of the system. j n Yes j n No
2. Does the state measure the impact of your consumer and recovery community outreach activity? j n Yes j n No
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state. Targeted Care Management inclusive of Peer support, Peer Support Specialists, peer run drop in programs,
4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. recovery coaches are included in all adult SUD treatment programs
5. Does the state have any activities that it would like to highlight?

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

Footnotes:

## Environmental Factors and Plan

### 18. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

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

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

Please respond to the following items

- Does the state's Olmstead plan include :
  - housing services provided.  Yes  No
  - home and community based services.  Yes  No
  - peer support services.  Yes  No
  - employment services.  Yes  No
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

DSAMH continues its efforts to provide services in the least restrictive environment and in the community instead of institution based treatment. We have successfully downsized the state operated psychiatric hospital to 80 beds for MH and 40 beds for forensic/DOC beds.

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

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

Footnotes:

## Environmental Factors and Plan

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

#### Narrative Question

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MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community<sup>66</sup>. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24<sup>67</sup>. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death<sup>68</sup>.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21<sup>69</sup>. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs<sup>70</sup>.

According to data from the 2015 Report to Congress<sup>71</sup> on systems of care, services:

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

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

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

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

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

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

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

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

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

<sup>71</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

Please respond to the following items:

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

. DPBHS is committed to collaboration within our department and state partners including juvenile justice and child protection divisions. Within the broader state system, DPBHS collaborates with the Department of Education and local school districts, and the Department of Health and Social Services and its divisions. DPBHS psychologists provide assessment and counseling services to youth in the Division of Youth Rehabilitation Services (DYRS) facilities. All youth entering DYRS facilities receive behavioral health admission screenings including a review of mental health and substance abuse records and the Massachusetts Youth Screening Instrument (MAYSI) is administered. Crisis evaluations, crisis stabilization, individual, family and group therapy including Trauma Grief Component Therapy for Adolescents (TGCT-A) are provided to youth as indicated. Behavioral health consultation services are offered to enhance safety and security of youth, help youth to be successful in the program, and identify youth who would benefit from additional behavioral health services providing referral and linkage to their families and other child serving systems (including juvenile justice and child welfare). Across all of the DYRS facilities, behavioral health staff conduct risk screenings to comply with the Prison Rape Elimination Act (PREA), and also provide training for staff around basic counseling, suicide awareness and prevention, and effective treatment planning.
- Does the state have any activities related to this section that you would like to highlight?

DPBHS provides a Delaware CARES program which is a specialized wraparound team that serves both children and youth receiving

services from DPBHS and DFS. Thus far, the program has demonstrated positive outcomes maintaining children in family and community settings. DPBHS Specialized Services Unit includes the Consultation and Assessment Services, which provides psychological assessments and consultations, competency evaluations, and consults with the Department staff on specific child and family-centered issues

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

Footnotes:

## Environmental Factors and Plan

### 20. Suicide Prevention - Required MHBG

#### Narrative Question

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

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No
2. Describe activities intended to reduce incidents of suicide in your state.
  2. Provide ongoing information and education about suicide problem in Delaware and raising awareness that suicide is a preventable public health problem.
  3. Facilitate ongoing monthly suicide prevention coalition meetings.
  4. Collaborate with private and public agencies in Delaware to implement Delaware Suicide Prevention Plan
  5. Assist with other organization's development and implementation of the Delaware suicide Prevention Plan.
  6. Conduct educational presentations to interest groups and agencies that inquire about stress, mental health and/or suicide prevention.
  7. Present suicide prevention training workshops to interested individuals and agencies.
  8. Promote depression screening for the adult and senior population.
3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No
4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No
5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?  Yes  No

If so, please describe the population targeted.

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

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

Footnotes:

# Environmental Factors and Plan

## 21. Support of State Partners - Required MHBG

### Narrative Question

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

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

Please respond to the following items:

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

If yes, with whom?

We need to bring more providers into the state to meet the demands of our service delivery system. The existing providers are reaching maximized size and capacity and we believe it would be beneficial to bring in additional providers.

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

The mission of the Division of Substance Abuse and Mental Health (DSAMH) is to promote prevention and recovery from substance use, gambling, mental health and co-occurring disorders by ensuring all adult Delawareans have access to high-quality, cost-effective and outcome-based services and supports.

#### KEY OBJECTIVES

- Develop and expand the role of persons in recovery in policy development, service planning, implementation and delivery and evaluation of services. Ensure care is customized based on the individual and family needs, choices and values.
- Ensure Delawareans receive mental health, substance use and gambling prevention and treatment services in a continuum of overall health and wellness. Strengthen interdepartmental and interagency collaboration.
- Eliminate disparities in substance use and mental health services. Provide individualized treatment, intervention and prevention services to special populations and traditionally underserved groups, including pregnant women
- Develop the clinical knowledge and skills of the DSAMH state and provider workforce. Develop and implement multiple training and education opportunities for DSAMH staff and community providers.

- Promote excellence in customer service in all settings. Ensure the service delivery system is informed by evidence-based practices, including peer-run programs and experiences. Promote accreditation and licensure of Delaware's behavioral health programs.
- Use technology to access and improve care and promote shared knowledge.

**BACKGROUND AND ACCOMPLISHMENTS**

DSAMH's core services provide prevention and treatment services to Delawareans with mental health, substance use, problem gambling and co-occurring conditions. The division's goal is to ensure behavioral health services are accessible, effective, facilitate recovery and are integrated into the community.

The continuum of services that are operated or funded by DSAMH include: inpatient psychiatric and residential substance abuse services, inpatient and ambulatory detox, opiate addiction services, group homes, recovery houses and Oxford houses, peer-run drop-in centers, supervised apartments, care management, outpatient clinic services and 24/7 mobile crisis services. In addition to these services, grant funds awarded to DSAMH are used through contracts with community providers to provide transitional and permanent housing, homeless outreach, substance use and abuse prevention and supported employment services.

The system includes plans for an expansion of certain services for persons with severe and persistent mental illness, including crisis services, Assertive Community Treatment (ACT), Intensive Case Management (ICM), Targeted Case Management (TCM), housing, supported employment and rehabilitation services and family and peer supports.

DSAMH has developed and improve training programs for mental health and trauma peers through use of a national peer training model. The national model ensures that certified peers are trained in both mental health and substance abuse services.

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

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

Footnotes:



## Environmental Factors and Plan

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

#### Narrative Question

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

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

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

Please respond to the following items:

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

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.

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

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

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*<sup>73</sup>

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

Footnotes:



**Governor's Advisory Council to the Division of Substance Abuse and Mental Health**  
**Chapel – Herman M. Holloway, Sr. Campus**  
**January 19, 2017 9:15 a.m.**

**Members Present:** Patricia Ayers, Anthony Brazen, Helena Carter, Janice Jolly, Devon Manning, Jim Martin, and Susan Phillips

**Members Excused:** Jack Akester, Robert Daniels, Andrea Guest, and Patricia Hill

**Members Absent:** John Evans, Thomas Hall, James Lafferty, George Meldrum, and Joanna Rieger

**Associate Members Present:** Lynn Fahey, James Larks, Bruce Lorenz, and Charles Sygowski

**Associate Members Excused:**

**Associate Members Absent:** Florence Alberque, Lisa Furber, Dan Hoefman, Edie McCole, and John McKenna

**Interested Parties Present:** Elizabeth Booth, Willard Hensen, Walter Silja, William Mason, Joshua Thomas-Acker, Greg Valentine, Norm Vetter, Julianna Tittle, Ira Kalbrosky, Adar Wells, Erin Goldner, Sean Keblen, Mary Beth Cichocke, Emily Vera, Tim Collins, Mike Gavvla,

Topic	Discussion	Action
Call to Order/Introductions	Chairman Jim Martin called the meeting to order at 9:00a.m. and welcomed everyone in attendance. Meeting participants were invited to introduce themselves and share their affiliation.	
Review and Approval of Minutes		November minutes were not approved due to the lack of a quorum
Chairman's Report	Chairman Jim Martin passed out various documents. The documents included the by-laws of the Governor's Advisory Council (GAC). Chairman Jim Martin briefly reviewed the GAC by-laws to explain the actual purpose of the council. He pointed out the by-laws allow for a budget committee. James Larks reported that years ago he was on the GAC budget	

committee. Chairman Jim Martin assigned Mr. Larks to be Chairman of the budget committee.

Chairman Jim Martin went over the list of goals for himself as chairman and the council as a whole. Chairman Martin perceives the gathering as a re-organization meeting. He wants to put all the meeting dates and times on Outlook so everyone can plan ahead to attend. Chairman Jim Martin reiterated that the GAC still needs a Co-Chairman. He reminded everyone that nominees should go Lynn Fahey or Bruce Lorenz. He stressed the importance of getting this position filled.

Chairman Martin reported on a *Community Concerns Survey* which was put out on social media. The survey had over 100 participants and over 300 comments. The only question on the survey was “what is most important to you concerning Substance Abuse and Mental Health in Delaware”.

Chairman Martin suggested some type of communication be drafted by the GAC to submit to Governor John Carney and Secretary Dr. Kara Walker. He also raised the issue of the GAC providing Director Mike Barbieri with a strategic plan.

<p>Director's Report</p>	<p>Director Mike Barbieri reported that due to the transition of local and federal administrations, the division is in a holding pattern. The new secretary, Dr. Kara Walker, will be started February 6, 2017. There will eventually be two deputy directors coming on board. Deputy Director Henry Smith and DMS Director Kevin Kelley have retired. Many of DSAMH's systems were designed around the Affordable Care Act and Medicaid and the goal is for these systems to stay intact.</p> <p>Director Mike Barbieri reports DSAMH will continue to strive for stronger community-based care. The quality of DSAMH services will be monitored by continuing with the DOJ quarterly reports. DSAMH is in the process of applying for the <i>Secures Grant</i> to help with more community outreach using recovery coaches and peers. There is a focus group in Seaford to evaluate the area's strengths and weaknesses to determine which services would be most beneficial to the population. This group will work with public health to promote healthy lifestyle living. There will be a subtle shift from "don't use drugs" to "living a healthy lifestyle".</p>	

<b>Standing Committee Reports:</b>		
Children's Committee	Helena Carter reported there will be Children's Conferences scheduled in April and May. She will provide more detailed information about the conferences at March's meeting.	
Employment Committee	No report given due to the absence of committee representation.	
Membership Committee	No report given due to the absence of committee representation but there was discussion on increasing full and associate members and to increase attendance of member to council meetings.	
Community Services Committee	No report given due to the absence of committee representation.	
DPC Advisory Committee	Norm Vetter reported on an unannounced visit from the joint commission in December. The compliment given by them was that the staff seems very caring and supportive of the clients. Census is 112 the break down is 71 civil and 41 forensic patients. In the last quarter, the average hospital stay has been 60 days. A uniformed security company was contracted in the beginning of December. The purpose of the security contract is to ensure safety during violent client episodes. Norm reported the security company was trained in the same non-aggressive interventions as the DPC staff to make sure they had the skills and understanding to safely and positively interact with DPC's clientele.	
Old Business	None	
New Business	Charles Sygowski mentioned March is National Problem Gambling Month.	
Public Comment	Mary Beth Cichocke spoke the importance of parity in mental health and addiction. She offered several instances of the	

	<p>difference in the treatment of substance abuse people compared to physical ailments. One example is that cigarette packs have a warning label regarding the dangers of smoking, but some people do it anyway and develop lung cancer. The medical community will do all they can to comfort and cure them but compassion and dedication to curing a person with an addiction seems to be lacking. She described the seven year struggle she went through with her son. This struggle caused her to realize the bias exists. A cancer victim would not be asked “what does your insurance cover” or be told “we don’t have a bed”. She said insurance companies give the impression that saving (curing) a person with an addiction is not a priority. The discrimination and stigma of a person with an addiction needs to change. It would be a great help if she knew who to go to get parity in Delaware enforced. Mary Beth vows to find out and be in touch with that person/entity as many times as it takes.</p> <p>Erin Goldner would like to know the procedure for billing Medicaid for peer services. She feels CMS should be amended to include substance abuse. Chairman Jim Martin stated a discussion on that topic will be added to future meetings.</p>	
Meeting Adjourned	A motion was made to adjourn the meeting. Meeting was adjourned at 10:50 a.m.	The committee approved the adjournment.



**Governor's Advisory Council to the Division of Substance Abuse and Mental Health**  
**Chapel – Herman M. Holloway, Sr. Campus**  
**March 16, 2017 9:00 a.m.**

**Members Present:** Anthony Brazen, Helena Carter, Robert Daniels Thomas Hall, Patricia Hill, Jim Martin, and Susan Phillips

**Members Excused:** Jack Akester, Patricia Ayers, Andrea Guest, and Devon Manning

**Members Absent:** Janice Jolly, James Lafferty, George Meldrum, and Joanna Rieger

**Associate Members Present:** Lisa Furber, James Lark, Bruce Lorenz, and Charles Sygowski

**Associate Members Excused:** Lynn Fahey

**Associate Members Absent:** Florence Alberque, Dan Hoefman, Edie McCole, and John McKenna

**Interested Parties Present:** Mike Barbieri Barbara Bell, Mary Beth Cichocki, Willard Heuser, Julianna Tittle, Greg Valentine, Emily Vera, Norman Vetter, and Pamela Willis

Topic	Discussion	Action
Call to Order/Introductions	Chairman Jim Martin called the meeting to order at 9:10am and welcomed everyone in attendance. Meeting participants were invited to introduce themselves and share their affiliation.	
Review and Approval of Minutes		There wasn't a quorum and the minutes from November and January have not been approved.
Chairman's Report	Chairman Jim Martin states he will reach out to everyone to get ideas about how to increase GAC membership. Chairman Martin reports Jim Lafferty and Jack Akester have to formally resign before the Chairman and Vice Chairman positions can be	

	<p>filled. There a few working committees that are lacking chairs. Chairman Jim Martin would like the present committee chairs to stay on. Patricia Hill has expressed an interest is becoming vice chair. Chairman Jim Martin believes they would make a good team since his perspective is on the substance abuse side and Patricia's on the mental health side.</p> <p>Chairman Jim Martin reported he will introduce Dorothy G. later in the meeting. Dorothy will share her journey with the council about her difficulties receiving services in Delaware.</p>	
<p>Director's Report</p>	<p>Director Mike Barbieri reported DSAMH is out of the DOJ settlement and doing everything it can to continue the services produced from it. The Governor's budget requested a 15% reduction which amount to about \$17 million. It would require measureable pairing back on what is being done and the services now offered to reach that goal. There is concern about how the system will look in 24 months in regard to Medicaid rollback and Block Grants to the states. Those events would cause DSAMH to redesign nearly all the present services offered. The Affordable Care Act (ACA) allowed services to be available to more people because of Medicaid. Many of the services started years ago are out for re-bid. DSAMH has RFPs going out that are going to be more locally driven.</p> <p>Director Mike Barbieri would like feedback on how DSAMH systems are working.</p>	



<b>Standing Committee Reports:</b>		
DPC Advisory Committee	<p>Norm Vetter reported nursing staff has increased 15% since December. DPC started a nurse recruiting office. In addition to recruiting, this office gets the applications through the hiring process faster. DPC is working on instituting a nurse mentoring program to help with retention. Exit interviews are being given to find the reason nurse are leaving.</p> <p>Norm Vetter reported the addition of uniformed security to DPC staff has been a positive experience with good feedback being received. The number of incidents along with the severity of incidents has declined.</p> <p>Norm Vetter reported the average daily census is 114 with 75 civil 39 forensic. In February, 19 people were discharged. 7 went to ACT teams, 1 to CRISP, and 11 to TCMs. This shows a roughly 25% civil discharge rate in a month. The next DPC Committee is in May.</p>	
Children's Committee	Helena Carter reported the Children's Department has also been asked to reduce their budget. There will not be a Mental Health Conference this year. Helena Carter reports it is a struggle to decide what to cut and try to keep the same level of service you're providing.	
Employment Committee	No report given due to the absence of committee representation.	
Membership Committee	No report given due to the absence of committee representation.	
Community Services Committee	No report given due to the absence of committee representation.	

Budget Committee	There was discussion on what the budget committee should be doing and who wants to be involved. James Lark agreed to chair this committee.	
Old Business	None	
New Business	Bruce Lorenz mentioned that there is a bill out to legalize marijuana in Delaware. Bruce thinks the council needs to figure out its position on this bill to share with legislators.	
Public Comment	Julianna Tittle introduced Dorothy G. who is a resident of Sussex County. Julianna first met Dorothy at the ACE Peer Resource Center. In talking with Dorothy, Julianna learned of her life and problems with seeking help. Julianna is concerned about the follow through in Delaware. She believes there are limited resources for people who cognitively impaired.	
Meeting Adjourned	A motion was made to adjourn the meeting. Meeting was adjourned at 10:50 a.m.	The committee approved the adjournment.



**Governor's Advisory Council to the Division of Substance Abuse and Mental Health**  
**Chapel – Herman M. Holloway, Sr. Campus**  
**May 18, 2017 9:00 a.m.**

**Members Present:** Patricia Ayers, Anthony Brazen, Helena Carter, Robert Daniels, Devon Manning, Jim Martin, George Meldrum, and Susan Phillips

**Members Excused:** Andrea Guest and Patricia Hill

**Members Absent:** Jack Akester, Thomas Hall, Janice Jolly, and Joanna Rieger

**Associate Members Present:** James Lark, Bruce Lorenz, John McKenna, and Charles Sygowski

**Associate Members Excused:** Lynn Fahey

**Associate Members Absent:** Florence Alberque, Lisa Furber, Dan Hoeftman, and Edie McCole

**Interested Parties Present:** Mike Barbieri, Barbara Bell, Elizabeth Booth, Mary Beth Cichocki, David Grubb, Bryce Hewlett, Willard Houser, William Mason, Felicia Risick, Joshua Thomas-Acker, and Norm Vetter

Topic	Discussion	Action
Call to Order/Introductions	Chairman Jim Martin called the meeting to order at 9:03am and welcomed everyone in attendance. Meeting participants were invited to introduce themselves and share their affiliation.	
Review and Approval of Minutes		Minutes were approved for November and January. March minutes were not available.
Chairman's Report	Chairman Jim Martin wants to have the GAC member's list updated. Chairman Martin asked Mike Barbieri for assistance in getting a meeting with Cabinet Secretary Kara Odom Walker.	

Chairman Martin wants to find out what Cabinet Secretary Kara Odom Walker's vision is for the GAC. Chairman Martin attended a panel presentation, at which Dr. Gerard Gallucci and former Cabinet Secretary Rita Landgraf were participating members. The panel discussed people in the community struggling with behavioral health issues. Chairman Martin thanked Greg Valentine for helping Dorothy G. who shared her problems and struggles with seeking services at the last GAC meeting.

Chairman Martin reported that Lynn Fahey and Bruce Lorenz are the nominating committee members. The GAC needs a Vice-chair who will also attend the DPC Advisory Committee meetings. Patricia Hill mentioned she would like to be considered for Vice-Chairman. Chairman Martin reported that the GAC will be adding a By-laws Committee and Liz Booth will serve as the Chair.

Chairman Martin has been in touch with the Department of Public Health and shared the desire to present a united front. Chairman Martin is interested in what their priorities and concerns are and how they align with substance abuse disorders.

Chairman Martin introduced David G., who conducts outreach for Projects for Assistance in Transition from Homelessness (PATH). David was a pioneer in implementation of three-quarter houses. Three-Quarter houses are sober-living houses or communities which allow more freedoms than a halfway house. David reports in the last 8-9 years that the total of three-quarter houses have increased from 6-7 to about 70-80. David spoke on his efforts in helping people get off the streets. He feels his own

	<p>struggles with homelessness and addiction help him to relate to those having some of the same issues. He noted he does not share his story until someone tells him “you don’t know what it’s like”. David gets great satisfaction from helping the homeless.</p> <p>Chairman Martin introduced Mary Beth Cichocki. Mary Beth reported legislative treatment of Addiction Parity Bill, HB 41 passed. Mary Beth reported HB 91 passed which in essence provides a monitoring system for physicians providing opioids. Mary Beth reported that HB 100 also passed. HB 100 supports individuals by ensuring persons with public and private insurance have the ability to insist they receive substance abuse coverage to which they are entitled by law and their insurance plan. It enables an individual to contact the DOJ to get an attorney to fight an insurance company.</p>	
<p>Director’s Report</p>	<p>Director Mike Barbieri reported DSAMH is still waiting on a budget, but it seems there will not be any services affected but there will be cuts on the administration side. There has been a reduction in the backlog of ACT services. Director Mike Barbieri will be meeting with providers to discuss a value-based payment system. Director Mike Barbieri thinks there needs to be integrated services that encompasses all the issues a person may face.</p>	

<b>Standing Committee Reports:</b>		
DPC Advisory Committee	Norm Vetter reported on the goals that were discussed at DPC's advisory committee meeting on May 10 <sup>th</sup> . The goals discussed were improving safety, increasing and retaining staff, improving treatment, and the speed and efficiency of admissions and discharges. The average length of stay for DPC's 1 <sup>st</sup> quarter was 106-130days. Census for the 1 <sup>st</sup> quarter was 113. Norm reported when he became DPC Director, staffing was down 40%, now DPC has 22% vacancies.	
Children's Committee	Helena Carter reported the Children's Department has a RFP out for the Summer and After-School program for 2017-2018. PBH funding extended hours in Wilmington for Safe Haven locations. PBH and YRS are being trained in an SA program, Seven Challenges, to be implemented in Ferris School. Seven Challenges is a comprehensive counseling program for young people that incorporates work on alcohol and other drug problems. Prevention is having success with implementing a wraparound approach in their care management/treatment. The wraparound model is where the child and family work directly with a team of professional and members of the family's community.	
Employment Committee	No report given due to the absence of committee representation.	
Membership Committee	No report given due to the absence of committee representation.	
Community Services	No report given due to the absence of committee representation.	

Committee	Emily Vera would like to chair this committee.	
Budget Committee	James Lark agreed to chair this committee.	
Old Business	None	
New Business	Charles Sygowski mentioned a 5K walk/run called “Peace by Piece”. It is a re-think addiction event to be held Saturday, May 20, 2017 at Glasgow Park, Newark, DE.	
Public Comment	None	
Meeting Adjourned	A motion was made to adjourn the meeting. Meeting was adjourned at 10:45 a.m.	The committee approved the adjournment.



**Governor's Advisory Council to the Division of Substance Abuse and Mental Health**  
**Chapel – Herman M. Holloway, Sr. Campus**  
**November 17, 2016 9:15 a.m.**

**Members Present:** Jack Akester, Patricia Ayers, Anthony Brazen, Robert Daniels, Andrea Guest, Patricia Hill, Janice Jolly, Devon Manning, Jim Martin, George Meldrum, Susan Phillips

**Members Excused:** John Evans, Thomas Hall, James Lafferty

**Members Absent:** Helena Carter, Joanna Rieger

**Associate Members Present:** Lynn Fahey, John McKenna, Charles Sygowski

**Associate Members Excused:** Bruce Lorenz

**Associate Members Absent:** Florence Alberque, Lisa Furber, Dan Hoeftman, James Lark, Edie McCole,

**Interested Parties Present:** Michael Barbieri, Barbara Bell, Elizabeth Booth, Tom Johnson, William Mason, Joshua Thomas-Acker, Greg Valentine, Norm Vetter, Daphne Warner, Erin Goldner

Topic	Discussion	Action
Call to Order/Introductions	Vice Chairman Jack Akester called the meeting to order at 9:10a.m. and welcomed everyone in attendance. Meeting participants were invited to introduce themselves and share their affiliation.	
Review and Approval of Minutes		The meeting minutes from September were approved.
Chairman's Report	Vice Chairman Jack Akester reported in Chairman James Lafferty's absence. Lynn Fahey reported there was one nomination for GAC Chairman. There were no nominations for Vice Chairman. Lynn informed the committee that Jim Martin was nominated for GAC Chairman. Mr. Martin was then appointed by an unanimous vote from the committee. There were no nominations submitted from the floor for Vice Chairman.	



<p>Director's Report</p>	<p>Director Mike Barbieri reported in October, DSAMH had been released from the DOJ Settlement Agreement and that Delaware was the first state to complete a settlement within the five year time frame. The issues that arose from the settlement will continue to be addressed. The DOJ was most impressed with the PEER Support Program. The division will put more focus on the Peer Program and getting more recovery coaches on board.</p> <p>Director Mike Barbieri informed the council that Greg Valentine has moved from Director of DPC to Director of Community Based Services and Norm Vetter has been appointed DPC Director. He invited Norm to speak. Norm Vetter reported he has over 30 years of mental health experience. Norm's last position was Assistant Director of Social Services at Eagleville Hospital in Montgomery County, where he managed the co-occurring section.</p> <p>Director Mike Barbieri reported that DSAMH is entering the new year with a significant budget deficit and the division has been asked to give back \$2.4 million. The premise is to do cut the budget without cutting programs. Medicaid dollars could help continue the level of support already being provided. Director Barbieri reported since the state is in transition with a new governor and administration, the division needs to memorialize the accomplishment achieved over the years to enable anyone coming in to carry them forward.</p>	
<p><b>Standing Committee Reports:</b></p>		
<p>Children's Committee</p>	<p>Daphne Warner reported in Helena Carter's absence that the Children's Committee budget has a request for four behavioral health consultants and 2 elementary family crisis therapist. The committee will contact physicians if those positions are funded. The crisis service bid has gone out and there are different locations being reviewed. More information should be available soon.</p>	

Employment Committee	Andrea Guest reported the Employment Committee met with an ACT Team to discuss strategies to increase employment of individuals at the ACT Team. The committee is gathering information over the next two months to report data on how many people are in “employment lines” and how many people have actually received jobs in the communities. A portion of the Vocational Rehabilitation program is set aside for working with youth and young adults with behavioral health issues. The committee is working with the Department of Education to create a Career Pathways Initiative. The transition from middle school to high school has the highest dropout rate so this program focuses on 14 year olds with disabilities. The approach today is not to stress the emphasis on a four year college experience, but a two year or vocational education instead. December 7 <sup>th</sup> there will be a youth conference at Dover Downs. The conference is for the benefit of parents, students, and teachers with professionals holding workshops.	
Membership Committee	Jack Akester reported membership includes 16 full members and 9 associate members. Jack reported that his position on the DPC Advisory Committee will be open as well as Jim Martin’s position on the Community Services Committee.	
Community Services Committee	Jim Martin reported there is a new hospital in Georgetown that will generate new jobs which is beneficial to Sussex County. There is a new recovery response center in Ellendale. A new sober living facility for women coming out of treatment has opened. Attack Addiction and Caring & Sharing are volunteer groups that are very active in the area of addiction.	
DPC Advisory Committee	Jack Akester reported that DPC Advisory Committee met on November 9 <sup>th</sup> and Greg Valentine introduced Norm Vetter as DPC Director. The daily census is between 111-112 clients. There are 80 civil beds at DPC. The facility has 17 long term clients waiting for a nursing/group home placement. The Infection Control department has increased its flu/pneumonia vaccinations for staff and clients. The three day readmission rate for August and September was zero. The number of seclusion and restraint incidents remains low.	
Old Business	None	
New Business	None	
Public Comment	Erin Goldner spoke on the importance of Peers. She feels that oftentimes	

	professionals are focused on the professional standards and more attention should be directed towards the relationships that peers bring to the treatment area. She thinks peer support is invaluable because the peer has experienced what an addicted or mentally ill person is going through. She senses when a peer tells their story it elicits trust and trust makes it easier to help that person in need. Erin also feels it is helpful when peers are a formal part of the community.	
Meeting Adjourned	A motion was made to adjourn the meeting. Meeting was adjourned at 10:10 a.m.	The committee approved the adjournment.

# Environmental Factors and Plan

## Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Florence Alberque	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		103 Delaplane Ave Newark DE, 19711 PH: 302-602-4486	floa49@yahoo.com
Patricia Ayers	State Employees	Department of Education	John G. Townsend Building, Suite 401 Dover DE, 19901 PH: 302-735-4108	drozumalski@doe.k12.de.us
Helena Carter, Psy. D.	State Employees	Division of Prevention & Behavioral Health Services	Baratt Bldg, Suite 102, 821 Silver Lake Blvd Dover DE, 19904 PH: 302-739-8380	helena.carter@state.de.us
Rev Robert Daniels	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		217 W 19th Street Wilmington DE, 19802 PH: 302-429-8963	rwdaniels2000@yahoo.com
Devon Degyansky	State Employees	Delaware State Housing Authority	18 The Green Dover DE, 19901 PH: 302-739-4263	Devon@delstatehousing.com
Lynn Fahey	Providers	Brandywine Counseling, Inc.	2713 Lancaster Ave Wilmington DE, 19805 PH: 302-225-9269	lfahey@brandywinecounseling.com
Lisa Furber	Others (Not State employees or providers)		Community Legal Aid Society, Inc Wilmington DE, 19801 PH: 302-575-0690	efurber@declasi.org
Andrea Guest	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Vocational Rehabilitation	4425 N. Market Street Wilmington DE, 19802 PH: 302-761-8275	andrea.guest@state.de.us
Thomas Hall	State Employees	DHSS/Division of State Service Centers	1901 N. Dupont Hwy New Castle DE, 19720 PH: 302-255-9605	
Patricia Hill	Others (Not State employees or providers)			
Daniel Hoeftman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1033 Governor House Circle Wilmington DE, 19809 PH: 302-762-7205	gotodan@comcast.net
			218 West 35th Street	

Janice Jolly	Providers		Wilmington DE, 19802 PH: 302-764-7781	jjollygirl@yahoo.com
James Larks	Others (Not State employees or providers)			jlarks@verizon.net
Bruce Lorenz	Providers	Thresholds	20505 DuPont Blvd., Unit 1 New Castle DE, 19720	
James, Jr. Martin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		217 Old LAurel Road Georgetown DE, 19947 PH: 302-628-3016	jimymartin767@gmail.com
Edie McCole	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		12 Hillside Road Claymont DE, 19703 PH: 302-793-1941	ediemccole@comcast.net
John McKenna	Providers	Rockford Center	100 Rockford Drive Newark DE, 19703 PH: 302-892-4262	john.mckenna@uhsinc.com
George Meldrum, Jr.	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Nemours Health and Prevention Services	Christiana Bldg., Suite 200, 252 Chapman Road Newark DE, 19702 PH: 302-444-9071	Bandit47@Comcast.net
Susan Phillips	Parents of children with SED		414 Evergreen Circle Milford DE, 19963	ss.phillips@verizon.net
Joanna Rieger	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		97 Dodge Drive Smyrna DE, 19977	joanna@delawarerecovery.org
Charles Sygowski	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		100 West 10th Street, Suite 303 Wilmington DE, 19801 PH: 302-655-3261	underdog@dcgp.org

Footnotes:

# Environmental Factors and Plan

## Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	13	
State Employees	4	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	8	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

# Environmental Factors and Plan

## 23. Public Comment on the State Plan - Required

### Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
  - a) Public meetings or hearings? j n Yes j n No
  - b) Posting of the plan on the web for public comment? j n Yes j n No
  - c) Other (e.g. public service announcements, print media) j n Yes j n No

If yes, provide URL:

Legal Notices were placed in the two major Delaware Newspapers. Delaware State News and the News Journal.

Draft plan posted on DSAMH website: <http://www.dhss.delaware.gov/dhss/dsamh/sabg.html>

Footnotes: