State Information

State Information

Plan Year

Start Year 2016

End Year 2017

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 Michael

Last Name Barbieri

Agency Name Delaware Health & Social Services

Mailing Address 1901 N. Dupont HWY Main Administration Building

City New Castle

Zip Code 19720

Telephone 302-255-9040

Fax 302-255-4427

Email Address michael.barbieri@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 Michael

Last Name Barbieri

Agency Name Delaware Health & Social Services

Mailing Address 1901 N. Dupont HWY, Main Admin Building

City	New Castle
Zip Code	19720
Telephone	302-255-9040
Fax	302-255-4427
Email Address	michael.barbieri@state.de.us

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

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Cliffvon
Last Name	Howell
Telephone	3022559415
Fax	3022552959
Email Address	cliffvon.howell@state.de.us

Footnotes:

State Information

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

Fiscal Year 2016

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

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Footnotes:

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

SECTION II - Planning Steps

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

Delaware is a small, but diverse state, located in the mid-Atlantic region of the country. Its land area of 2,000 square miles is divided among three counties: New Castle County, Kent County and Sussex County. Fifty-nine (59) percent of the state's population resides in New Castle County. The City of Wilmington, which is the state's largest city, is located within New Castle County and has a population of 73,190. This represents 13% of New Castle County's total population. 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 State Capitol, Dover, is located in Kent County which is designated as an urban area.

Delaware is divided into four sub-state planning areas designated by SAMHSA's Office of Applied Studies and adopted by Delaware's State Epidemiological Outcomes Workgroup (SEOW), also known as the Delaware Drug and Alcohol Tracking Alliance (DDATA). The areas are the city of Wilmington, the remainder of New Castle County, Kent County, and Sussex County.

Based on the US 2010 Census population and updated estimates by the Delaware Population Consortium, the total state population is expected to reach 957,513 in the year 2017. 78% (740,844) of the population will be represented by individuals ages 18 and over, and 22% (208,956) of the population will be represented by children and youth (age 0 - 17). African-Americans will comprise 22% and individuals of Hispanic origin will comprise 8.7%[1] of the total state population.

From 2010-2014 Delaware saw over a 4% population growth and much of it has been driven by increases in minority populations (Census.gov). Over the next decade spanning 2010 to 2020, there is an anticipated 6% growth in both the 0 – 9 year old and 10 – 19

[1] Data on Hispanic origin is based on US Census Bureau figures. 2013 American Community Survey

year old populations in the State of Delaware (Kids Count 2013). Recent census data show a decrease by 7% of 20-64 year olds between 2000 and 2030 but an increase of 100% in the 65 and older population and 300% in the 85+ population, with one in four being a minority. These demographic trends and Delaware's growing multicultural communities, make the needs of youth and young adults, minorities, veterans and the elderly even more compelling as data suggest these populations are most in need of resources.

The median household income in Delaware for 2009-2014 was $59,878. Delaware's major businesses include chemical, banking and financial services, healthcare and pharmaceutical industries. The single largest employer in SFY 2015 was the State of Delaware, while the Services Industries as a group employed the largest number of Delawareans. More than half a million business entities have their legal home in Delaware including more than 50% of all U.S. publicly-traded companies and 60% of the Fortune 500. Delaware maintained an unemployment rate of 4.5% as of April 2015[2].

ADULT BEHAVIORAL HEALTH SYSTEM

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

The following describes the adult mental health system in Delaware:

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

[2] State of DE Department of Labor website; http://www.delawareworks.com/oolmi/Information/LMIData/LAUS/Current-Labor-Force-Statistics.aspx

between the Secretaries and Division Directors, and between key staff of the Divisions of Substance Abuse and Mental Health and Child Mental Health Services. The two Divisions have worked to develop and implement two Memorandums of Understanding to formalize their respective roles and responsibilities in meeting federal Community Mental Health Services Block Grant requirements:

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

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

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

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

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

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

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

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

Administrative Structure and Service System

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

Central Office. Administration of statewide substance abuse services and mental health services for adults 18 years of age and older is the function of the Central Office. The Central Office has the following responsibilities: implementing Delaware Health and Social Services policy; setting the mission, vision and values to serve as decision

templates within the Division; Strategic planning, allocating resources and developing the service system; Managing state and federal inter governmental relations; Managing access and use of the service delivery system; and managing the flow of consumers with serious mental conditions and substance use disorders into inpatient, residential, and outpatient state and community programs. The Central Office includes the following sections: Administrative Services (MIS, Fiscal, and Quality Improvement); Planning and Program Development; Human Resource Development and Training; Office of the Director/Deputy Director inclusive of the Office of Consumer Affairs. The Director of Community Mental Health and Substance Abuse Services and Gambling Affairs oversee the mental health, substance abuse, and gambling service system for the Division.

Delaware Psychiatric Center. The Delaware Psychiatric Center (DPC) is the single state operated psychiatric hospital. It is licensed for 200 beds, though we are actively downsizing this facility with the assistance of the USDOJ. DPC operates five discrete units: two acute care units of 22 beds each; a 22 bed geri-psych unit for mostly medically complex individuals with a history of a serious mental condition; a longer stay, 16 bed all male unit for persons who have stepped down from forensic settings, are labeled as sex offenders or who may be considered aggressive; and a 42 bed Level Five forensic program. The Delaware Psychiatric Center's average daily census was 117 clients for the period ending – 6/30/2015.

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

Community Support Program Structure for Adults

The previous *Community Continuum of Care Programs (CCCPs)* has been eliminated in

favor of an Assertive Community Treatment (ACT), which is based on the Program of Assertive Community Treatment model. An *ACT Team* is a group of ten (10) ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ACT team members are assigned by the team leader and the psychiatric prescriber to work collaboratively with an individual and his/her family and/or natural supports in the community by the time of the first individual assessment and subsequent person directed recovery planning meeting. The ACT team serves up to 100 individuals and thus has a maximum staff to client ratio of 1:10. Five teams serve consumers in New Castle County, two teams provide services in Kent County and a single team serves 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 individual. The team has continuous responsibility to be knowledgeable about the individual's life, circumstances, goals and desires; to collaborate with the individual to develop and write the recovery plan; to offer options and choices in the recovery plan; to ensure that immediate changes are made as a individual's needs change; and to advocate for the individual's wishes, rights, and preferences. The ACT team is responsible for providing much of the individual's treatment, rehabilitation, and support services. Team members are assigned to take separate service roles with the individual as specified by the individual and the person directed recovery plan.

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 an individual and his/her family and/or natural supports in the community by the time of the first individual assessment and subsequent person directed recovery planning meeting. The ICM team serves up to 200 individuals and thus has a maximum staff to client ration 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 individual. The team has continuous responsibility to be knowledgeable about the individual's life, circumstances, goals and desires; to collaborate with the individual to develop and write the recovery plan; to offer options and choices in the recovery plan; to ensure that immediate changes are made as a individual's needs change; and to advocate for the individual's wishes, rights, and preferences. The ICM team is responsible for providing much of the individual's treatment, rehabilitation, and support services. Team members are assigned to take separate service roles with the individual as specified by the individual and the person-directed recovery plan.

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:

1. 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.
2. Rapid engagement of individuals wherever the individual is located including emergency departments, psychiatric hospitals, homeless shelters, etc.
3. 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.

4. Person-centered recovery planning with clients served that is strengths based, focusing on the client's goals, particularly short term goals. This includes goals that include the anticipated length of TCM involvement as well as a plan to link the individual to longer term community supports and providers.

5. Linkage of the individual to appropriate community based behavioral health organizations. The 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.
6. Advocacy on the individual's behalf in reaching the supports they desire and in meeting their recovery goals. As such, all services are planned and carried out with full participation of the client, the client's family and other supports when appropriate.
7. Services only as long as needed and desired by the individual served. 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.
8. Immediate access to crisis apartments that have capacity to provide short term emergency housing.

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

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

There are two *day programs* operating in Delaware. One program, serving consumers

in New Castle County and one program serving consumers in Kent County, provides community based supportive and recovery services in a group format and is run by community provider agencies.

Twenty four hour supervised residences are either linked as program components to community support services or are organized as self-contained programs. Throughout DSAMH's Continuum of Care, there exist 321 beds statewide that provide 24hour supervised residential services. These services are provided via DSAMH's group home, supervised apartment, transitional and permanent housing programs. These programs are currently under review and revision with guidance from USDOJ and consultants.

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

Systematically, Delaware's Substance Abuse Prevention and Treatment systems operate similarly in general construct to the Mental Health system. There is no city- or county-funded public human services in the state.

The Division of Substance Abuse and Mental Health (DSAMH) serves as the Single State Authority for the State of Delaware for both substance abuse and mental health services for the State of Delaware. DSAMH collaborates with the Department of Services for Children, Youth, and their Families' Division of Prevention and Behavioral Health Services (DSCYF/DPBHS) in the planning and implementation of behavioral health services, especially in areas of service transition and prevention for youth reaching adulthood and development of decision-support systems. DSAMH administers substance abuse services for the adult system (individuals 18 years of age or older), while DPBHS administers the substance abuse services for the youth system in Delaware (those ages 17 years of age or younger). The two Divisions have developed a Memorandums of Understanding (MOU) to formalize the respective roles and responsibilities of each of the Divisions. The MOU is 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.

DSAMH operates primarily through contracts with private agencies to implement a comprehensive substance abuse system 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; short and long term residential programs; and residential detoxification services. DSAMH operates the Treatment Access Center (TASC) which provides targeted services and liaison with the Courts and criminal justice system. DSAMH also supports services directed toward problem/compulsive gambling, as well as primary prevention substance abuse programs.

In alignment with the systematic impact of the Affordable Care Act, DSAMH and DPBHS have begun working closely with the Division of Medicaid and Medical Assistance (DMMA). DMMA is the agency responsible for the administration of the State's Medicaid program. Due to Medicaid Waiver Section 1115, DMMA and DSAMH will continue to work together to write the new Mental Health and Substance Abuse Medicaid reimbursement sections of the 2014-2015 state contracts. These changes in operating procedures are intended to benefit Delaware's population by expanding the substance abuse services that Medicaid will pay for, and better leverage resources throughout the state.

Substance Abuse Treatment Services

In 2014, 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 Recovery. 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 a number of 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 of our provider contracts the expectation that services and supports will be accessible and seek to, first, work 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 Naltexone, Methadone, and Buprenorphine can be very effective; however, although 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.

Below please find information of the different components of Delaware's Substance Abuse Treatment System. Delaware has released several Requests for Proposals (RFPs) to better address the systematic needs within Delaware's substance abuse treatment system; additional RFPs will be released throughout. RFPs include, but are not limited to the following: Detoxification services; services for pregnant women and women with dependent children; and residential treatment services for individuals with co-occurring disorders.

Eligibility and Enrollment Unit (EEU)

The EEU in Delaware is the gatekeeper to the substance use disorder treatment system. The goal of the EEU is to gather information about the consumers in order to place them in the level of care that is the most appropriate for the individual as determined by best practice assessment tools and the individuals themselves. The EEU uses 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 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 five axis DSM diagnoses. The results of the assessment help make a determination about appropriate intensity of care focused on ASAM PPC-2R.

Detoxification Services, including Ambulatory (Detox)

The State of Delaware currently has one residential detoxification program that provides services for up to five days, although, seven days is available for medication assisted detoxification. DSAMH contracts with Northeast Treatment Centers, Inc. (NET) to provide medically monitored inpatient detoxification. NET's incentive based contract emphasizes successful linkages to the next level of care. The state currently pays for 26 beds at this facility.

Core services include 24 hour physician, psychosocial services, medical services, linkages to substance abuse treatment facilities. This program now provides Vivitrol (Naltexone). This injection is used along with counseling and social support to help

people who have stopped drinking large amounts of alcohol to avoid drinking again. This program offers Buprenorphine for medical management of the detoxification process.

DSAMH recently released a Request for Proposal (RFP), seeking develop Detox services statewide by re-organizing the current structure to make available 15 beds each of Delaware's three counties (New Castle, Kent and Sussex counties). This restructure will account for an additional 19 beds (45 statewide). In addition, the proposal request there be twelve (12) "23 hour" beds at each site to be utilized for stabilization for those who do not need medically monitored Detox. Ambulatory Detox will also be offered at each site.

DSAMH has witnessed an increase in referrals to admissions for young adults with Opioid addiction. DSAMH is implementing ambulatory detoxification programs in the outpatient and methadone programs. DSAMH feels this less restrictive setting will be more attractive to the target population of young adults. It uses Buprenorphine for medical management of the detoxification process. These programs will be fully integrated with outpatient treatment services. Ambulatory Detox will still be offered resulting from the recently released RFP; however, operations will shift according to proposals.

The resulting changes will begin execution in September 2013. DSAMH reserves the right to move these services and funding around based on need.

Medication Assisted Recovery

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

Counties. Both programs currently prescribe Suboxone (Buprenorphine) and Vivitrol (Naltexone) for alcohol dependence. Ambulatory detoxification is required for the transition to outpatient services.

Residential Services

DSAMH contracts for three residential treatment programs statewide:

- Gateway is contracted to provide 80 beds for inpatient services, of which 60 are for males, and 20 are for females. This program provides services to a mix of community and criminal justice referred clients.
    - Due to deterioration of the facility structure, the 80 Gateway beds must be relocated. Gateway will not close until all other beds have become operational. It is expected that 40 beds will be moved to the Delaware Hospital for the Chronically Ill campus. These beds will be high intensity treatment beds. The balance of the beds will be relocated to different facilities statewide to increase accessibility.
    - This change is anticipated to occur in December 2013.
- Gaudenzia is contracted to provide residential Opioid services for young adults aged 18 to 25. While alcohol or any drug can be treated, admission preference is given to those with Opioid addiction. This program treats both males and females. During the treatment phase, the core services are to provide services geared to the young adult population, daily regimen of individual and group therapy, daily regimen of community meetings, educational or vocational services. Finally during the reintegration phase of treatment, consumers will develop a continuing care plan, attend outside 12 step programs and engage in other social support activities.
    - A new component has been added to the Gaudenzia treatment program, 16 transitional beds. Clients will be allowed to stay in these beds until permanent placement has been identified. DSAMH will utilize peers to assist with this process. This program will replace the 8 beds that were lost due to the closing of Chance House.

- The BCCS "Lighthouse Program" provides residential services in Sussex County for pregnant women and women with dependent children. Core services include, providing a safe and therapeutic environment, provides 24 hour on-site staff, provide an evidence based model for co-occurring mental health and substance use conditions, psychiatric services, relapse prevention, relationship issues, family counseling, conflict resolution, anger management, improve parenting skills, pre employment training, social skill building, life skills, and instilling empowerment.
    - In July 2013, DSAMH released an RFP for treatment services for pregnant women and women with dependent children.
        - In FY12 DSAMH received technical assistance through CSAT to help the State clarify its understanding of and practices associated with the "Special Services for Pregnant Women and Women with Dependent Children" requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Pamela Petersen-Baston, M.P.A., CAP, CPP, and Jennifer Keyser Bryan, D.H.Sc., M.P.A., M.S.W., consultants with JBS provided the specific technical assistance. The information gained through the technical assistance was influential in the development of the RFP that was developed for treatment services for pregnant women and women with dependent children. In addition to the RFP, language for gender specific and targeted women's services was included in all contracts funded by the Substance Abuse Block Grant funds (Appendix A). Through these efforts (both residential and non-residential services), DSAMH will enhance the treatment services offered to women throughout the state, specifically for pregnant women and women with dependent children.

Outpatient Programs (OP)

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

- An RFP will be released in FY14 to include co-occurring service components to outpatient programs.

Intensive Outpatient Programs (IOP)

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

Halfway Houses

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

- Halfway houses in all counties will continue; however, a Kent County halfway house will be going from 9 beds to 18 in October to increase capacity.

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.

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

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

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

Cornerstones Residential Program

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

Crisis Services

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

- DSAMH is working towards enhancing help line services for consumers. The help line would be divided into emergency and non-emergency calls. Emergency calls would go to Mobile Crisis. Staffing for the non-emergency component needs to be identified.

The Bridge Program

The Bridge Program is a mechanism designed to aid and assist individuals receiving care in a residential treatment facility to transition to fully integrated, independent living units, in the community. Bridge funds assist DSAMH mental health and substance use clients to access and maintain affordable housing.

Oxford Houses

DSAMH contracts with Oxford House International to provide a network of 44 Oxford Houses, 200+ beds. They also use state general funds to maintain a revolving loan fund to

open new houses. No Substance Abuse Prevention and Treatment Block Grant Funds are used to maintain the revolving loan fund.

- In FY14, this contract will increase to 60 houses in increase access and availability for consumers (no RFP required).

Transportation Services

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

1212 Clubs

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

Project Renewal

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

Delaware Council on Gambling Problems (DCGP)

DSAMH realizes that there is a high rate of gambling among consumers 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 people score high on the

SOGS, they are provided access onsite to gambling counseling or referred to a gambling program. DCPG also offers gambling prevention and a toll free help line.

Needle Exchange Program

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

Co-occurring Services

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

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

The Division maintains a 100% screen rate for co-occurring disorders for individuals receiving treatment services from Community Mental Health Clinics, Institutes for Mental Disease (IMD), Assertive Community Treatment (ACT), substance abuse

outpatient programs, TASC, residential treatment programs, mental health group homes and the Gambling Council.

Substance Abuse Prevention Services

Delaware's prevention infrastructure has improved significantly over the past five years. There are many factors that have impacted Delaware's current status, including the appointment of Kevin A. Huckshorn as the Director of the Division of Substance Abuse and Mental Health by Governor Markell (2009) who recognized the importance of increasing 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. Governor Markell reorganized state agencies to include prevention mandates within their infrastructure. There was an increased level of commitment by DSAMH and DPBHS, the Division's partnering agency, to continue working collaboratively to provide comprehensive substance abuse prevention services throughout the state, as well as to build community capacity through workforce development initiatives. DSAMH and DPBHS have adopted the Strategic Prevention Framework (SPF) within Delaware's substance abuse prevention infrastructure which has improved prevention services statewide.

Due to the increased importance and relevance of prevention in the State, DSAMH and DPBHS with the inclusion of prevention providers throughout the state, developed a Statewide Substance Abuse Prevention Plan targeting individuals throughout the lifespan. The Strategic Plan, using the SPF model, guides the State's prevention activities. The Strategic Plan is reviewed by DSAMH, DPBHS, and the Delaware Prevention Advisory Committee (a consortium of substance abuse prevention providers throughout the state) on a regular basis to ensure benchmarks are being met, appropriate services are being provided, and emerging substance consumption and consequence trends are discussed. The Plan was updated in 2014 in conjunction with the State's application for the next generation of Strategic Prevention Framework (SPF) grant from SAMHSA. Delaware is committed to building the capacity of the prevention network to respond to state priorities. Delaware's small geographic size provides advantages to developing,

strengthening and sustaining prevention efforts across the State that are relevant to multiple communities and target populations. To better serve Delaware, DSAMH and its state and other partners set out to develop a comprehensive Strategic Plan to address the prevention needs and enhance the prevention infrastructure in the state.

Delaware's commitment to promote prevention can be seen through the adoption of the Certified Prevention Specialist (CPS) credential in 2011 by the Delaware Certification Board (DCB). In the first year and three months, DCB grandfathered 70 professionals to obtain their CPS. Through the support of the Substance Abuse Prevention Block Grant and the Strategic Prevention Framework – State Incentive Grant (SPF SIG), Delaware now has almost 90 individuals who hold the CPS credential.

Currently, Delaware has few institutionalized procedures for providing prevention training and technical assistance to professional staff and community providers; however, DSAMH and DPBHS continue to work to enhance workforce development procedures. DSAMH provides professional training each year at the Summer Institute, a week-long training conference focused on the behavioral health professional. In addition, DPBHS provides a two-day training conference annually on substance abuse and mental health topics. Through the support of the SPF-SIG and the Center for the Application of Prevention Technologies (CAPT), Delaware has had the opportunity to offer the Substance Abuse Prevention Skills Training (SAPST), June 2012 and April 2013, which has helped to further develop the skills and abilities of Delaware's prevention professionals.

DSAMH contracts with two community agencies to provide prevention strategies throughout the state. 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 are prior recipients of treatment services or have been diagnosed with a substance abuse disorder. DSAMH contracts with BCCS and the Latin American Community Center (LACC).

BCCS primarily targets individuals 18-25 years of age within the City of Wilmington; however, their prevention efforts range statewide to the adult populations at highest risk for developing substance use disorders. Services include individual, peer, and community approaches to prevention. Programming is done through social media campaigns, social norm strategies, and evidence-based programs. BCCS collaborates with the local institutions of higher education to provide educational sessions and prevention resources to their student population. BCCS also implements a Fetal Alcohol Spectrum Disorder (FASD) program focused on working with women to increase their knowledge about FASD. BCCS also participates as one of the Co-Chairs on Delaware's FASD Task Force.

LACC provides prevention programs based on the six CSAP prevention strategies to the Spanish and English speaking Latino adults, as well as other adults ages 18 – 35 in the City of Wilmington. Notably, LACC has worked closely with the CAPT with their Service to Science program to move their parent education program to an evidence-based program.

In 2009, DSAMH received a SPF SIG from SAMHSA/CSAP. As of July 2015, Delaware has recently completed an extended fifth year of the cooperative agreement. The SPF SIG contracted with more than a dozen community based agencies to implement substance abuse prevention services. The SPF SIG also contracted with the University of Delaware for community assessment and evaluation support, and for the State Epidemiological Outcomes Workgroup (SEOW), otherwise known as the Delaware Drug and Alcohol Tracking Alliance (DDATA). Much of the work conducted under the SPF SIG continues through the SPF-PFS (Strategic Prevention Framework-Partnerships for Success) grant with statewide prevention staff to develop comprehensive prevention efforts and enhance Delaware's prevention infrastructure through training and development.

In 2011, DSAMH received the Strategic Prevention Enhancement (SPE) grant through SAMHSA/CSAP. The grant, originally a one-year opportunity, 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

within the state. The SPE, in conjunction with the SPF SIG and SAPT Block Grant have helped to transform Delaware's prevention system.

CHILD BEHAVIORAL HEALTH SYSTEM

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

The Department of Services for Children, Youth and their Families (The Delaware Children's Department) was established in 1983 by the General Assembly of the State of Delaware. Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and after care. The Children's Department wants every child to be safe, live in a stable home, learn and grow in self-esteem, and embrace a sense of hope about the future. The Department 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.

The Division of Prevention and Behavioral Health Services (DPBHS) is part of the Delaware Department of Services for Children, Youth and Their Families employing 294 staff across 17 facilities located throughout the state. On July 1, 2010, the Division of Child Mental Health and the Office of Prevention and Early Intervention blended to become the new Division. DPBHS provides a statewide continuum of prevention services, early intervention services, and mental health and substance abuse (behavioral health) treatment programs for children and youth. These services have graduated levels of intensity that are child-centered and family focused. DPBHS' prevention and early

intervention services focus on promoting safe and healthy children, nurturing families and strong communities through community and school-based initiatives. DPBHS' treatment services are accredited under the Business and Services Management Standards of 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.

DPBHS is committed to addressing the needs of Delaware's children, youth and their families. Our vision has driven significant changes in our state's service system for children in crisis, which began forming a System of Care with a focus on child safety and evolved into a comprehensive trauma and behavioral health services for children and families that are community based with limited reliance on inpatient or residential care. Our partnership with private service providers and community supports significantly reduced juvenile detentions and contributed to improving juvenile rehabilitation services. DPBHS is an integrated children's services agency with responsibility for programs in prevention, mental health and substance abuse (DPBHS), juvenile justice (Division of Youth Rehabilitative Services-DYRS), child protective and prevention/early intervention programs (Division of Family Services-DFS). Within DSCYF, DPBHS is responsible for:

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

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

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

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

DPBHS System – Present and Future

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

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

Our Departments mission: "We are strengthening foundations for children and families by giving them the tools and support they need to be successful. By forging community partnerships and being responsive to the needs of those we serve, we will provide long-term, sustainable solutions for our youngest Delawareans "

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

The office of Prevention and Early Intervention (OPEI) was merged into DCMHS to become the **Division of Prevention and Behavioral Health Services (DPBHS)** on July 1, 2010. The Division of Child Mental Health Services (DCMHS) provided a continuum

of mental health and substance abuse treatment for youth under the age of 18. The office of Prevention and Early Intervention (OPEI) provided a wide range of community services focused on family and youth education and supportive activities to strengthen families, and lessen the likelihood of entry or reentry into more intensive services. Together our new Divisions mission is: To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care.

Division of Family Services (DFS) provides intervention services for abused, neglected and dependent children and youth. Division of Youth Rehabilitative Services (DYRS) provides treatment, habilitation and rehabilitation for youth involved in the juvenile justice system, both pre- and post-adjudication.

Division of Management Support Services (DMSS), in addition to providing human resources, fiscal and management information support services, works with the service divisions to provide or coordinate educational services for DSCYF clients in day and residential treatment programs. These services are coordinated through varies approaches:

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

DPBHS Central Office functions include strategic and budgetary planning, policy and procedure development, accountability and quality assurance. Functional units within Central Office include Intake and Assessment, Clinical Services Management, Program Administration, Information Management and Training. Units with direct client and family contact, including Clinical Services Management and Assessment, are located in regional offices across the state to facilitate service access. DPBHS continues to be

accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), as a managed Behavioral Healthcare Organization and in Children and Youth Services.

The DPBHS treatment network is composed of over 100 service agencies operating from more than 81 sites across the state. In two sites services are provided by state-operated programs; all others are contracted agencies or providers. DPBHS is a leader in community education on prevention and treatment across the state.

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

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

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

Media Campaigns: DPBHS coordinates statewide media campaigns that address the

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

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

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

services for children through collaboration with families and service partners.

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

- Planning and implementing the statewide continuum of behavioral health care services for children who require publicly funded services.
- Operating a system of case management with the goal of providing treatment in the least restrictive, clinically appropriate setting, minimizing utilization of hospital or residential programs, and involving families and communities in active treatment partnerships.
- Collaborating with other children's service agencies to plan and implement integrated and supportive systems of care to facilitate the highest possible levels of community functioning.
- Providing leadership in children's behavioral health program development, preferred-practices policy and training, and data-driven decision-making.

The DPBHS Continuum

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

DPBHS has a continuum that consists of Clinical Services Management Teams (CSMTs) with a coordinator assigned to each client and over forty agencies providing a wide array of mental health and substance abuse services for children and adolescents. Although not all service levels are available in each community, most services are available statewide. Services include 24-hour mobile crisis units and short-term crisis beds, clinic and

home/community-based outpatient care, community aides ("wraparound"), intensive outpatient, community and hospital-based day and part-day programs, residential treatment and psychiatric hospitalization.

In DSCYF, the Division of Family Services is the primary agency responsible for providing foster and group homes. DPBHS youth requiring those services are the responsibility of an interdivisional team that develops an integrated plan of care. This multi-disciplinary planning offers significant potential advantages for children who are without family resources and have concurrent needs for treatment, rehabilitative/vocational services or the development of independent living skills.
Since FY 90 to FY13 there has been an increase in expenditures for community based services and residential services, Care has been facilitated by an effective program of Medicaid cost recovery and by DPBHS assertive management of psychiatric hospital usage, an ongoing initiative that has allowed for significant reallocation of resources for the development of community-based programs.

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

Case Management System: Care Assurance

- All children active in intensive service levels in DPBHS are assigned to a Clinical Services Management Team (CSMT) that works with the child and family, mental health / substance abuse providers and related services to design and implement service plans. Each CSMT is led by a licensed mental health professional and includes individually assigned Clinical Services Coordinators and a Family Services Assistant. Psychiatrists, neuropsychologists, assessment and substance abuse specialists on the DPBHS staff provide consultation and evaluation at the request of the teams. Intensive services teams are located across the state; other teams manage

acute care (crisis services and emergency hospitalization) and routine outpatient services. A Center for Mental Health Services grant-funded CSMT works closely with special education and the families of special needs children.

- Monitor and evaluates client's progress in treatment, re-authorizing services as clinically indicated.
- Facilitating transitions across levels of service and providers.
- Coordinates service provision, including service entry, transition, and discharge or transition to adult services.

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

During FY07, DSCYF adopted department-wide implementation of the Delaware System of Care. The planning process for rollout of the System of Care included all DSCYF divisions, provider agencies, parents, and representatives of other child-serving departments and services, including, for example, the Department of Education, Division of Substance Abuse and Mental Health Services, and Division of Public Health. The plan for training was initiated in FY04 and is continuing with intensive training on the System of Care and on the Integrated Service Planning policy and procedures for front-line workers and supervisors. The Delaware System of Care is driven by the following principles:

- Services are individualized and include strength strength-based solutions
- Services are appropriate in type and duration
- Services are child-centered and family-focused
- Services are , as much as possible community-based
- Services are culturally competent

- Services are provided within and across a seamless system
- Services are planned and managed within a team-framework which includes the child; the family and whatever natural and system supports are available to them.

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

The Flow of Services: How the DPBHS System Works

Prevention: The Prevention unit provides a wide range of community services focused on family and youth education and supportive activities to strengthen families, and lessen the likelihood of entry or reentry into more intensive services.

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

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

Network of Service Providers: The network is made up of public and private treatment

agencies and independent practitioners. Service providers are required to involve the family in planning and treatment and to participate in regularly scheduled treatment progress reviews and in inter-agency collaborative efforts.

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

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

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

DPBHS has a website for dissemination of information at:

www.kids.delawre.gov

www.twitter.com/delkids

Integration of Mental Health and Substance Abuse Services

DPBHS expanded its focus on integration of mental health and substance abuse services. Research in the field of substance abuse services and DPBHS survey data suggested a

high rate of co-occurring mental health and substance abuse issues in the youth population. DPBHS data indicated that up to 52% of youth in mental health treatment exhibited behaviors and had risk factors suggesting the existence of substance abuse problems; only 21% were receiving focused treatment for substance abuse.

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

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

Relationship of Primary Health Care and Behavioral Health Services

On January 1, 1996, the State of Delaware launched the Diamond State Health Plan

(DSHP), a managed-care health program for Medicaid recipients. Currently families have the choice of tow managed care organizations, Delaware Physicians Care (DPCI) or United Healthcare. The plan provides a basic benefit package, including:

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

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

Approximately 85% of DPBHS clients are included in the 1115 waiver under which DPBHS provides services to the Medicaid-eligible population. DPBHS also provides services to clients covered by SCHIP and to those who are uninsured or whose insurance benefits for behavioral health services have been exhausted. DPBHS and providers assist any who may be eligible on the basis of income or disability to apply for Medicaid benefits.

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

While primary health care is well covered in the DPC, dental care remains a problematic

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

Relationship of Educational Services and Behavioral Health Care

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

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

DPBHS was once awarded a $350.000 U.S. Department of Education grant for "integration of schools and the mental health system". This grant allowed DPBHS to visit every public school in Delaware and to promote education on mental health and substance abuse signs and symptoms in children and to educate on the mental health services in the State. This initiative and others continues to help strengthen our relationship with DOE.

Other initiatives include Family Crisis Therapist in 53 elementary schools and a new initiative soon to come in FY14 is 30 new Behavioral Health Consultants in our middle schools.

Relationship of Rehabilitation and Employment Services and Behavioral Health Care

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

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

intensive outpatient program.

The interdivisional DSCYF committee on independent living services will continue developing plans for coordination of the various components of independent living, including DVR and employment services. The DSCYF System of Care Integrated Service Plan requires development of a plan for independent living for any youth 14 or older.

A transition committee was established as part of the Advisory Council. This committee's participant goal is to be made up of youth and families, a representative from DVR, DPBHS, providers and interested parties. One outcome to mention in the past is that this group completed a transition guide for youth and families that continue to be used today. Much focus continues to be on transitional youth and adding momentum to this committee. Our Division is committed to put efforts in youth transitions.

Relationship of Housing and Behavioral Health Care

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

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

health treatment services.

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

Principles of an Integrated Child System: System of Care.

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

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

- Educational services are provided by the Department of Education (DOE) and 19 school districts as well as numerous private and parochial schools and a growing home-schooling movement.
- DPBHS and DOE have established a partnership through our previous families and Communities Together (FACT), a CMHS grant under the Comprehensive Community Mental Health Services for Children and Families Program. We DOE, the Office of Early Learning to assure effective childhood and school-based treatment occurs.
- DOE is also responsible for the implementation of IDEA and the operation of the Interagency Collaborative Team (ICT) for services to children under the provisions of IDEA. DSCYF service divisions are partners in the ICT and share planning and monitoring of services for special education students in the ICT program.

- The Medicaid Office in DHSS is responsible for the Delaware Physician Care (DPC), the SCHIP program and numerous waiver programs under which services may be provided to children and families. DPBHS currently acts as a public MCO in the DSHP for behavioral health services beyond the 30-unit outpatient annual benefit for Medicaid-eligible children.
- The Division of Developmental Disability Services in DHSS is responsible for services to the population of persons with developmental disabilities. DPBHS participates on the Steering Committee.
- The Division of Public Health in DHSS has responsibility for community clinics, wellness centers in the high schools, services to children with special health care needs, and the Maternal and Child Health Block Grant (MCHBG). DPBHS is represented on the Steering Committee for the MCHBG. DPH is also the lead agency for the Early Childhood Comprehensive Systems (ECCS) Initiative planning grant. A DPBHS staff member sits on this steering committee.
- The Family Court deals not only with adjudication of juvenile and domestic issues, but also provides substance abuse treatment through the Drug Court Program. DPBHS manages the clinical services and progress monitoring for youth assigned to the Drug Court and Mental Health Court programs, implemented in October 2002 and continues today with great achievements and accomplishments.
- The State Interagency Council on Children and Youth (ICCF). A forum to facilitate ongoing communication and collaboration across all agencies dealing with children at both the local and the state level. County Level ICCF groups meet monthly to address challenges to collaboration and work at creative solutions for serving children and families. The State Level ICCF addresses systems and policy level challenges to the ongoing collaboration.
- The Division of Substance Abuse and Mental Health (DSAMH) provides behavioral health services to adults. During FY03 DSAMH and DPBHS initiated leadership meetings to improve communication, coordination and project collaboration. Activities range from sharing new information, to Data Infrastructure Grant activities to a mutual emphasis for on continued improvements in transition planning for youth served by DPBHS as they approach age 18. These meeting remain however; there is

frequent informal meeting that take place when situations arise.

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

Targeted Services for Rural Populations

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

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

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

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

We increased our budget request which has allowed our Department to continue to include significant investments in services for our rural areas. We received additional funding for Kent and Sussex county intake workers and to train professionals living in those areas.

Today all of our prevention, mental health and substance abuse services mention earlier

in the application are state-wide with a continuous focus maintaining providers in our rural areas. The Division continues to look tele-psychiatry as an option to assist in strengthening our continuum.

Additionally, our staff is better trained in trauma, and we have increased the use of evidenced based practices throughout our state-wide system. We will continue to implement sound business practices, including data analysis, best practice, and performance outcomes. We have received four Delaware Quality Awards, CARF Accreditation and continuous improvements as noted on various reviews and audits.
DPBHS will maximize our most valuable resources: staff and our providers/contractual services, which are 51% and 45 % of our budget respectfully. Delaware is committed to identifying and addressing ongoing needs to ensure a comprehensive system of care for Delaware's children and families. Additional information on needs and plans to address un-met needs are discussed throughout this application.

Planning Steps

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

Narrative Question:

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

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (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 abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

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[18] 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.

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

PLANNING STEPS

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

ADULT BEHAVIORAL HEALTH SERVICE SYSTEM

Adult Community Mental Health System

The major areas/issues that have been identified as areas of need in the Delaware service system for the upcoming years are listed below. Efforts to address these needs and or critical gaps will be achieved through the execution of the DSAMH Strategic Plan and the Delaware Combined Behavioral Health Assessment and Plan. Funding for these initiatives will come from the 2016-17 Combined Behavioral Health Services Block Grant, other grants, and Delaware General Fund State dollars. Some areas will need to be addressed in the 2016 and 2017 State Funding Year(s) as more funds are requested by the Division.

- Youth receiving mental health and substance abuse services need improved transition mechanisms and engagement tactics to successfully serve the young adult in the adult behavioral health system. A recent report estimated that 109 youth will age out of the Delaware Foster Care system during SFY 2013. A previous version of the report indicated overall better linkages among the vast number of identified services, programs, and partnerships that already exist as an identified opportunity for improvement. This opportunity is highlighted by the fact that some youth indicated that the paperwork required to extend Medicaid after aging out of foster care is complicated and, without assistance, youth often do not realize they can extend their coverage. This becomes a particular impediment to individuals whom are receiving treatment for a mental illness while simultaneously aging out of the youth system. Often times, the adult system doesn't come into contact with these individuals until 2-3 years later when they have had an episode which leads them into the adult system of care.

  The Division of Substance Abuse & Mental Health (DSAMH) and the Department of Services for Children and their Families (DSCYF) have made strides towards a better coordination of care for individuals with a mental health condition transitioning from the youth system to the adult system of care for individuals with an identified housing need, but there continues to be room for improvement. The drafting of a memorandum of agreement between the two organizations and a shared housing resource between the two agencies is largely responsible for the improved coordination.

  DSCYF staff anticipates Affordable Care Act provisions to extend medical insurance coverage through the age of 26 to be a major help to their transition planning process for youth aging out of the Delaware foster care system. Both agencies will have a better opportunity to coordinate the care of these individuals in a more seamless

manner that may render this area of service gap non-existent during future CBHSBG Application periods.

- Specialized services for the elderly continue to be an area for improvement for Delawareans. While progress has been made in partnership with the Division of Services for Aging, more services need to be offered to this population. DSAMH implemented a psycho-geriatric outreach team several years ago that is mobile and available to do in home or community agency assessments and make treatment and support recommendations and provide services to try and maintain current placements of these clients. A recent award from the Department of Housing and Urban Development, under the Section 811 program provides new housing opportunities for disabled persons, some with serious mental illness in Delaware.

- Peer Support Programs have been fully implemented for several years and are expanding upon the services that were being implemented during the previous project period. To date DSAMH has implemented an inpatient service at the Delaware Psychiatric Center's Peer Integrated Support Specialist, Peer Navigators working with community treatment provider ACT Teams, and three drop in resource centers run by consumers. Peer run services will continue to be a priority focus this grant period and in future years as Delaware works towards being a leader among states in peer activity. Ongoing trainings and the continued development of peer positions are planned to further support the development of Peer Supports.

- Care management services are needed at the less-intensive PROMISE Centers, formerly community mental health clinics, to offer consumers support to successfully reside in the community. These services are being offered at the Wilmington (New Castle County), Dover (Kent County) and Georgetown (Sussex County) PROMISE sites during this FY2016-17. The growth of "targeted care management" continues to be a priority of focus for the coming years. DSAMH continues to commit general funds to support this service. These funds will allow DSAMH to assure that all clients have access to some level of care management.

- Continued improvement in coordination of care is needed between DSAMH and the multiple other agencies that interface with consumers of mental health and substance abuse services. Examples of agencies identified as key partners are: Department of Corrections, Emergency Departments, Federally Qualified Health Centers, Division of Vocational Rehabilitation, Public Health, Medicaid, and Nursing Homes

- Recovery and hope must always be a part of the conversations with providers and consumers. An ongoing effort is to help doctors and clinicians understand and focus on recovery as a system as well as an individual goal. Over the past several years DSAMH has made strides to fully implement a person-centered planning at the epicenter of all recovery plans. The Division still has ground to gain in this area, but the implementation of person-centered recovery plans that feature hope as a vital component to the recovery philosophy is a key contributor to the strides the Division is making in this area.

- Previously DSAMH evaluated its overuse of provider managed representative payees and developed a RFP for this service as a standalone, non provider agency..

- DSAMH worked closely with state lawmakers to provide legislative changes to the DE involuntary commitment statute to assist in reducing the abuse of this law and the unnecessary hospitalization of individuals in inpatient settings.

- DSAMH will continue to support consumers with nicotine addiction as the treatment system has moved towards nearly an entire smoke-free environment. The Division will continue efforts that focus on maintaining smoking cessation efforts and continue support in other treatment modalities to address nicotine addiction throughout the system of care.

- DSAMH will continue to offer information about access to services in numerous modalities to ensure consumers are able to obtain the accurate information they need about services in an efficient and easy-access manner.

- DSAMH will continue to expand services that focus on health and wellness, and improve collaborations between DSAMH providers and primary health care providers.

Sources of Needs Data

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

Substance Abuse Prevention and Treatment

Substate Planning Areas:
Delaware is divided into four sub-state planning areas designated by SAMHSA's Office of Applied Studies and adopted by Delaware's State Epidemiological Outcomes Workgroup (SEOW), also known as the Delaware Drug and Alcohol Tracking Alliance (DDATA), are the city of Wilmington, the remainder of New Castle County, Kent County and Sussex County.

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

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

Through ongoing technical assistance from SAMHSA/CSAT as well as grant evaluation teams, additional data sources are being identified to further develop Delaware's state profile and guide planning and decision making as it relates to substance abuse services. Future data collection will include semi-annual reports directly from service providers regarding the compliance, progress and intentions for the use of SAPTBG funding in reference to the grant goals and objectives. There will also be specific reporting requirements for positions funded by SAPTBG funds, programs for pregnant women and women with dependent children, as well as waiting lists and capacity reporting requirements, to be submitted quarterly. In addition, DSAMH will implement a new data reporting system for its behavioral health system, CORE Solutions. CORE Solutions will enable DSAMH to pull relevant reports and track outcomes in a more efficient way. These new forms of data collection are being developed and will be implemented in FFY14-15.

Unmet Needs and Gaps
There continues to be gaps in services throughout the state due to lack of data and substance abuse supports. In FY12 the State of Delaware received technical assistance through SAMHSA to identify an appropriate needs assessment approach for the State. Gwen Grams, Ph.D., a Data and Management Specialist for the CSAT State Technical Reviews Project at JBS worked with the DSAMH to identify an array of data sets available to Delaware through a matrix of national and Delaware-specific needs assessment databases. The matrix included a description of each data set as well as information about the target population studied, sponsoring agency, frequency of data collection, unique or notable characteristics of the databases and indicators, strengths and limitations for Delaware's use of the data, statistics implications, availability for use, and recommendations for use within a Delaware needs assessment system. The information provided through the technical assistance also detailed the indicator by type of drug; by the indicator's use to describe consumption, consequences, or intervening variables that

indicate a likelihood of substance use or abuse; and by the indicator's ability to forecast need for specific substance abuse services. The information gained from the technical assistance is extraordinarily helpful for DSAMH; however, the ability to utilize and analyze some of the identified datasets on an ongoing basis proves to be a weakness for the Division. Personnel are working to increase capacity to address the analysis of epidemiological data on a regular basis in the most efficient way.

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

Prevention Service System Gaps- Adult

DSAMH and DPBHS work closely with the Center for Drug and Alcohol Studies (CDAS) at the University of Delaware. CDAS was founded in 1991 as an outgrowth of funding opportunities initiated by the National Institute on Drug Abuse (NIDA). In 2008, DSAMH and CDAS collaborated to establish the Delaware State Epidemiological Outcomes Workgroup (DE-SEOW) as a collaborative body of representatives of State agencies, community organizations, statewide non-profits, Universities, and Federal partners, known as the Delaware Drug and Alcohol Tracking Alliance (DDATA). ***DDATA has a 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 activities that are being undertaken by the DDATA include the following: (a) The collection and assembling of data from state and national sources; data being collected includes 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; (b) The creation of specific committees or task forces to address ongoing and/or current issues (e.g., SBIRT Task force, Early Warning Network for identifying and reporting on drug crises (heroin overdoses) and emerging drug problems (e.g., youth prescription misuse); (c) The analysis and synthesis of data to illustrate consumption patterns and consequences and their impact on Delaware's health and culture; (d) The use of data to identify specific prevention targets and to facilitate the development of an achievable, effective prevention plan; (e) The monitoring of prevention progress and of the development of a true strategic prevention framework for the State; and, (f) The clear communication of data analyses to the public and to Delaware decision-makers to facilitate planning, monitoring and evaluation of prevention efforts.

In addition to data from the National Survey on Drug Use and Health and the efforts of

CDAS which include the Delaware School Health Profiles, the Delaware Youth Risk Behavior Surveys and the Delaware Alcohol, Tobacco and Other Drug Abuse Survey, DSAMH and DPBHS, as a result of projects funded through the Strategic Prevention Framework State Incentive Grant (SPF-SIG) and the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) contracted providers, through adherence to the Strategic Prevention Framework have completed both local and statewide community assessments collecting significant community level data prior to the planning and implementation of prevention strategies throughout the state.

Through these data sets, Delaware's Prevention System continues to identify gaps in needs assessment data as well as service delivery. For example, the YRBS produce qualitative data which discusses the consumption patterns of 5th, 8th, and 11th public school students throughout the state. However, this data does not reflect school drop-outs, and many individuals in alternative school settings such as individuals who are home schooled, delinquent, or individuals enrolled in private schools. The CRBS focus is on the University of Delaware student body, and while efforts are being pursued to expand the survey to other institutions of higher education in the state, there are still gaps with this data collection method. Through the initial assessment of the current data collection systems in the state, it was identified the Epi Profiles also utilize data from the BRFSS and other state and community systems, however, other gaps that have been identified in data for specific populations are as follows: Emergency Room, military families, Historically Black Colleges/Universities, LGBT populations, etc. The state will continue to enhance the data collection methodology through continued work with the SEOW and other state and community agencies.

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

Delaware's SEOW continues to work with DSAMH's Prevention Unit, including community providers funded through the SPF SIG initiative to collect more community level data to develop a more comprehensive Epidemiological Profile. An enhanced Profile will allow the State to better direct services in alignment with the identified substance abuse priorities.

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

Delaware's unmet service needs and critical gaps that are identified in the state are the following:

1. We need accurate and timely data on adults in Delaware by sub-state planning area. We have good data on youth but not adults, particularly high risk young adults. The NSDUH is at best two years out of date and only provides information on a limited number of outcomes). This was and remains the biggest data gap and prevention research priority. In fact it is our established Data Gap as presented to CSAP and DSAMH in the fall of 2008 (see attached report submitted to DSAMH at the time).

2. Need more information for the general population (not treatment populations) on mental health and its correlation with other risk behaviors and protective factors (e.g., substance abuse, violence, suicide, school involvement, job satisfaction, physical health). There are very few mental health indicators in the YRBS and NSDUH. This is an emerging national priority for SAMHSA, and we need more data so we can assess degree and type of issues facing both youth and adults)

3. For sustainability, we need to do a better job of inculcating data collection into all the prevention activities done at the community level. ("If you don't measure it, it is as if it did not happen.") Measurement and a continuous quality improvement process based on what you measure need to become second nature to prevention providers.

Data Source
Needs Statistics:

2012 University of Delaware College Risk Behavior Study

According to the 2012 UD College Risk Behavior Survey, 60% of Delaware undergraduate students reported alcohol use alone, 23% reported using neither drugs nor alcohol, and 18% reported using both. For past month binge drinking, 58% reported past month binge drinking (5 or more drinks at a time). They were most likely to be male. Nineteen percent of students reported past month drug use, of whom 47% used marijuana, 10% used only other drugs, and 42% used multiple drug types. Thirteen percent reported past month cigarette use. Nine percent of males self-reported alcohol related DUI and 14% reported drug related DUI, versus only 7% and 9% for females respectively.

National Household Survey on Drug Use and Health (NSDUH) Results[1]:

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

[1] National and state level statistics come from averaged data from 2010-2011. County level data comes from averaged 2008, 2009, and 2010 data.

Delaware, at 5.89%, is lower than the national average of 6.45% for those needing, but not receiving treatment for alcohol use. 13.82% of those aged 18 -25 reported needing but not receiving treatment for alcohol in the past year followed by 4.84% of those 26 years or older.

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

Between 2008 and 2010 the highest rates for needing treatment for illicit drugs and not receiving treatment over the past year were in Kent County at 2.87 %, and the City of Wilmington at 2.75%. More recent state level data finds that 7.29% of those aged 18 -25 reported needing but not receiving treatment for illicit drugs for the past year, followed by 4.2% of those aged 12 -17.

Injection Drug Users

Injection Drug use is a rare event in the general population, and there have been no estimates of it generated by NSDUH for Delaware for adults in recent years.

Women, Pregnant Women, Recent Mothers:

There have been no estimates of substance use by pregnant or new mothers it generated by NSDUH for Delaware for adults in recent years.

According to the Delaware Drug and Alcohol Tracking Alliance, Vol. 6, Issue 3, "Drinking During Pregnancy in Delaware – Most Likely to be White, Educated, Married Mothers", mothers who over the age of 35 were six times more likely than teen mothers and more than twice as likely as mothers 20 – 24 years old to report alcohol use. These data are from the Delaware PRAMS study supported by the CDC.

Veterans in Delaware

According to the US Department of Veterans Affairs, there were 79,166 veterans in Delaware in November 2010. Reports on veterans' risk factors are quite dated. One of the most recent reports comes from the National Household Survey on Drug Use and Health (NSDUH, 2007) Report, "Serious Psychological Distress and Substance Abuse Disorder Among Veterans," which found 7% of veterans experienced past year severe emotional distress (SED), and 7.1% met the criteria for substance use disorder (SUD). Veterans aged 18-25 were more likely than older veterans to have higher rates of SPD, SUD, and co-occurring disorders. There are no recent numbers on substance abuse risk factors among Delaware veterans, but it is expected the national numbers are good estimates for Delaware.

Elderly Populations

According to the Drug and Alcohol Services Information System, "Older Adults in Substance Abuse Treatment: 2005", (DASIS, 2007), 10% of all substance abuse treatment admissions were for people over 50. Of these, 65% reported alcohol as the primary substance of abuse. Opiates were the second most commonly reported substance 2006-2008 NSDUH found that 5.2% of adults aged 50 or over reported using illicit drugs in the past year, as described in the report "Illicit Drug Use Among Older Adults."

(NSDUH, 2011). Because of sample size limitations, NSDUH does not provide estimates for the elderly in Delaware.

LGBTQ Trends 2011

The Delaware data from the Youth Risk Behavior Surveillance System (YRBSS) reports trends in sexual minorities compared to the heterosexual population.

- Past Month Alcohol Use
  - 40.4% of heterosexuals compared to 58.8% of homosexual s or bisexuals (p<.001).
- Binge Alcohol Use:
  - 23.8% of heterosexuals compared to 32.1% of homosexuals or bisexuals (p<.05).
- Past Month Marijuana Use:
  - 26.5% of heterosexuals compared to 45.3% of homosexuals or bisexuals (p<.001).
- Heavy Marijuana Use:
  - 4.4% of heterosexuals compared to 10.2% of homosexuals or bisexuals (p<.01).
- Ever Used Painkillers
  - 18.1% of heterosexuals compared to 29.9% of homosexuals or bisexuals (p<.01).
- Past Month Cigarette Use:
  - 16.8% of heterosexuals compared to 39.7% of homosexuals or bisexuals (p<.001).

- It appears that this is a high risk group that needs to be considered when planning prevention or treatment programs, policies, or practices. Patterns such as these have been found in several years of YRBS data. 2013 YRBS data for Delaware should become available in December 2013.

Division of Substance Abuse and Mental Health Treatment Admission Trends 2008 to 2012

Over the past five fiscal years, there has been a slight decline in total admissions, 8,419 in 2008 to 7,496 in 2012 with some fluctuation up and down from year to year.

- Primary Drug at Admission:
  - Alcohol admissions declined noticeably as the primary drug of admission with 2,107 in 2008 and 1,579 in 2012. Alcohol related admissions made up 21% of all admissions in 2012, whereas they had made up 26% of admission in 2010.
  - Marijuana admissions declined even more dramatically from 1,613 in 2008 to 1,161 in 2012, with a very noticeable drop between 2010 and 2012.
  - Heroin admission also declined from 2,120 in 2008 to 1,845 in 2012, and admissions fluctuated markedly during the five year period.

- Methamphetamines and Amphetamines as the primary drug averaged only 15 admissions per year in the five year period, a small fraction of total admission each year.
- Opiates and Other Synthetics admissions have been increasing at a very fast rate from 433 admissions in 2006 to 927 in 2008 to 1,359 in 2010 and to 1,793 in 2012.
    - This represents a 414% increase in admissions since 2006 and almost a doubling since 2008.
        - Over this period all three Delaware counties have witnessed a marked growth in admissions with opiates and other synthetics as the primary drug.

DUI Arrest Data

Using arrest counts for 2012 from Delaware State Police and adjusted census data on population size, it is possible to calculate DUI arrest rates for Delaware counties. It should be noted that Sussex County, followed by Kent County, have a high percentage of visitors at seasonal times that inflate their per capita rates. Also there are fewer drivers and miles driven in the City of Wilmington. It should be also be noted that variations in these values are likely due not only to differences in DUI patterns but also differences in annual and seasonal enforcement patterns and officer availability. Sussex County has the highest arrest rate for alcohol related DUI -- 7.395 per 1,000. This is followed by Kent County, which had an arrest rate of 5.166 per 1,000. New Castle County (except Wilmington) and the City of Wilmington had the lowest arrest rates for DUI, with rates of 3.188 and 1.851 per 1,000 respectively. Over three-quarters (77.8%) of these arrests were for persons 26 or older.

Arrest rates for DUIs that involved both alcohol and drugs were much lower. The highest was Sussex, with a rate of .782 per 1,000, and the lowest was for Wilmington, with a rate of only .07 per 1,000. 78% of arrestees were 26 years or older. Lastly, Sussex leads for DUI arrests that only involved drugs, with a rate of 1.224 per 1,000. This was followed by Kent County with a rate of .978 and New Castle County (except Wilmington) with a rate of .412 arrests per 1,000. Wilmington had the lowest arrest rate of only .267 per 1,000. In this case a noticeably larger number of youth were being arrested, as only 61.8% of arrests involved persons that were 26 years or older. Drug related DUI is harder to detect and likely leads to lower reports. In sum though the arrest rates for DUI from all substances for 2012 are:

9.401 per 1,000 for Sussex County
6.496 for Kent County
3.823 for New Castle County other than Wilmington
2.188 for the City of Wilmington

Annual AIDS Diagnosis Rate 2011 per 100,000:

According to the Division of Public Health, "2012 HIV Statistics - Epidemiology/Surveillance Profile", in 2011, 1,384 Delawareans were living with HIV and another 2,283 were living with AIDS. In that same year, the cumulative number of HIV/AIDS cases in Delaware reached 5,398. Delaware's AIDS incidence rate at 15.1 cases per 100,000, is among the highest in the nation. In 2010, Delaware's AIDS incidence rate was the 7th highest in the United States. The average number of new infections diagnosed in Delaware over the past five years in Delaware was 148 diagnoses per year. In 2011, the racial distribution for people living with HIV or AIDS in Delaware was:

- 31% of HIV cases and 30% of AIDS cases were Caucasian
- 60% of HIV cases and 62% of AIDS cases were African American
- 8% of HIV cases and 7% of AIDS cases were Hispanic
- Less than 1% of both HIV and AIDS cases were other races

From 2007 to 2011, the most common mode of transmission:

- Injection Drug Use (IDU) accounted for 33% of the cases
- Men having sex with men (MSM) accounted for 31% of the cases
- Heterosexual contact with partner who has HIV/AIDS accounted for 19% of cases
- Heterosexual contact with an IDU accounted for 8% of cases
- IDU that are MSM accounted for 5% of cases
- No identified risk accounted for 2% of cases

TB Rate 2011 per 100,000

According to the Division of Public Health (DPH), Delaware case rate is 2.3 compared to the national case rate of 3.4. The rate in New Castle County was 2.4. The rate for Kent County was 2.5. The rate in Sussex County was 2.0, all below national estimates.

YOUTH AT RISK OF SUBSTANCE ABUSE DISORDERS

DRUG USE

Trends in Drug Use by County

→In general, use of any of the drugs illegal for youth, including cigarettes and alcohol, do not differ significantly among the three Counties in Delaware. This pattern has been true for each of the 5th, 8th, and 11th grade samples for a number of years. In general, there is little evidence that illegal substance use by Delaware youth is, for example, an urban problem or a Northern Delaware problem; the problem of substance use is generally consistent and persistent across the state. The notable exception to this pattern may be greater use of smokeless tobacco and cigarette use in Sussex County across all grades.

Trends in Tobacco Product Use

→ Between 1989 - 2012, reports of monthly drug use by 5th graders have remained low and stable.
→Cigarette use by 8th and 11th graders has fluctuated greatly since 1989 with statistically significant increases in the early 1990s and significant declines since 1998, though leveling off in recent years. The levels of past month cigarette smoking reported in 2012 for 8th graders (5.2%) and 11th graders (13.2%) were the lowest since the surveys began in 1989. The decrease in youth smoking since the late 1990s is one of the great public health success stories nationally. The declines have been even more dramatic in Delaware where smoking prevention efforts have been a priority of the State and schools.
→ Smokeless tobacco and cigar use are notably less common than use of cigarillos. In 2012, 11.1% of 8th graders have tried cigarillos, while 4.9% have tried smokeless tobacco. For 11th graders, 25.7% have tried cigarillos and 10% have tried smokeless tobacco. In all cases numbers are lower than they were for 2010. The lower tax rate for cigarillos compared to cigarettes may have led to some youth switching to a less expensive version of this drug.

Trends in Alcohol Use

→ Over one-third **of Delaware 11th graders (36.7%) and one-sixth of 8th graders (16.3%) report past month alcohol use in 2012.** There have been gradual declines in rates of alcohol use, and current rates are the lowest measured since the beginning of the surveys. However, alcohol remains the most consistently reported drug in all grades.
→ High levels of binge drinking (defined as 3 or more drinks at a time in the past 2 weeks) were reported by both 8th graders (6.8%) and 11th graders: 21.1%.

Trends in Marijuana Use

→ In 2008, a trend in decline of marijuana use by 8th and 11th graders ended, and rates have increased slightly since that time, with 11.1% of 8th graders and 26.5% of 11th graders reporting past month use in 2012. These patterns have mirrored national trends.
→ Both 8th and 11th graders are more likely to report past month marijuana use than past month cigarette use – not just because marijuana use is up, but even more because cigarette use is down.

Trends in Prescription Drug Abuse

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

11th graders was at its highest in 2003 at 12%. It has declined since, with 8.4% of 11th graders reporting past year painkiller use in 2010.
→ Painkillers were the most commonly abused drugs in the past year for both 8th and 11th graders in Delaware after cigarettes, alcohol, and marijuana.
→ Painkillers were followed in the list of most abused "other illegal drugs" by psychoactive medications (Ritalin, Adderall, Cylert, and Concerta), downers, and uppers. **These data support recent national findings that the illegal diversion of prescription medications has an emerging youth drug problem**. It is likely that changes in Delaware law in 2013 and the actions of the state Prescription Drug Advisory Council will lead to fewer prescriptions issued, more controls and less opportunity for diversion.
→ Use of psychoactive medications was significantly associated with concurrent cigarette, alcohol, marijuana, and other drug use for both 8th and 11th graders. In 2012, the survey asked about non-prescribed use of Ritalin and similar drugs "to get high**." 1.1% of 8th graders and 6.3% of 11th graders reported use of Ritalin and like drugs "to get high" in the past year.**

Driving Under the Influence

→ Reported levels of drinking and driving for Delaware high schoolers remain very close to reported levels of driving under the influence of marijuana. In 2012, 5.2% of 11th graders reported drinking and driving, while 7.6% of 11th graders reported driving after smoking marijuana.

Delinquency

→Among both 8th and 11th graders in 2012, past month substance use – whether cigarettes, alcohol, or marijuana – was highly correlated with other delinquent behaviors such as gang fights, stealing, illegal entry, and trouble with police.

RISK AND PROTECTIVE FACTORS
Individual

Grade

→2012 data shows that most 5th graders have not yet experimented with drugs. Even the most common drug tried – alcohol -- has only been tried by 11.2% of 5th graders. Cigarettes have been tried by 5% and marijuana by 1.5%. A recent disturbing trend among 5th graders is for an old problem: use of inhalants was much higher 1n 2012 than in 2010, increasing from 5% to 10.9%. Fifth graders who have tried cigarettes declined from 18% in 1998 to 8% in 2005 and to 3.2% in 2012. In 2012, only 1% of 5th graders have tried a cigar and .9% have tried smokeless tobacco. Only .7% report having used Ritalinor similar ADHD medications to get high, though other data indicate a number of 5th graders are prescribed these.

Gender

→ in 2012 8th grade Delaware girls were *slightly* more likely to drink alcohol, use inhalants, painkillers, and over the counter drugs to get high than 8th grade boys. On the other hand, 8th grade boys were slightly more likely to use cigarettes, hallucinogens, and steroids. For 11th graders, cigarette and inhalant use was similar for girls and boys, but girls were a little more likely to have ever drunk alcohol, though there was no gender difference for binge drinking. Boys were more likely to smoke, use ecstasy, hallucinogens, and steroids. Girls were more likely to use downers- all other drugs were used evenly across genders. **For 11th graders, boys were significantly more likely to use marijuana than were girls.** In addition, boys are now more likely to use over the counter drugs to get high than girls -- a reversal from the 8th grade data. In all cases, these differences are quite small, though in those noted cases statistically significant. If anything the most remarkable gender difference is how few there are.

Peers as a Source

→ For 11th graders in Delaware in 2012 who are current smokers (e.g., smoked in the past month), the most likely place they get cigarettes is from friends: 66% of smokers get cigarettes from friends. Getting cigarettes from a store cashier is the next most common, with 45.9% reporting they did this. It is important to note that a number of 11th graders are over 18 and can buy cigarettes legally. Lastly, 26.6% reported getting cigarettes from knowing adults and 21.3% used siblings. Other categories such as stealing them from parents were less prevalent. Similar patterns remain for 8th graders, though they are noticeably more likely to steal cigarettes from adults and less likely to go to a store to buy them. This also applies to 5th graders, though there were very few smokers to look at in the data.

Family Relationships

→ For all grades surveyed in Delaware in 2012, the more students reported that they got along well with their parents, did not fight with their parents, and communicated well with their parents, the less likely they were to use drugs. Positive parental involvement seems to be a strong protective factor, and this is particularly true for middle school students.

→ Students whose parents or siblings smoked cigarettes were more likely to smoke cigarettes and also to use other drugs. For example- 20.6% of 11th graders with parents who smoked also smoked in the past month, while only 9.7% of students with non-smoking parents smoked. Similarly, 30.2% of students with siblings who smoke have smoked in the past month, versus only 11.4% who have non-smoking siblings.

CHILD BEHAVIORAL HEALTH SYSTEM

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

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

- Stronger data to support services
- Out of state placements
- Continuing to build hope & resilience within our youth
- Diminishing work force
- Legislative and gubernatorial changes

Our Governor reviewed state services through the Delaware Government Performance review, which challenged agencies to develop strategies for creating program efficiencies across state government. This was the basis for the integration of prevention, early intervention and treatment.

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

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In FY16, DSAMH will continue to utilize CORE Solutions for its transition towards the use of an Electronic Health Records system. CORE Solutions has developed a system for Delaware which will collect relevant assessment data and assist with 3rd party billing practices. CORE Solutions will enhance Delaware's data collection systems and the implementation of information technologies.

Barriers with Claims based approach to payment

DSAMH currently has a mixed approach to reimbursement of contractual providers. These reimbursement mechanisms include cost reimbursement, unit of service reimbursement and case rate payments. Barriers to using a claims based approach would include the cost of developing such as system and a desire to expand unit of service reimbursement.

Technical Assistance

- Assistance with exploring legal and ethical issues associated with participating in the DHIN.
- Assistance with migrating to a claims based information system from the current multifaceted approach to reimbursement

Substance Abuse Prevention

In FY11, in collaboration with DSAMH, DPBHS established a contract with KIT Solutions, Inc. for the utilization of the web-based software, data hosting services and training for collecting specific data elements required to satisfy the federal reporting requirements of the SAPT Block Grant. KIT Solutions is intended to allow for accurate, real time data collection for Block Grant reporting on the adult and youth prevention systems. SAPT Block Grant funded providers were informed that use of the web-based reporting system would be mandatory effective January 15, 2013. The standard service components of the contract between DPBHS and KIT Solutions, Inc. include: standard system modification and upgrading service to maintain regulatory compliance; access to the performance tools and knowledge base; Technical support including the toll free Help Desk and On-line Support Web Site; and, access to the an Online Chat system and on-line multimedia training system. The service also includes the ability to participate in a Learning Community that provides access to added modules or functionality from the Learning Community Library without added cost and PBH'S commitment to contribute to the library and any functionality it adds to PBH'S services, along with the ability to participate in face-to-face and on-line Learning Community User Group meetings, and professional networking site.

Use and monitoring of the KIT Solutions system is currently at ifull capacity by funded providers, as well as state staff.

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: Person-Centered Service Delivery System

Priority Type: SAT, MHS

Population(s): IVDUs, HIV EIS

Goal of the priority area:

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

Objective:

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 person-centered 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: (Maintain) 24 Peer Specialist

Baseline Measurement: 24 Peer Specialist

First-year target/outcome measurement: 24 (Maintain)

Second-year target/outcome measurement: 24 (Maintain)

Data Source:

USDOJ Data Settlement Agreement tracking of compliance

Description of Data:

Maintain 24 Peer Specialist employed by the Division of Substance Abuse and Mental Health as of 6/30/2015.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: The percentage of consumers receiving community-based services who actively participate in their own treatment planning.

Baseline Measurement: 82%

First-year target/outcome measurement: 82%

Second-year target/outcome measurement: 83%

Data Source:

DSAMH Consumer Satisfaction Survey

Description of Data:

Increase by 1% the number of consumers who respond positively to questions on the Consumer Satisfaction Survey regarding their role in setting goals and treatment strategies

Numerator: # of surveys marked "agree" on specific items
Denominator: Total valid responses on consumer satisfaction item

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: The percentage of consumers responding positively to the Division's Consumer Satisfaction Survey on questions regarding satisfaction with the type, location, frequency, timeliness, and level of services.

Baseline Measurement: 83%

First-year target/outcome measurement: 83%

Second-year target/outcome measurement: 84%

Data Source:

DSAMH Consumer Satisfaction Survey

Description of Data:

Increase by 1% the number of consumers who respond positively to questions on the Consumer Satisfaction Survey regarding the type, location, frequency, timeliness, and level of services.

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Percentage of consumers reporting positively regarding outcomes.

Baseline Measurement: 75%

First-year target/outcome measurement: 75%

Second-year target/outcome measurement: 76%

Data Source:

DSAMH Consumer Satisfaction Survey

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::

Indicator #: 5

Indicator: Percentage of consumers who are satisfied with their level of functioning.

Baseline Measurement: 82%

First-year target/outcome measurement: 82%

Second-year target/outcome measurement: 84%

Data Source:

DSAMH Consumer Satisfaction Survey

Description of Data:

DSAMH Consumer Satisfaction Survey

Data issues/caveats that affect outcome measures::

Increase the number of consumers responding positively about level of functioning by 2%

Numerator: # of surveys marked "agree" on specific items
Denominator: Total valid responses on consumer satisfaction item

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Indicator #:	6
Indicator:	Positive responses regarding social supports/social connectedness
Baseline Measurement:	82%
First-year target/outcome measurement:	82%
Second-year target/outcome measurement:	84%

Data Source:

DSAMH Consumer Satisfaction Survey

Description of Data:

Increase the number of consumers responding positively about social supports/social connectedness by 2%

Numerator: # of surveys marked "agree" on specific items
Denominator: Total valid responses on consumer satisfaction item

Data issues/caveats that affect outcome measures::

Indicator #:	7
Indicator:	100% of all substance abuse treatment provider agencies are licensed to provide treatment services and are educated on referral and access to other health and social services available to their clients
Baseline Measurement:	Number of substance abuse treatment providers in the State of Delaware (number of licensed providers)
First-year target/outcome measurement:	100% of all substance abuse treatment providers in the State of Delaware are licensed
Second-year target/outcome measurement:	Maintain 100% of all substance abuse treatment providers are licensed

Data Source:

DSAMH's Quality Assurance and Performance Improvement Unit (QAPI); Treatment provider monitoring reports

Description of Data:

Number of service providers currently licensed to provide substance abuse treatment by the State of Delaware; Number of surveys disseminated and completed by substnace abuse treatment service providers for current capacity for referral and access to other health and social services; number of participation of provider representatives in educational opportunities

Data issues/caveats that affect outcome measures::

No anticipated issues that will affect outcome measurement

Priority #:	2
Priority Area:	Culturally Competent System of Care
Priority Type:	SAP, SAT, MHS
Population(s):	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, LGBTQ, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LBGTQ individuals

Objective:

Strategies to attain the objective:

Consumers throughout Delaware's behavioral health system will have access to a system of care that is culturally and linguistically competent by requiring contracts with service providers contain cultural competency plans that are updated annually and reflect the populations they serve.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of contracted agencies and community providers educated on cultural competence
Baseline Measurement:	100% of contracted agencies and community providers educated on cultural competence in FY15 & FY16
First-year target/outcome measurement:	100% of all contracted agencies are educated on cultural competence and culturally competent programs
Second-year target/outcome measurement:	Maintain 100% of all contracted agencies are educated on cultural competence and culturally competent programs

Data Source:

Quality Assurance and Performance Improvement Unit (QAPI) Program Reports
Training Evaluation Program reports (evaluation survey summaries)

Description of Data:

QAPI Progam reports detail contract compliance - contractors are required to implement culturally competent programs and be trained in cultural competence.
Survey substance abuse prevention service providers for level of knowledge attained during cultural competence trainings through pre and post-tests instruments; implement assessment surveys on a regular basis to providers implementing prevention surveys to assess the current level of cultural competence (semi-annually) and any changes in cultural sensitivity.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	DSAMH relationship with state recognized tribes
Baseline Measurement:	Participation of state recognized tribes in state facilitated substance abuse prevention meetings and events
First-year target/outcome measurement:	Increase participation of state recognized tribes in state facilitated substance abuse prevention meetings and events, participation in at least 50% of meetings annually.
Second-year target/outcome measurement:	Increase participation of state recognized tribes in state facilitated substance abuse prevention meetings and events, participation in at least 75% of meetings annually.

Data Source:

Delaware Prevention Advisory Committee Reports

Description of Data:

Number of communications with the Nanticoke Indian Tribe and the number of individuals in attendance at the Delaware Preventioni Advisory Committee (DPAC) Meetings.

Data issues/caveats that affect outcome measures::

Priority #: 3

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: Maintain (4) crisis apartments throughout the state

Baseline Measurement: 4

First-year target/outcome measurement: 4

Second-year target/outcome measurement: 4

Data Source:

USDOJ Settlement Agreement Tracking Form

Description of Data:

Maintain (4) crisis apartments throughout the state, pursuant to the terms of the voluntary Settlement Agreement between the State of Delaware and the United States Department of Justice.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Maintain (2) Crisis walk-in clinics statewide

Baseline Measurement: 2

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 2

Data Source:

USDOJ Data Settlement Agreement tracking of compliance and annual report

Description of Data:

Maintain (2) walk-in clinics throughout the state, pursuant to the terms of the voluntary Settlement Agreement between the State of Delaware and the United States Department of Justice.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Increased access to services

Baseline Measurement: 7,501

First-year target/outcome measurement: 7,501

Second-year target/outcome measurement: 7,651

Data Source:

DSAMH MIS Unit

Description of Data:

CMHC Front-Door clients

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

Baseline Measurement: 8%

First-year target/outcome measurement: 8%

Second-year target/outcome measurement: 7.5%

Data Source:

MIS, Consumer Information Manager, MH CRF Master Table

Description of Data:

Reduce the number of readmissions to the State psychiatric hospital within 30 days by .5%.

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

Baseline Measurement: 10

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 9.5

Data Source:

MIS, Consumer Information Manager, MH CRF Master Table

Description of Data:

Reduce the number of readmissions to the State psychiatric hospital within 180 days by .5%.

Numerator: # of adults with SMI who were readmitted within 180 days
Denominator: # of adults with SMI who were discharged during fiscal year

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Accountability and Uniform Reporting

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Increase accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.

Objective:

Strategies to attain the objective:

Delaware's behavioral health system agencies employ increased accountability standards for behavioral health services through uniform reporting on access, quality, and outcomes of services. Data derived from the uniform reporting tools will be used to assess strengths and weaknesses of the behavioral health system and provide data-driven service solutions where applicable.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Completion of the Basic and Developmental Tables under the Data Infrastructure

Baseline Measurement: 19

First-year target/outcome measurement: 19

Second-year target/outcome measurement: 19

Data Source:

DSAMH Consumer Survey, DSAMH MIS

Description of Data:

Complete 100% of the DIG Data Tables (19 total)

Numerator: # of required URS Tables completed
Denominator: Total number of required URS Tables

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Create an annual report to comply with DOJ requirements

Baseline Measurement: USDOJ Annual Report Due on 6/30/20XX

First-year target/outcome measurement: Complete DSAMH USDOJ Annual Report by June 30th 2016

Second-year target/outcome measurement: Complete DSAMH USDOJ Annual Report by June 30th 2017

Data Source:

USDOJ Data Settlement Agreement tracking of compliance and annual report

Description of Data:

Create an annual report to comply with DOJ requirements (DOJ activities are not funded by SAPT BG)

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: 100% admissions of pregnant women and woman with dependent children are admitted into substance abuse treatment services within statute required timelines.

Baseline Measurement: Number of women requesting, and accessing substance abuse treatment services.

First-year target/outcome measurement: 100% compliance (number of women requesting and accessing substance abuse treatment services within statute required timeline)

Second-year target/outcome measurement: Maintain 100% compliance (number of women requesting and accessing substance abuse treatment services within statute required timeline)

Data Source:

DSAMH Treatment Admissions Reports; Substance Abuse Treatment Wait Lists (if applicable)

Description of Data:

Number of pregnant women and women with dependent children requesting, referred, and admitted into substance abuse treatment services each year; data analysis and evaluation twice each year by comparing wait times to those required by federal statute.

Data issues/caveats that affect outcome measures::

Potential access to treatment, number of available beds for women and women with dependent children

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Indicator #: 4

Indicator: 100% compliance with substance abuse service delivery through the implementation of Quality Service Reviews (QSRs) system-wide at least once a year with each service provider licensed by DSAMH

Baseline Measurement: QSRs for each DSAMH licensed service provider

First-year target/outcome measurement: 100% compliance with substance abuse service delivery as reported in QSRs.

Second-year target/outcome measurement: Maintain 100% compliance with substance abuse service delivery as reported by QSRs

Data Source:

Service Provider Quality Service Reports

Description of Data:

Delaware will maintain compliance with all regulations stated within the following: Title II of the American Disabilities Act (ADA), 42 U.S.C. § 12101, and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Compliance will be monitored by an independent third -party that reports to the US District Court; evaluation of findings will be conducted twice per year. In sum, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, by virtue of the agreement, the State will ensure principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved.

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Substance Abuse Prevention Services

Priority Type:

Population(s): PWWDC, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.

Objective:

Strategies to attain the objective:

Implementation of substance abuse prevention strategies throughout the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Misuse of prescription opiates and use of illegal narcotics (youth prevention)

Baseline Measurement:	Prescription opiate and illegal narcotic use (for youth) as reported in the 2014-2015 State Epi Profile
First-year target/outcome measurement:	10% reduction in the misuse of prescription opiates and use of illegal narcotics
Second-year target/outcome measurement:	10 reduction in the misuse of prescription opiates and use of illegal narcotics

Data Source:

State Epi Profile, School Surveys, NSDUH; KIT Solutions

Description of Data:

Repeated measures of the Performance Indicators updated quarterly for short term measures and at least annually for long term measures changes in laws, policies and operating procedures.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Substance abuse prevention training and technical assistance opportunities for state contractors and community providers
Baseline Measurement:	Number of state supported substance abuse training and technical assistance opportunities offered in FY13
First-year target/outcome measurement:	Increase the number of state supported substance abuse training and technical assistance opportunities offered to state contractors and community prevention specialists by 10%
Second-year target/outcome measurement:	Increase the number of state supported substance abuse training and technical assistance opportunities offered to state contractors and community prevention specialists by 10%

Data Source:

DSAMH & DPBHS Prevention Program Data

Description of Data:

Relevant substance abuse prevention trainings and technical assistance are provided to both contracted and additional community agencies to build the prevention workforce in order to enhance the prevention services being provided throughout the state. Number of core competencies for prevention providers; Number of Certified Prevention Specialists (CPS); number of Trainings provided; number of individuals served at prevention trainings.

Data issues/caveats that affect outcome measures::

Indicator #:	3
Indicator:	Underage alcohol use and misuse prevention (youth prevention)
Baseline Measurement:	Underage alcohol use and misuse (for youth) as reported in the 2014-15 State Epi Profile
First-year target/outcome measurement:	Decrease alcohol use, misuse, and abuse by 10% for those underage and 5% for young adults
Second-year target/outcome measurement:	Decrease alcohol use, misuse, and abuse by 10% for those underage and 5% for young adults

Data Source:

State Epi Profile, School Surveys, NSDUH; KIT Solutions

Description of Data:

Repeated measures of the Performance Indicators updated quarterly for short term measures and at least annually for long term measures changes in laws, policies and operating procedures.

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Development and implementation of comunity based substance abuse prevention contracts

Baseline Measurement: Number of substance abuse prevention contracts in FY15

First-year target/outcome measurement: Maintain number of substance abuse prevention contracts throughout the state

Second-year target/outcome measurement: Maintain number of substance abuse prevention contracts throughout the state

Data Source:

DSAMH and DPBHS Contracts

Description of Data:

Engage prevention stakeholders and coordinate substance abuse prevention services in Delaware through the implementation of State and Community-level Strategic Prevention Plans supported by state funded community contracts. Number of DSAMH prevention contracts; number of individuals served by contracts; number of prevention activities, strategies, events, as well as number of specialized activities such as programming for FASD, etc.

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Marijuana use among youth and young adults (youth prevention)

Baseline Measurement: Marijuana use among youth and young adults are reported in the 2014-15 State Epi Profile

First-year target/outcome measurement: 10% reduction in the use and abuse of marijuana among youth and young adults

Second-year target/outcome measurement: 10% reduction in the use and abuse of marijuana among youth and young adults

Data Source:

State Epi Profile, School Surveys, NSDUH; KIT Solutions

Description of Data:

Repeated measures of the Performance Indicators updated quarterly for short term measures and at least annually for long term measures, changes in laws, policies and operating procedures.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Substance Abuse Treatment and Recovery Services to IVDUs

Priority Type:

Population(s): PWWDC, IVDUs

Goal of the priority area:

Conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.

Objective:

Strategies to attain the objective:

Increase access to substance abuse treatment and recovery services to IVDUs through the implementation of treatment programs throughout the state; Increase the number of participants in t he needle exchange program (the needle exchange program is not funded by the SAPT BG)

Priority #: 7

Priority Area: HIV Prevention and Early Intervention Services to Individuals receiving Substance Abuse Treatment

Priority Type:

Population(s): PWWDC, IVDUs, HIV EIS

Goal of the priority area:

Provide HIV prevention as early intervention services at the sites at which individuals receive substance use disorder treatment services.

Objective:

Strategies to attain the objective:

Individuals receiving substance abuse treatment services will be offered HIV prevention and early intervention services, as well as referral to treatment for HIV as needed through community-based contracts.

Priority #: 8

Priority Area: Data Driven Decision Making

Priority Type: SAP, SAT

Population(s): PWWDC, IVDUs, HIV EIS, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Military Families)

Goal of the priority area:

Increased accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery supp

Objective:

Strategies to attain the objective:

Delaware's behavioral health system agencies and provider organizations employ increased accountability standards for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services. Data derived from the uniform reporting tools will be used to assess strengths and weaknesses of the behavioral health system and provide data-driven service solutions where applicable.

Priority #: 9

Priority Area: Comprehensive Substance Abuse and Mental Health Services

Priority Type:

Population(s):

Goal of the priority area:

Ensure access to a comprehensive behavioral health system of care of prevention, early identification, treatment and recovery support services; including education, employment, housing, case management, rehab, dental and health services.

Objective:

Strategies to attain the objective:

Delaware's behavioral health system agencies and provider organizations will ensure access to a comprehensive system of care, including education, employment housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports. The services will be delivered in a manner that is evidence-based. Uniform data tools will be used to identify gaps of service. Identified gaps of service will be addressed via data-informed care solutions

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Determination of prevalence estimate of SMI and SPMI for adults

Baseline Measurement:

First-year target/outcome measurement: (2016) SMI = 51,289 // SPMI = 24,695

Second-year target/outcome measurement: (2017) SMI = 51,706 // SPMI = 24,895

Data Source:

Delaware Population Consortium

Description of Data:

State of Delaware estimation of prevalence data study

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Percent of persons receiving evidence-based practices (EBPs) at community service provider sites

Baseline Measurement: 82%

First-year target/outcome measurement: 82%

Second-year target/outcome measurement: 83%

Data Source:

DSAMH MIS

Description of Data:

Increase by 2% the number of persons receiving evidence-based practices (EBPs) at community service provider sites

Numerator: # of individuals receiving EBPs
Denominator: total # of consumers receiving treatment at a Community Service Provider

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Percentage of adults with SMI or COD receiving Evidence Based Supportive Employment as part of their recovery plan.

Baseline Measurement: 21.5%

First-year target/outcome measurement: 21.5%

Second-year target/outcome measurement: 22.5%

Data Source:

DSAMH MIS

Description of Data:

Increase by .5% the number of adults w/ SMI that receive Evidence Based Supported Employment

Numerator: # of consumers employed
Denominator: total # of consumers receiving treatment at a Comm Serv Provider

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Maintain the number of available permanent and permanent supported housing

opportunities for persons with SMI

Baseline Measurement: 650 by July 1, 2015

First-year target/outcome measurement: 650 by July 1, 2016

Second-year target/outcome measurement: 650 by July 1, 2017

Data Source:

USDOJ Data Settlement Agreement tracking of compliance and annual report

Description of Data:

Permanent housing and permanent supported housing targets established by the Voluntary Settlement Agreement between the State of Delaware and the United States Department of Justice.

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Percentage of Adults w/ SPMI receiving ACT in the DSAMH behavioral health system

Baseline Measurement: 34%

First-year target/outcome measurement: 34%

Second-year target/outcome measurement: 35%

Data Source:

DSAMH client census and service data

Description of Data:

Increase the percentage of consumers receiving ACT by 1%

Numerator: # of consumers that received ACT Services
Denominator: total # of consumers receiving treatment at a Comm Serv Provider

Data issues/caveats that affect outcome measures::

Indicator #: 6

Indicator: Number of Evidence Based Practices (system-wide)

Baseline Measurement: 6

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 6

Data Source:

DSAMH client census and service data

Description of Data:

Maintain a total of six EBPs provided by the State service system.

Data issues/caveats that affect outcome measures::

Indicator #: 7

Indicator: Mental health training for emergency, health and human services professionals

Baseline Measurement: 18

First-year target/outcome measurement: 18

Second-year target/outcome measurement: 18

Data Source:

DSAMH Training Office

Description of Data:

Maintain the current number of training programs and seminars provided (18)

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: Integration with the Affordable Care Act

Priority Type:

Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS

Goal of the priority area:

Maximize the utilization of the Affordable Care Act to ensure Block Grant funds are concentrated on identified service gaps.

Objective:

Strategies to attain the objective:

State agencies and their contracted providers will work with the State Partnership Health Insurance Exchange to ensure community behavioral health services are provide in a manner that maximizes the utilization of the Affordable Care Act to ensure Block grant funds are concentrated on identified service gaps

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Collaboration and coordination of substance abuse and mental health services with Health Insurance Exchanges

Baseline Measurement: New practice management and accounts receivable systems that address billing, collection, risk management and compliance associated with substance abuse and mental health services and the Affordable Care Act; hire 1 health "navigators"/monitors to assist with health insurance exchange integration in each county.

First-year target/outcome measurement: Maintain the new practice management and accounts receivable systems that address billing, collection, risk management and compliance associated with substance abuse and mental health services and the Affordable Care Act; hire 1 health "navigators"/monitors to assist with health insurance exchange integration in each county.

Second-year target/outcome measurement: Maintain the new practice management and accounts receivable systems that address billing, collection, risk management and compliance associated with substance abuse and mental health services and the Affordable Care Act; hire 1 health "navigators"/monitors to assist with health insurance exchange integration in each county.

Data Source:

DSAMH Annual Report and/or biweekly report
Number of (contracted) health "navigators"/monitors who will assist with enrollment processes during the ACA system change/redesign; number of newly enrolled individuals through health exchange

Description of Data:

DSAMH Annual Report and/or biweekly reports will indicate progress of system redesign as it relates to the ACA and Health Insurance Exchanges.
DSAMH will focus on the development, redesign, and implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance associated with substance abuse and mental health services and the impact of the Affordable Care Act.

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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	$4,219,475		$0	$0	$14,805,642	$0	$0
a. Pregnant Women and Women with Dependent Children*	$0		$0	$0	$492,000	$0	$0
b. All Other	$4,219,475		$0	$0	$14,313,642	$0	$0
2. Substance Abuse Primary Prevention	$1,465,446		$0	$2,216,724	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$121,181	$0	$0
4. HIV Early Intervention Services	$315,829		$0	$0	$96,980	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$315,829		$0	$0	$0	$0	$0
13. Total	$6,316,579	$0	$0	$2,216,724	$15,023,803	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
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		$938,095	$5,111,300	$0	$64,542,700	$0	$0
8. Mental Health Primary Prevention**		$23,000	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$52,615	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$38,590	$0	$0	$0	$0	$0
13. Total	$0	$1,052,300	$5,111,300	$0	$64,542,700	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$938,095
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$23,000

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$961,095

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$4,547,685
2 . Substance Abuse Primary Prevention	$1,579,435
3 . Tuberculosis Services	$0
4 . HIV Early Intervention Services**	$340,396
5 . Administration (SSA Level Only)	$340,396
6. Total	$6,807,912

* Prevention other than primary prevention

** 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 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 CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for 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 does not meet the AIDS case rate threshold for the fiscal year involved. 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 FY 2016 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: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$189,532
	Selective	
	Indicated	
	Unspecified	
	Total	$189,532
Education	Universal	$710,746
	Selective	$110,560
	Indicated	$15,794
	Unspecified	$221,121
	Total	$1,058,221
Alternatives	Universal	$78,972
	Selective	
	Indicated	
	Unspecified	
	Total	$78,972
Problem Identification and Referral	Universal	$15,794
	Selective	
	Indicated	
	Unspecified	
	Total	$15,794

Community-Based Process	Universal	$78,972
	Selective	
	Indicated	
	Unspecified	
	Total	$78,972
Environmental	Universal	$78,972
	Selective	
	Indicated	
	Unspecified	
	Total	$78,972
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	$0
Total Prevention Expenditures		$1,500,463
Total SABG Award*		$6,807,912
Planned Primary Prevention Percentage		22.04 %

*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: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$742,335	
Universal Indirect	$710,746	
Selective	$110,560	
Indicated	$15,794	
Column Total	$1,579,435	
Total SABG Award*	$6,807,912	
Planned Primary Prevention Percentage	23.20 %	

*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: 10/1/2015 Planning Period End Date: 9/30/2017

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

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$213,224	$0	$0	$213,224
2. Quality Assurance	$56,860	$0	$0	$56,860
3. Training (Post-Employment)	$191,901	$0	$0	$191,901
4. Education (Pre-Employment)	$71,075	$0	$0	$71,075
5. Program Development	$71,075	$0	$0	$71,075
6. Research and Evaluation	$71,075	$0	$0	$71,075
7. Information Systems	$35,537	$0	$0	$35,537
8. Total	$710,747	$0	$0	$710,747

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	$10,000
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	$28,590
Total Non-Direct Services	$38590
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] 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.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse 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.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment 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.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] 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 mental and substance abuse treatment 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 electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] 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, care, 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[39] and ACOs[40] 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.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] 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 finding a provider.[46] 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 ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

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.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, 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.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] 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 illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

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

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____

11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

1. – Healthcare System and Integration

Successful implementation of the Affordable Care Act (ACA) in Delaware has greatly improved service delivery throughout the health care system. Efforts to improve the integration of behavioral health services and physical health services has resulted in some system modifications to better serve the holistic needs of an individual in need of healthcare services.

Prior to implementation of the ACA, Delaware was ahead of the curve in recognizing the need for integrating physical and behavioral health services. As early as 2008, staff from the Delaware Division of Substance Abuse and Mental Health (DSAMH) developed a partnership with the Division of Medicaid and Medical Assistance (DMMA) to create Delaware's Medicaid Parity Plan. The partnership helped to establish an enhanced line of communication between DSAMH and DMMA that still exists and is assisting the policy makers and leaders of the Division of Medicaid and Medical Assistance, the Department of Insurance (DOI), and the Division of Substance Abuse and Mental Health establish program guidelines and performance indicators that include consumer education regarding parity.

More recently, in an effort to ensure maximum utilization of Medicaid eligible service delivery via the Affordable Insurance Marketplace, DMMA staff , DSAMH staff and staff from the Department of Insurance (DOI) updated the Medicaid Parity Plan to include a "collaboration protocol" that mandates parity integration throughout the public educational campaign for Medicaid, Affordable Insurance Marketplace, Navigator and Marketplace Assisters programs. This is deemed to be the most advantageous approach to strategic coordination and increasing parity awareness and understanding throughout the public and private sectors serving the eligible population.

Many of the services included in Table 3 of the application have been covered under Delaware's Medicaid program for several years as Delaware expanded Medicaid services prior to the implementation of the ACA. By January 1, 2016 all of the services offered under table 3 will be covered via Medicaid and/or the QHP's offered in this state. As such, Delaware does not anticipate significant changes to the coverage offered via the state EHB. All Medicaid services in Delaware are monitored via DMMA policy. In addition to those efforts, if a client in need of behavioral health services requires a level of care that lands them on the DSAMH's service rolls, DSAMH's Quality Assurance Unit and PROMISE Care Managers monitor the service delivery process to ensure adequate access to mental health and substance us dependency services offered via the state's QHP and Medicaid programs.

DSAMH's Quality Assurance Unit also monitors all contracted service providers quarterly to ensure full contract compliances. Among the items monitored is the full compliance with State and Federal regulations pertinent to the services being delivered and adequate financial and client-level record keeping. In addition to monitoring access to M/SUD services, Delaware's SSA/SMHA [DSAMH] plays a role in the review of

complaints and or possible violations of MHPAEA that originate from one of the Division's consumers or against a state-funded behavioral health provider.

DSAMH is involved in several coordinated care initiatives throughout the state. 100% of the Division's contracts are integrated for both mental health and substance use dependency recovery treatment and planning. The Division continues to work with multiple agencies to increase integration of physical and behavioral health care service delivery. The transformation of the State's community mental health clinics into PROMISE care sites is a demonstration of the Division's efforts to be a leader in the delivery of integrated services throughout Delaware.

The Division works very well with the Delaware Managed Care Organizations, community health centers, and the Delaware Hospital Association; but the Division continues to identify the relationship with the state's FQHCs as an area where improvement is possible.

Delaware has understood the value of smoking cessation for almost a decade. Dating back to 2008, Delaware has been smoke free on state grounds and in state facilities. DHSS/DSAMH has been a leader in forwarding the smoking cessation agenda to state-funded behavioral health providers throughout the state. Behavioral health facilities regularly screen and assess for nicotine dependence. Though screening and assessment occurs for all consumers at state-funded behavioral health sites, M/SUD service delivery continues to be the emphasis of the coordinated care at those locations. The Division is hopeful that the efforts to increase parity care and increased integration of physical health care and behavioral health care will lead to a system where nicotine dependence is truly on par with substance use dependency. DSAMH's efforts to bring smoking cessation on par with substance dependence includes the regular offering of smoking cessation education courses for providers and consumers, a 24-hour quit hotline and peer support specialist to aid in the recovery process for individuals with nicotine dependence issues.

As previously stated Delaware's most prevalent example of integrated service delivery will take place at the state operated PROMISE sites. Among the array of integrated health care services offered at the PROMISE sites are prevention and wellness education; health risk assessment for hypertension, heart disease, high cholesterol, diabetes; and Peer support programming.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], 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 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, and people living with HIV/AIDS or other chronic diseases/impairments) 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 standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the 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 top Secretarial priority in the Action Plan is to "[a]ssess 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."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] 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.[58] 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 population 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 being served or 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, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

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[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

2. – Health Disparities

ADULT BEHAVIORAL HEALTH SYSTEM

The Division of Substance Abuse and Mental Health will track access or enrollment in services, types of services received and outcomes by race, ethnicity, gender LGBT, and age by developing a comparative study of who the division is currently serving against prevalence data and demographic information of individuals DSAMH estimates it should be serving.
The Division of Substance Abuse and Mental Health does not currently address or track language needs of disparity-vulnerable subpopulations on its primary client level data collection tool, the Consumer reporting Form (CRF). Currently these subpopulation language needs are identified and addressed through the service provision contracts with community providers that serve the specific subpopulations.
The DSAMH develops plans to address the aforementioned subpopulations and eventually reduce disparities in access, service us and outcomes through analysis of data submitted by community providers and comparing it against population studies and prevalence rates for the subpopulation.
If it is determined that disparity exists Block Grant funds will be used to contract with the appropriate community provider to address the disparity.

For substance abuse prevention programs currently, monthly reports serve as the only monitoring tool to track prevention services, enrollment, as well as performance and outcome measures. The monthly reports do not currently capture information to adequately track access and enrollment of services for specific populations. DSAMH and DPBHS are currently working with KIT Solutions to develop a tracking system to monitor the substance abuse prevention services within the state. KIT Solutions is intended to track access and enrollment of prevention services as they relate to health disparities.

KIT Solutions is the identified mechanism intended to track access and enrollment of prevention services as they relate to health disparities. DSAMH and DPBHS will work with the Delaware Prevention Advisory Committee, as well as the Behavioral Health Subcommittee, to review and track data collected through KIT Solutions. Data will be used to enhance the State Prevention Plan to address and reduce disparities in access, service use, and outcomes.

Block Grant funds will be used to support the KIT Solutions Contract.

CHILD BEHAVIORAL HEALTH SYSTEM

The above question 1-3 refers to our FACTS I and FACTS II system respectively of which have been presented earlier in this plan. Our Family and Children Tracking Systems are designed and have been enhanced to track enrollment in services, types of services, race ethnicity gender and age. Additionally it can track prescription medications and language preferences. Currently we are not tracking LGBTQ. However we do offer training on that topic.

DPBHS track access, enrollment in services, types of services including language preferences received and outcomes by race ethnicity, gender, and age through our FACTS system that is mentioned throughout this document. Our FACT I system currently provides:

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

Our enhanced FACT II will provide:

Project Objectives

- Development of an integrated case management and service delivery information system
- Use of unique service type definitions and codes for procurement and fiscal processes
- Enhanced and improved reporting capabilities
- Expansion of data exchanges with other agencies
- Expanded information exchanges with service providers
- Development of an organizational change management process that facilitates implementation and acceptance of FACTS II

Features

- Shared processes across service areas.
- Replacement of the program-centric FACTS with a child-centric system linking family members and other relevant people and resources
- Shared data and case management information to facilitate improved outcomes through coordinated effort
- Secure access to FACTS II for external providers to:
  - Inform case planning and service delivery activities
  - Input case management and billing information
- Supports all existing functions
- Integrates functionality among Divisions

- Adds significant new functionality

With stronger and more accessible data our division will be able to identify and address disparities more effectively and efficiently.
Currently we do not track for LGBTQ. However we have provided training and supports for that population.
DPBHS does not currently use it block grant funds to track and respond to the above disparities.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. 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[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] 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."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), 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, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. 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 Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (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 substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] 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 mental health and substance abuse services.

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    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 incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] Ibid, 47, p. 41

[60] 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

[61] 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.

[62] 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.

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

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

4. Prevention for Serious Mental Illness

The Division of Substance Abuse and Mental Health are partnering with the Division of Prevention and Behavioral Health to develop and implement a collaborative project that is locally being referred to as Project CORE (Community Outreach, Referral and Early Intervention).

Project CORE will identify youth between the ages of sixteen (16) and twenty-five (25) with early psychosis conditions and engage them into counseling, support and coaching to prevent conversion (i.e., first episode) and hospitalization. CORE service delivery will consist of the following components: intensive community outreach, assessment, and treatment for those who are positive for early onset conditions. Treatment will consist of participation in a multi-family psycho-education support group, educational/vocational support services and medication when necessary.

All three components of the Project CORE approach will be delivered via team approach. CORE teams will consist of two (full time) social workers, occupational therapist (part time), educational/vocational support (part time) and a psychiatrist (part time).

Project CORE will serve the entire state via a 2-stage implementation strategy. During Phase 1 (months 7-30) CORE will be implemented throughout the New Castle County zip codes north of Newark with an estimated population of 324,893 and all of Sussex County with an estimated population of 203,390. During Phase 2 (month 31-54) The New Castle County CORE team will adopt the remainder of New Castle County serving an additional 221,183 members of the population and the Sussex County CORE team will expand geographically upward into Kent County to serve an additional 167,626 population.

Epidemiologist from the Delaware Department of Prevention and Behavioral Health estimated Delaware's assessed need based on the national implementation of a similar evidence based program concentrating on early detection and intervention for the prevention of psychosis. The evidence based program was implemented in 6 regions that served a combined catchment area of roughly three million people. That study indicated that approximately .05% of the population was referred to Coordinated Specialty of Care (CSC) teams. Of these, approximately 30% were assessed as positive; and of those positive cases, approximately 80% received treatment from a Coordinated Specialty of Care team. Based on the size of Delaware's catchment area, Delaware's estimate of persons served by the CORE project can be found in the following table:

	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	Total
Referral	30	60	90	120	60	360
Assessed	10	20	30	40	20	120
Treated	8	16	24	32	16	96

Statistical Analysis and program evaluation of the CORE project will be conducted by the University Of Delaware Center for Data and Information.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

5. – Evidence Based Practices for Early Intervention (5% Set-Aside)

The Division of Substance Abuse and Mental Health (DSAMH) will utilize Delaware's five percent set-aside of the MHBG to provide funding for the implementation of an evidence based program concentrating on early detection and intervention for the prevention of psychosis. The Division of Substance Abuse and Mental Health will partner with the Division of Prevention and Behavioral Health to develop and implement a collaborative project that is locally being referred to as Project CORE (Community Outreach, Referral and Early Intervention).

Delaware's Project CORE is influenced heavily by the Portland Maine PIER model. Delaware's Project Core fuses principles and concepts of the established PIER model with some cutting edge concepts developed by mental health professionals that have worked with Dr. McFarland on a methodology for the delivery of early psychosis services to the non-prodromal population. As such, Delaware will utilize State funds to train Project CORE staff in the nuances of applicable PIER concepts and the CMHBG 5% Set-Aside will be used exclusively to educate Project CORE staff to accurately identify and assess non-prodromal early psychosis cases. The funds will permit Delaware to secure the resources of the leading mental health professionals of this discipline to train Project CORE staff.

The CMHBG 5% Set-Aside will be used to train Project CORE staff in the identification and assessment of recent non-prodromal early onset psychosis; engagement of families with a member who has non-prodromal early psychosis; the use of intensive case management, family psycho-education and multi-family groups with non-prodromal recent onset psychosis.

Project CORE will identify youth between the ages of sixteen (16) and twenty-five (25) with early psychosis conditions and engage them into counseling, support and coaching to prevent conversion (i.e., first episode) and hospitalization. CORE service delivery will consist of the following components: intensive community outreach, assessment, and treatment for those who are positive for early onset conditions. Treatment will consist of participation in a multi-family psycho-education support group, educational/vocational support services and medication when necessary.

All three components of the Project CORE approach will be delivered via team approach. CORE teams will consist of two (full time) social workers, occupational therapist (part time), educational/vocational support (part time) and a psychiatrist (part time).

Project CORE will serve the entire state via a 2-stage implementation strategy. During Phase 1 (months 7-30) CORE will be implemented throughout the New Castle County zip codes north of Newark with an estimated population of 324,893 and all of Sussex County with an estimated population of 203,390. During Phase 2 (month 31-54) The

New Castle County CORE team will adopt the remainder of New Castle County serving an additional 221,183 members of the population and the Sussex County CORE team will expand geographically upward into Kent County to serve an additional 167,626 population.

To better understand the implementation strategy, take note of a short demographic makeup of Delaware. Delaware has 3 counties. The northern most county (New Castle County) is also Delaware's most population dense county and it is designated as entirely metropolitan. Wilmington resides within New Castle County. Wilmington is by far Delaware's largest city. The zip codes identified as north of Newark encompass Wilmington in its entirety and a couple smaller cities in the most heavily populated area of the state. The Phase 1 identified area contains one half of the target population for the entire state.

Delaware's lower two counties are Kent (Central Delaware) and Sussex (Lower Delaware) are designated as rural areas, with the exception of Dover, Delaware's Capital. Combining those two counties with the zip codes south of Newark represent the other half of the project's target population. Breaking the project down into two phases permits the Project CORE staff roll out the services to half of the target population and identify potential gaps in services prior to the services being available to the entire state population.

The implementation of the project consists of educating the social workers, psychiatrist, occupational therapist, and educational/vocational staff that will be working on the CORE teams to the methodology and strategy employed by the model.

Epidemiologist from the Delaware Department of Prevention and Behavioral Health estimated Delaware's assessed need based on the national implementation of a similar evidence based program concentrating on early detection and intervention for the prevention of psychosis. The evidence based program was implemented in 6 regions that served a combined catchment area of roughly three million people. That study indicated that approximately .05% of the population was referred to Coordinated Specialty of Care (CSC) teams. Of these, approximately 30% were assessed as positive; and of those positive cases, approximately 80% received treatment from a Coordinated Specialty of Care team. Based on the size of Delaware's catchment area, Delaware's estimate of persons served by the CORE project can be found in the following table:

	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	Total
Referral	30	60	90	120	60	360
Assessed	10	20	30	40	20	120
Treated	8	16	24	32	16	96

Statistical Analysis and program evaluation of the CORE project will be conducted by the University Of Delaware Center for Data and Information.

Budget

Specifically, the Division of Substance Abuse and Mental Health proposes using the entire 5% set-aside award ($52,615) to fund the training of 20-25 staff persons, inclusive of the CORE Team's staff, program administrators, and essential law enforcement and school system personnel.

Training (CORE Personnel)	FTE
Social Worker (NCC & North KC)	1
Social Worker (SC & South KC)	1
Occupational Therapist (North Team)	1
Occupational Therapist (South Team)	1
Educational Support Specialist (North Team)	1
Educational Support Specialist (South Team)	1
Psychiatrist (North Team)	0.5
Psychiatrist (South Team)	0.5
Total CORE Personnel	**7**
Total CORE Training Cost	**49,500**
Training (Non-CORE Personnel)	
Police Chiefs Council	
School and Education Institution Staff	
SSA Staff (CMHSBG Administrator)	
Total Non- CORE Training Cost	**3,115**
Total Training Cost	**52,615**

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

4. Participant Directed care

The Delaware Behavioral Health system was transformed to a system that places the consumer at the core of the recovery process via true person centered planning dating back to 2012. The person-centered recovery plans which focus on stabilization; rehabilitation and recovery are developed in partnership with the consumer. The planning process emphasizes the consumer's role in shaping the nature and scope of services and outcomes, and the ability of the treatment team, which includes the consumer, to review and update the treatment plan as the needs of the individual change.

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

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

- As a primary proponent of consumer recovery and full inclusion in the community, DSAMH will continue to provide consumer employment opportunities and engagement in planning activities.

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

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

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

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

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

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

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

- The Division supported the development of the consumer-run Rick Van Story Resource Center.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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 USC § 300x– 55, 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 to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible 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 abuse 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 SABG and MHBG. 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 mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

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

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

7. – Program Integrity

1. Does the state have program integrity plan regarding the SABG and MHBG?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH does not have an integrity plan regarding the SABG and MHBG. However DPBHS does have policy and procedures, including, but not limited to an MOU between DSAMH and DPBH that guard DSAMH's integrity fiscally and the programmatic information that is discussed throughout the application and State Plan.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS does not have an integrity plan regarding the SABG and MHBG. However DPBHS does have several policies and procedures that guard the division's integrity fiscally and programmatically that are discussed throughout the application.

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH utilizes the Director of Planning as the person that is responsible for the program integrity. Additional program integrity activities are assigned to DSAMH's Mental Health Planner and Substance Abuse Planner.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS does have a corporate compliance officer that is responsible for overseeing federal funds and a controller of fiscal services.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices: a. Budget review; b. Claims/payment adjudication; c. Expenditure report analysis; d. Compliance reviews; e. Encounter/utilization/performance analysis; and f. Audits.	
ADULT BEHAVIORAL HEALTH SYSTEM:	The fiscal operations of the Division of Substance Abuse and Mental Health (DSAMH) including all the facilities and programs it administers are governed by the State of Delaware's Budget and Accounting Manual and must comply with its provisions. Furthermore, each year the

	State of Delaware's Auditor of Accounts conducts an independent audit of the State of Delaware's financial records and transactions which includes Delaware's Department of Health and Social Services and the Division of Substance Abuse and Mental Health, in order to obtain reasonable assurance that the department has, in all material respects, complied with laws and regulations of the State of Delaware and with the federal requirements of OMB Circular A-133. Independent audits are completed annually. Prior year Single Audit Financial statements can be found at the Auditor of Accounts website (http://auditor.delaware.gov/Audits).
CHILD BEHAVIORAL HEALTH SYSTEM:	The fiscal operations of the Division of Prevention and Behavioral Health Services (DPBHS) including all the facilities and programs it administers are governed by the State of Delaware's Budget and Accounting Manual and must comply with its provisions. Furthermore, each year the State of Delaware's Auditor of Accounts conducts an independent audit of the State of Delaware's financial records and transactions which includes Delaware's Department of Services for Children, Youth and Their Families (DSCYF), and DPBHS, in order to obtain reasonable assurance that the department has, in all material respects, complied with laws and regulations of the State of Delaware and with the federal requirements of OMB Circular A-133. Independent audits were conducted for FY10, FY11, and has been just completed for FY12. Prior year Single Audit Financial statements can be found at the Auditor of Accounts website (http://auditor.delaware.gov/Audits). Questions concerning DPBHS accounts payable and receivable should be directed to Controller, DSCYF Fiscal Services, at 892-4548. i. Budget review; DPBHS reviews both block the substance abuse and mental health block grant budgets on a bi-monthly basis during a cumulative financial meeting ii. Claims/payment adjudication; DPBHS has fiscal policies and audits that warrants claims, and payments adjudications iii. Expenditure report analysis; DPBHS reviews all block grant expenditures for timeliness and accuracy of billing on a bi-monthly basis during a cumulative financial meeting iv. Compliance reviews; Monitoring for compliance is integrated into DPBHS policies and procedures as well as

	our Divisions culture. This is discussed throughout the application. v. Encounter/utilization/performance analysis; DPBHS monitors this via our Quality Committees outlined throughout this application. vi. Audits. DPBHS is randomly audited by KPMG LLC (Klynveld Peat Marwick Goerdeler) one of the accounting firms that the State Auditor's Office has on contract to handle regular audits of state agencies.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH utilizes Block Grant funds as a payer of last resort methodology. DSAMH's Senior Financial Officer and the Planning Unit staff responsible for the MH and SA block grants meet one a month to discuss expenditures and financial transactions for each grant. The monitoring of the appropriateness for type and quantity of services is accomplished by cross checking clients receiving services that are Block Grant funded against the records acquired from the Division of Medicaid and Medical Assistance.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS does have a corporate compliance officer that is responsible for overseeing federal funds and a controller of fiscal services.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?	
ADULT BEHAVIORAL HEALTH SYSTEM:	All DSAMH contracts contain explicit language clearly identifies the program requirements, including quality and safety standards. Periodic monitoring of the contracts by DSAMH's Quality Assurance and Performance Improvement Unit identifies areas of non-compliance. Those areas must be addressed or the contract may be terminated.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS requires all providers in our continuum to become accredited by an accrediting body so that they have appropriate policies and practices in place. We also have quarterly meetings with providers to advise them of any changes or information relevant to their

	organizations. Our Division Provider Administrators (PA's) have meetings with their providers throughout the year and regular contact then to address issues and or concerns. The QIU does monitoring where they get written feedback on compliance and the organization is required to make corrections until they reach compliance. Incident reports are used to assess safety issues and how address how organizations respond.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH utilizes Block Grant funds as a payer of last resort. The monitoring of the appropriateness for type and quantity of services is accomplished by cross checking clients receiving services that are Block Grant funded against the records acquired from the Division of Medicaid and Medical Assistance. DSAMH and DMMA both utilize an identical unique client identifier which helps staff quickly determine whether services have been render by either agency.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS does yearly billing audits on all providers.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] 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 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. 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.

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

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

8. Tribes

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

In the absence of a federally recognized tribe in Delaware, DSAMH values having a relationship with a state recognized tribes. In 2011, DSAMH began working with the Nanticoke Indian Tribe in Sussex County and will treat that relationship with the same level of care and attention that would be afforded a federally recognized tribe until a pending application for federal recognition had been ruled upon. The Nanticoke is state recognized and they are currently working toward becoming federally recognized. A representative from the Nanticoke Indian Tribe attends the Delaware Prevention Advisory Committee (DPAC) meetings on a regular basis.

In 2012, DSAMH began working with the Lenape Indian Tribe, also a state recognized tribe, located in Kent County. In 2013, through the support of Delaware's Strategic Prevention Framework – State Incentive Grant, a member of the Nanticoke was afforded the opportunity to attend the Community Anti-Drug Coalitions of America's (CADCA) Annual Forum in National Harbor Maryland.

The Chiefs of both the Nanticoke and Lenape Tribes have identified that they have a strong interest in pursuing involvement with increasing the substance abuse prevention efforts within their communities; however, they have also identified that they currently have low capacity to implement activities. The DSAMH and DPBHS prevention staff will continue to foster the relationships with the members of the tribes as well as provide resources as needed in order to increase community capacity and readiness.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

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

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

10. Quality Improvement Plan

ADULT BEHAVIORAL HEALTH SYSTEM

DSAMH has an active Quality Assurance and Performance Improvement (QAPI) unit which engage in activities which support the Division's goals of providing safe and effective substance abuse and mental health prevention, treatment, and assessment services. QAPI performs ongoing monitoring visits of substance abuse and mental health providers to ensure contract and licensure compliance. QAPI coordinates monitoring efforts with project management staff to identify and track provider outcomes.

Data obtained through all facets of contract and grant monitoring are aimed to measure critical outcomes and performance measures, based on valid and reliable data, that will describe the health and quality of Delaware's mental health and substance abuse systems.

DSAMH will monitor and amend the Division's Quality Improvement Plan to ensure continuous quality improvement. DSAMH's Quality Assurance and Performance Improvement Unit will continue to monitor compliance of the mandatory existence of a Quality Assurance and Performance Improvement plan in all DSAMH funded contracts.

Agency Procurement Policy

Following the State's procurement procedures, for services requiring contracts $50,000 or greater, agencies are required to complete a bid solicitation process, Requests for Proposals (RFP).

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

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

- According to the CARF site, "…accreditation process is based on the concepts of peer review, networking, and sharing ideas. CARF's hallmark is a consultative approach to surveys, not an inspective one. The purpose of the CARF on-site survey is for a team of peers to provide an impartial, external review based on conformance to the standards. Link: http://www.carf.org/Providers.aspx?content=content/Accreditation/Opportunities/BH/AccreditationStandards.htm

- According to the JCAHO website, "the accreditation process for JCAHO Joint Commission's accreditation process concentrates on operational systems critical to the safety and quality of client care. To earn and maintain accreditation, a behavioral health care organization must undergo an on-site survey by a Joint Commission survey team at least every three years. The objective of the survey is not only to evaluate the organization, but to provide education and guidance that will help staff continue to improve the behavioral health care organization's performance. The survey process evaluates actual care, treatment or services provided by tracing clients and analyzing key operational systems that directly impact the quality and safety of client care." Link: http://www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare/bhc_facts.htm
- Staff from our DSAMH Licensing Unit conducts these reviews. DSAMH conducts annual licensure and Medicaid Certification audits of 100% of our licensed and Medicaid Certified programs. We do a 5%-10% audit of each program's total census.

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

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

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

AOD programs are reviewed annually unless they have Deemed Status in which case

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

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

CHILD BEHAVIORAL HEALTH SYSTEM

DSCYF/DPBHS has an active Quality Management Committee (QMC) which engages in activities which supports the Division's goals of providing safe and effective prevention, early intervention, and assessment and treatment services. The committee also reviews information related to service outcome including consumer satisfactions. The QMC committee works closely with the Quality Improvement Unit (QIU). The QIU carries out the process for responding to emergencies, critical incidents, complaints and grievances.

The QMC performs task below:

Review the results of DPBHS program monitoring

Receive updates from the QIU regarding status of active performance improvement plans

Receive periodic updates from the QIU regarding aggregate data on appeals and complaints received by DPBHS

Propose revised performance measures related to safety and quality of services provided by DPBHS

Reviews specific incidents at that request of the QIU regarding aggregate data on appeals and complaints received by DPBHS;

Annually review of quality assurance indicators with data for each DPBHS unit/section

Review aggregate consumer satisfaction data and provide recommendations to Network Administration and Data Management Unit

As a result of the above, the Quality Management Committee:

Initiates appropriate continuous improvement related to safety and quality of services, and refers to major performance improvements comments related to safety and quality of services to the QIU and makes recommendations to leadership.

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DSAMH has an active Quality Assurance and Performance Improvement (QAPI) unit which engage in activities which supports the Division's goals of providing safe and effective substance abuse and mental health prevention, treatment, and assessment services. QAPI performs ongoing monitoring visits of substance abuse and mental health providers to ensure contract and licensure compliance. QAPI coordinates monitoring efforts with project management staff to identify and track provider outcomes.

Data obtained through all facets of contract and grant monitoring are aimed to measure critical outcomes and performance measures, based on valid and reliable data, that will describe the health and quality of Delaware's mental health and substance abuse systems.

DSAMH will monitor and amend the Division's Quality Improvement Plan to ensure continuous quality improvement. DSAMH's Quality Assurance and Performance Improvement Unit will continue to monitor compliance of the mandatory existence of a Quality Assurance and Performance Improvement plan in all DSAMH funded contracts.

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

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- According to the JCAHO website, "the accreditation process for JCAHO Joint Commission's accreditation process concentrates on operational systems critical to the safety and quality of client care. To earn and maintain accreditation, a behavioral health care organization must undergo an on-site survey by a Joint Commission survey team at

least every three years. The objective of the survey is not only to evaluate the organization, but to provide education and guidance that will help staff continue to improve the behavioral health care organization's performance. The survey process evaluates actual care, treatment or services provided by tracing clients and analyzing key operational systems that directly impact the quality and safety of client care." Link: http://www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare/bhc_facts.htm

- Staff from our DSAMH Licensing Unit conducts these reviews. DSAMH conducts annual licensure and Medicaid Certification audits of 100% of our licensed and Medicaid Certified programs. We do a 5%-10% audit of each program's total census.

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

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

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

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

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

- Review of discharge process.

CHILD BEHAVIORAL HEALTH SYSTEM

DSCYF/DPBHS has an active Quality Management Committee (QMC) which engages in activities which supports the Division's goals of providing safe and effective prevention, early intervention, and assessment and treatment services. The committee also reviews information related to service outcome including consumer satisfactions. The QMC committee works closely with the Quality Improvement Unit (QIU). The QIU carries out the process for responding to emergencies, critical incidents, complaints and grievances. Please also note that in addition to our Divisions requirement all of our providers are required to be accredited by one of the accredited bodies.

The QMC performs task below:

Review the results of DPBHS program monitoring

Receive updates from the QIU regarding status of active performance improvement plans

Receive periodic updates from the QIU regarding aggregate data on appeals and complaints received by DPBHS

Propose revised performance measures related to safety and quality of services provided by DPBHS

Reviews specific incidents at that request of the QIU regarding aggregate data on appeals and complaints received by DPBHS;

Annually review of quality assurance indicators with data for each DPBHS unit/section

Review aggregate consumer satisfaction data and provide recommendations to Network Administration and Data Management Unit

As a result of the above, the Quality Management Committee:

Initiates appropriate continuous improvement related to safety and quality of services, and refers to major performance improvements comments related to safety and quality of services to the QIU and makes recommendations to leadership.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful 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, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

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.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach". [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

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

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

75 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.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

11. - Trauma

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Adult Activities

While the Division of Substance Abuse and Mental Health (DSAMH) does not at this time have actual policies requiring trauma history screening, nearly all new clients and some existing clients served by behavioral health contract providers are currently being screened using the Trauma Adult Assessment (TAA) by Trauma Peers. Ten (10) different providers in the state of Delaware have Trauma Peers at their facility. This process is underway as part of implementing the SAMHSA Mental Health Transformation Grant on Trauma-Informed Care. Oversight of the Trauma Peers is being conducted by the researchers from the University of Pennsylvania.

DSAMH will add such requirements to contracts starting in July, 2013.

Child Activities

The state maintains a twice-annually updated list of clinicians with training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This list can be accessed by going to **http://kids.delaware.gov/information/serious_trauma.shtml** and clicking on ***"Trained trauma-focused therapists in Delaware".*** The state also pays for a part-time employee to work with parents exiting to the CACs to connect with clinicians trained to deliver TF-CBT.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

Adult Activities

Individuals screening positive on the TAA are enrolled in the grant data collection process, and their positive screen is forwarded to the agency clinician for full assessment and treatment planning. There is no requirement at this time for the agency to provide trauma-focused services, as indicated, although the grant training and technical assistance activities are explicit regarding the organization's professional obligation to do so.

Individuals who screen positive for a history of trauma are immediately linked to a Trauma Peer and Wellness Recovery Action Planning (WRAP) is available to any organization that is interested in holding WRAP groups. DSAMH's ultimate goal is to have all DSAMH sponsored peers trained to facilitate WRAP groups.

DSAMH will add such requirements to contracts starting in July, 2013.

Child Activities

The State maintains a twice-annually updated list of clinicians with training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This list can be accessed by going to **http://kids.delaware.gov/information/serious_trauma.shtml** and clicking on ***"Trained trauma-focused therapists in Delaware".*** The State also pays for a part-time employee to work with parents exiting to the CACs to connect with clinicians trained to deliver TF-CBT.

DPBHS expanded Child Priority Response (CPR) responds to traumatic Issues.

3. Does your state have any policies that promote the provision of trauma-informed care?

Adult Activities

While the Division of Substance Abuse and Mental Health (DSAMH) does not at this time have actual policies requiring implementation of trauma-informed care, we are at the mid-point in implementing a SAMHSA grant for that purpose. We plan to add such requirements to contracts starting in July, 2013. The grant's core focus in transformation of behavioral healthcare organizations, and we are also collaborating with these other State service systems to offer training and technical assistance: prison, probation and parole; homeless services; young adult services; domestic violence; children in foster care; and law enforcement. In addition to training and technical assistance, each behavioral health partner organization, and many of the homeless service providers are completing a trauma organizational self-assessment tool, and participating in subsequent data analysis and performance improvement processes.

Child Activities

The Department of Prevention and Behavioral Health Services do not have any formal

policies that promote the provision of trauma-informed care.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

Adult Activities

The Division of Substance Abuse and Mental Health (DSAMH) contracts with a set of behavioral health providers to offer a range of services ranging from standard outpatient services to ACT teams and Intensive Case Management. The Division does not require providers to offer any specific trauma-specific treatment modalities nor does it survey the providers to identify which modalities they may be providing. Anecdotally, however, we are aware that Trauma-focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, SELF groups (Sanctuary Model), and Seeking Safety are in use; arts and creative expressive activities are available in some organizations, and comfort rooms and comfort carts are increasingly available.

Child Activities

Child and Family Traumatic Stress Intervention (CFTSI) for 7-18 year olds recently exposed to trauma (offered through our crisis service); and TF-CBT for 7-18 year olds with significant symptoms or a diagnosis of Posttraumatic Stress Disorder.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Adult Activities

The Division of Substance Abuse and Mental Health (DSAMH) has offered trauma training to both behavioral healthcare providers and the broader array of public health and social service agencies for the past three years. Each year the Division of Substance Abuse and Mental Health (DSAMH) sponsors the Summer Institute which has offered a variety of presentations focused primarily on encouraging the transformation to trauma-informed care. Funded by SAMHSA's mental health transformation grant, we have reached hundreds of practitioners in behavioral health, public health, corrections, and children and family services settings. However, because the grant is focused on trauma-informed care rather than trauma-specific services, the latter have not been widely promoted. Materials relating to trauma-focused services have been forwarded to providers and resources (books, manuals, DVDs) are being purchased and made available through the Division of Substance Abuse and Mental Health (DSAMH)'s significant lending library holdings. We are funding one trauma clinician to consult with several organizations on their transformation activities, and have proposed to expand the number of consultants recruited.

The Division of Substance Abuse and Mental Health also sponsored a two-day trauma conference in October of 2012 and DSAMH staff is currently organizing a peer conference focusing on trauma specific interventions and care.

It's important to note that currently Trauma Informed Care is not integrated into the substance abuse prevention system. Through Mental Health Transformation Grant (MHTG), Delaware has made great strides within the mental health and substance abuse treatment systems for trauma assessments and the implementation of a Trauma Informed Care service delivery system. In FFY 14-15, MHTG staff will begin working with prevention staff to identify methods of integrating substance abuse prevention and trauma activities.

Child Activities

Twice-annually, the Office of Evidence-based Practice in the state's Division of Prevention and Behavioral Health Services (DPBHS) delivers TF-CBT training, tape-review and consultation to 15-20 community clinicians. In this fiscal year (2012-2013), we are contracting to train our entire subcontracted child crisis service in the delivery of CFTSI.

We also train in GAIN, PCIT, TCIT and CARES.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

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 substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG 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. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths 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.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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 mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility 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.

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided 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?

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

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] 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, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

12. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?	
ADULT BEHAVIORAL HEALTH SYSTEM:	With the impending changes set to occur within the behavioral health system, the State of Delaware is making strides to enhance the lines of communication among each of the state agencies involved with the implementation of the Affordable Care Act enabling programs such as the Affordable Insurance Marketplace and Marketplace Assister Programs (Division of Substance Abuse and Mental Health (DSAMH), Division of Medicaid and Medical Assistance (DMMA), Department of Insurance(DOI), Department of Correction (DOC), etc.). Communication and planning are integral to ensure the success of these programs and that Delawarean's receive appropriate and accessible care. The DOC participation in the enhanced communication and coordination effort is designed to get eligible DOC clients enrolled in Medicaid or linked to the Affordable Insurance Marketplace as part of their discharge process.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS does not track the number of youth eligible for Medicaid (unless the youth is going into placement since that has to be reported. Probation officers will at times help families apply for Medicaid but this isn't a formal process (e.g. screen and if eligible work with family to apply). For youth who are on lower level probation through their contractors it seems they do ask families about insurance and assist if the family would like help applying for Medicaid.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?	
ADULT BEHAVIORAL HEALTH SYSTEM:	Prior to adjudication, Delaware special court participants or candidates for alternatives to detention are accessed via the Addiction Severity Index (ASI) tool which utilizes the American Society of Addition Medicine (ASAM) level of care. When a focused mental health evaluation is

	ordered, DSAMH currently sends the order to a contracted provider to complete. DSAMH is exploring options to migrate to the utilization of the Global Appraisal of Needs (GAIN) tool as it provides mental health information in addition to substance use information.
CHILD BEHAVIORAL HEALTH SYSTEM:	All youth who enter the two juvenile detention facilities pre-adjudication receive mental health and substance use screening (MAYSI). Additional screenings are provided based on initial screening and review of records and include the UCLA PTSD RI, Beck Depression Inventory and Connors Rating Scales. Additional assessment is provided as needed for substance use (Global Appraisal of Individual Needs) and mental health assessment is available through PBHS Assessment Unit when indicated. All youth in detention receive substance-use psycho-education weekly. Where indicated, youth may also receive substance use individual treatment (motivational enhancement focus) and mental health services (psychiatric evaluation and medication management; crisis counseling (for youth with self-harm thoughts/behaviors), individual and family counseling). Post-adjudication, youth who enter residential services receive additional mental health screening and then are provided necessary services for mental health or substance use problems (individual, group and family counseling). For youth who are placed on community probation, probation officers refer youth to mental health and substance use services.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?	
ADULT BEHAVIORAL HEALTH SYSTEM:	The DSAMH is the SMHA and SSA in Delaware. Additionally the DPBH is a sibling agency to the juvenile justice jurisdiction, under the Department of Services for Children, Youth and their Families. DSAMH is an active participant in the Drug Court Diversion program in New Castle County, as well as the statewide Mental Health Court Diversion Courts. DSAMH participates in the State's re-entry program known as the Individual

	Assessment, Discharge and Planning Team (IADAPT). Division staff is represented on each county's team.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS and DYRS have a process in place to address diversion of youth with behavioral health disorders who are placed in the Juvenile Justice residential programs. DPBHS staff who work in those programs serve as a liaison to DPBHS unit manager and Division Deputy/Director to review youth who DYRS feels are not appropriate for detention (youth are referred to crisis bed/ hospital/RTC's when appropriate). For youth who are adjudicated DYRS and DPBHS discuss identification of a program that can meet the youth's behavioral health needs and there is co-funding of such programs. With regard to services provided within the facilities, DPBHS and YRS coordinate along with the YRS health care provider (Christina Care) to assure youth receive needed behavioral services. Each facility has behavioral health staff that are responsible for identifying behavioral health services that youth will require at re-entry and to work with YRS and the family to make referrals for these services.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?	
ADULT BEHAVIORAL HEALTH SYSTEM:	The DSAMH continues to work with criminal justice partners to identify gaps or critical issues in care coordination.
CHILD BEHAVIORAL HEALTH SYSTEM:	For youth who are involved with clinical services management, there is an integrated plan with Juvenile Justice to assure that there is coordination of care.

5. What cross-trainings do you provide 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?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH utilizes resources from the Co-occurring State Incentive Grant (COSIG), specifically David Mee-Lee, MD and Mark Carney, Ph.D. to train our system partners throughout the state. DSAMH has conducted multiple trainings for behavioral health providers and criminal justice partners.
CHILD BEHAVIORAL HEALTH	DPBHS (SMHA) is responsible for providing suicide

SYSTEM:	prevention and intervention and basic counseling skills training for all juvenile justice residential staff (training is provided at time of hire and annually). In addition, PBHS provides training to juvenile justice staff in the detention centers on understanding substance abuse/dependence. DPBHS and DYRS jointly received two grants during 2011/2012. The first was through the National Child Traumatic Stress Network and was focused on staff working in juvenile justice residential facilities. A DPBHS/DYRS team (five folks) was trained to deliver a trauma-focused curriculum to Juvenile Justice staff as well as in a trauma-specific treatment intervention (Trauma-Grief Component Therapy for Adolescent- TGCTA). The second was through the National Center for Mental Health and Juvenile Justice and was a train the trainer opportunity on a full day training curriculum for Juvenile Justice staff that includes modules on understanding behavioral health and trauma for youth in the juvenile justice system. PBH and YRS staff are co-training on this curriculum. DYRS had their annual conference open to behavioral health providers and had a session on understanding the relationship between substance use and trauma for youth in Juvenile Justice. DPBHS has their annual conference open to behavioral health providers and Juvenile Justice personnel. DPBHS staff have presented to DYRS community services in the past on behavioral health (substance use and trauma) and most recently (in the past year) presented to the DYRS assessment unit using the PACT to identify youth in need of behavioral health services.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

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. 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. SMHAs and SSAs should collaborate with their state's 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.

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

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

13. – Parity Efforts

ADULT BEHAVIORAL HEALTH SYSTEM

Delaware state agencies have embraced the importance of increasing the consumer knowledge base regarding parity dating back to 2008, when staff from the Delaware Division of Substance Abuse and Mental Health developed a partnership with the Division of Medicaid and Medical Assistance to develop Delaware's Medicaid Parity Plan. The partnership helped develop an enhanced line of communication between DSAMH and DMMA that still exists and is assisting the policy makers and leaders of the Division of Medicaid and Medical Assistance, the Department of Insurance, and the Division of Substance Abuse and Mental Health develop program guidelines and performance indicators that include consumer education regarding parity.

The State's Medicaid, Affordable Insurance Marketplace, Navigator and Marketplace Assisters public information campaigns will focus primarily on outreach, identifying and enrolling clients into the benefit that best meets their need, but there will also be a component of the educational campaign that reflects the importance of parity in healthcare service delivery. DMMA, DSAMH and DOI are confident that an updated Medicaid Parity Plan and parity integration throughout the public educational campaign for Medicaid, Affordable Insurance Marketplace, Navigator and Marketplace Assisters benefits will be the most advantageous approach to strategic coordination and increasing parity awareness and understanding throughout the public and private sectors serving the eligible population.

DSAMH Prevention Staff will utilize the Delaware Prevention Advisory Committee (DPAC) as a mode of communication to discuss, educate, and raise awareness about parity. The DPAC represents a collaboration of state and community agencies throughout the behavioral health continuum of care, with specific interest in the enhancement of substance abuse prevention activities. This body will work together to develop strategies ensure that information is disseminated regarding parity.

CHILD BEHAVIORAL HEALTH SYSTEM

DSCYF/DPBHS receives a little over $200,000 annually from the Mental Health Block Grant. All of the resources received go directly to community based services. However our Department/Division has a communication plan and is currently in the process of updating our plan.

Currently our Department collaborates with variety of organizations, state agencies, private and not for profit organizations along with coalitions and faith based organizations just to name a few. This strong collaboration and partnerships helps us increase awareness and decrease stigma around children's mental health.

Currently our Department/Division utilizes a variety of vehicles to promote our messages. These messages include but are not limited to:

- Department's websites:

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

- Department's Newsletters and Kids Line and DSCYF insiders.

Other steps to ensure that information is disseminated strategically and broad through our Advocacy and Advisory Council described early on in this document, Coalition meetings and multiple staff sit on a variety of State and local committees throughout the State.

We continue to be committed to educating Delaware children youth and families about parity and raising awareness and would welcome the expertise to strengthen our communication with Delaware children and families.

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for 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 medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. 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.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

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

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders 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 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[89] ,

> "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 array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

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

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

13. – Crisis Services

ADULT BEHAVIORAL HEALTH SYSTEM

The Division of Substance and Mental Health offers a continuum of Crisis Intervention Services. These services are located throughout the State in the Crisis Intervention Service Centers, the Community Mental Health Centers, the Recovery Response Center and Emergency Rooms. Crisis Intervention Service (CIS) staff are available 24 hours a day to assist people, 18 years and older, with severe personal, family or marital problems. These problems may include depression, major life changes such as unemployment or loss of an important relationship, anxiety, feelings of hopelessness, thoughts of suicide, delusions, paranoia and substance abuse.

The goal of CIS is the prevention of unnecessary or inappropriate hospitalizations of a person experiencing severe symptoms of a mental illness or substance related problem. By providing services in the community, CIS staff can better assess the consumer's environment, support systems and current level of functioning. They can gain a clear understanding of type of treatment and support services that will be needed.

CIS Staff are also co-located in the Crisis And Psychiatric Emergency Services (CAPES) unit at Wilmington Hospital Emergency Department as part of a joint venture with Christiana Care Health System and DSAMH. Crisis Staff also operate under a Memorandum of Understanding with St. Francis Hospital to provide mental health and substance use evaluations and assist with discharge planning as requested by the Emergency Department Staff.

In addition to these services the crisis staff work in conjunction with every police department throughout the state, providing training in police academies, individualized roll call trainings and assisting in the evaluation of persons picked up on criminal charges who may require mental health evaluations and who may be appropriate for the State's Mental Health Courts.

CHILD BEHAVIORAL HEALTH SYSTEM

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is 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. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

SECTIONIV - Narrative

Step M. – Recovery

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES
CHILD BEHAVIORAL HEALTH SYSTEM:	YES

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?	
ADULT BEHAVIORAL HEALTH SYSTEM:	Individuals receiving block grant funded serves take part in person-centered care management where they actually help determine and direct the appropriate level of care and the services delivered to them.
CHILD BEHAVIORAL HEALTH SYSTEM:	

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – Peer-delivered services are a major component of the service delivery to specific populations in Delaware. Of the populations listed above, the largest gains can be made in the area of veterans. Currently DSAMH utilizes client provided identification of veteran status to appropriately assist clients and when appropriate refer them to the Kirkwood Highway Veterans Administration Center located in Wilmington, DE.
CHILD BEHAVIORAL HEALTH SYSTEM:	YES- DPBHS system has always been designed to meet the needs of people with a history of trauma. However recently we have expanded our focus through our GLS grant to targets veterans, military families and LGBTQ populations.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run

services?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – The training is offered through the DSAMH Training Department. The trainings are coordinated by the DSAMH Director of Consumer Affairs and the DSAMH Training Department.
CHILD BEHAVIORAL HEALTH SYSTEM:	YES- DPBHS provides a plethora of training as described throughout the application for the professional work force as well as for our providers in DPBHS continuum of services.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES
CHILD BEHAVIORAL HEALTH SYSTEM:	YES

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).	
ADULT BEHAVIORAL HEALTH SYSTEM:	As a primary proponent of consumer recovery and full inclusion in the community, DSAMH will take further steps in 2016 to provide consumer employment opportunities, and engagement in planning activities. Throughout the ACT/ICM and PROMISE sites, consumers increase the skills of daily living and social functioning of consumers and are encouraged to expand their role in community life, particularly in the areas of social relationships, work and school. Recovery plans that are monitored in ACT/ICMs are consumer-centered and responsive to individual, cultural and linguistic needs. Delaware's adult behavioral health system is a team based service system that provides consumers with access to a variety of the disciplines relevant to their rehabilitation and recovery services regardless of where they are in the continuum. The end result is that the consumer is afforded the opportunity to establish relationships to support their recovery. The majority of behavioral health services are delivered

	to individuals in a community setting, i.e., in vivo, and not "on-site." The end result of this transformational activity is that the consumer's recovery process occurs in the least restrictive manner; promotes social connectedness and functionality as keys to recovery process; .and affords family members and other interested persons increased opportunities to participate in the consumer's recovery process. Delaware's behavioral health system includes a consumer ombudsman that provides consumers with a ready means for making complaints or stating concerns regarding provider services and staff behavior. The goal is to provide a forum in which to present and mediate client concerns and to ensure that clients are seen and treated as "managing partners" in their treatment design and delivery. DSAMH is continuing to work on an automated system that will allow tracking of complaints and concerns. This system will result in better management of providers. Additionally, there is strength in volume. If a consumer's complaint has been heard several times regarding a specific issue it provides more strength to the process of change with the provider. Consumers should have the ability to see and make determinations of which providers are delivering services at a level to their liking when making a service provider choice. Previously, DSAMH reorganized the Office of Consumer Relations, the goals of which are to increase the planning role of consumers in the Division's program planning and evaluation process; to ensure a consumer voice in contract development and monitoring; and to provide a forum in which consumer complaints, suggestions and concerns can be heard and effectively acted upon. The Division is currently developing a computer based tracking system for complaints. During this grant cycle the Peer Specialists program will be supplemented by a Peer Navigators and increase opportunities to promote shared decision making and assist the consumer in directing their care. Peer Specialists routinely work with consumers and their families in refining their recovery goals. DSAMH employs consumer-interviewers as part of the Consumer Client Satisfaction Survey, and provides

	training on consumer advocacy to enhance planning for community integration and supports. The DSAMH supported the development of the consumer-run Rick Van Story Resource Center. DSAMH has included the utilization of peers in a majority of new solicitations for proposals to acquire DSAMH contracts.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS attempts to use our Advocacy and Advisory Council to involve youth and families in the planning, delivery and evaluation of behavioral health services. The Teen Summit is developed by teens for teens. This statewide conference is planned by teens with staff support.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES
CHILD BEHAVIORAL HEALTH SYSTEM:	YES

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH utilizes the annual collection of data via the Consumer Satisfaction Survey measure and track the impact of the Division's consumer activities
CHILD BEHAVIORAL HEALTH SYSTEM:	

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.	
ADULT BEHAVIORAL HEALTH SYSTEM:	Delaware has understood the value of smoking cessation for almost a decade. Dating back to 2008, Delaware has been smoke free on state grounds and in state facilities. DHSS/DSAMH has been a leader in forwarding the smoking cessation agenda to state-funded behavioral health providers throughout the state. Behavioral health facilities regularly screen and assess for nicotine dependence. Delaware's most prevalent example of integrated service delivery will take place at the state operated

	PROMISE sites. Among the array of integrated health care services offered at the PROMISE sites are prevention and wellness education; health risk assessment for hypertension, heart disease, high cholesterol, diabetes; and Peer support programming.
CHILD BEHAVIORAL HEALTH SYSTEM:	SAME AS ABOVE

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH continues to create new integrated housing opportunities for persons with SPMI. The creation of these opportunities is the result of collaboration with Department of Health and Social Services sister agencies and the State Housing Authority. The end result is a completely state-funded voucher program that provides housing opportunities for the targeted population. The program operates utilizing the Housing First evidence based model.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBH utilizes a service system that places primary responsibility for housing the population with the client's parents. It is our goal that all children in our care will live with their families or in family-like settings and that this "housing plan" will be interrupted only for periods of time during which it is clinically necessary for the child to receive intensive and restrictive treatment services in a 24-hour residential or hospital program.

11. Describe how the state is supporting the employment and educational needs of individuals served.	
ADULT BEHAVIORAL HEALTH SYSTEM:	As previously stated, all clients served via Block Grant funds develop person-centered care plan. Part of the development of those plans includes assessing the education and vocational goals and needs of the consumer.
CHILD BEHAVIORAL HEALTH SYSTEM:	

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

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 substance abuse and mental illness 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 arrangement appropriate 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 of 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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

17. – Community Living and the Implementation of Olmstead

Delaware Olmstead activities have been specifically targeted towards achieving the performance markers established via the voluntary Settlement Agreement between the State of Delaware and the U.S. Department of Justice.

U.S. Department of Justice vs. State of Delaware

The lawsuit, filed to compel Delaware's compliance with the *Americans with Disabilities Act* (specifically, the Supreme Court Olmstead lawsuit opinion) concerns the civil rights of individuals with serious and persistent mental illnesses (SPMI) who are served in Delaware's public programs. The Court appointed a Monitor who reports every six months on his findings and recommendations relating to the State's progress toward compliance. The Settlement Agreement was signed July 15, 2011, and is in effect for a period of five years.

Delaware is currently on schedule to meet or exceed all performance markers under the Settlement Agreement. This document includes the most recent Settlement Agreement Implementation Report (July 15, 2015). The Implementation Report provides the narrative information requested in the guidance for the completion of this section.

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health 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.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

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.[93] 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 liaison 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 more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders 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's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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

[91] 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.

[92] 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.

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

[94] 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.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women, Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

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

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

20. – Suicide Prevention

The Delaware Suicide Prevention Plan was developed by the Delaware Mental Health Association. The document can be obtained by visiting http://mhainde.org/wp/wp-content/uploads/2014/05/Delaware-Suicide-Prevention-Action-Plan.pdf. The Plan is valid beginning July 2013 and concludes July 2018.

Environmental Factors and Plan

21. Support of State Partners

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 mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local 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 emergency management/homeland security 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 consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

21. Support of State Partners

In the dual capacity as the SSA and SMHA, the Delaware Division of Substance Abuse and Mental Health (DSAMH) must rely on positive relationships with multiple agencies throughout the Delaware service system. Cooperative agreements and/or memorandums of agreement with the Department of Prevention and Behavioral Health; The Division of Services for Aging and Adult Populations; Delaware Housing Authority; Division of Medicaid and Medical Assistance, Delaware Department of Education, Delaware department of Insurance, The Delaware Mental Health Association, The National Alliance for the Mentally Ill; and the Delaware Department of Labor highlight some of the most instrumental relationships to achieving the goals established in the agency's strategic plan.

Environmental Factors and Plan

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

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 mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, 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 abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, 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.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

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.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe 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.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] 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.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

ENVIRONMENTAL FACTORS & PLAN

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

ADULT BEHAVIORAL HEALTH SYSTEM

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

The (GAC) to the Division of Substance Abuse and Mental Health was re-classified via State codification to be representative of the entire Behavioral Health System in Delaware. This effort was not one that was easily accomplished as each member of the committee is Governor appointed and in accordance with State legislation. DSAMH worked with the Chair of the (GAC) to add Substance Abuse Prevention and treatment to the Committee's oversight.

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

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

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

State's legislative bodies on issues relevant to substance abuse and mental health.

CHILD BEHAVIORAL HEALTH SYSTEM

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

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

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

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

Primary sources of planning input to DPBHS

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

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Anthony Brazen	State Employees	Medicaid	Div of Medicaid & Medical Assistance, 1901 N. Dupont HWY New Castle, DE 19720 PH: 302-255-9620	anthony.brazen@state.de.us
Andrea Guest	State Employees	Vocational Rehabilitation	4425 N. Market Street Wilmington, DE 19802 PH: 302-761-8275	andrea.guest@state.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
James Lafferty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health Association	100 West 10th Street, Suite 600 Wilmington, DE 19801 PH: 302-654-6833	JLafferty@mhainde.org
George Meldrum, Jr.	Individuals in Recovery (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
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
John Akester	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4900 Limestone Road Wilmington, DE 19808 PH: 302-239-1798	akester2@aol.com
Janice Jolly	Providers		218 West 35th Street Wilmington, DE 19802 PH: 302-764-7781	jjollygirl@yahoo.com
Steven Hagen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		21116 Arrington Drive Selbyville, DE 19975	steven.hagen@hotmail.com
Current Vacancy 2 Current Vacancy (Advocate)	Others (Not State employees or providers)		Newark, DE 19702 PH: 302-369-1501	
Susan Phillips	Parents of children with SED		414 Evergreen Circle Milford, DE 19963	ss.phillips@verizon.net
John Evans	State Employees	Delaware State Police	PO Box 430 Dover, DE 19903 PH: 302-739-5911	john.evans@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
Patricia Ayers	State Employees	Department of Education	John G. Townsend Building, Suite 401, Federal Street Dover, DE 19901	drozumalski@doe.k12.de.us

			PH: 302-735-4108	
Thomas Hall	State Employees	DHSS/Division of State Service Centers	1901 N. Dupont Hwy New Castle, DE 19720 PH: 302-255-9605	
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

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies		
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* 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:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Dr. Gerard Gallucci
Delaware Health & Social Services
1901 N. Dupont Highway
New Castle, DE 19720

Dear Dr. Gallucci:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Cliffvon Howell
James Lafferty

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory