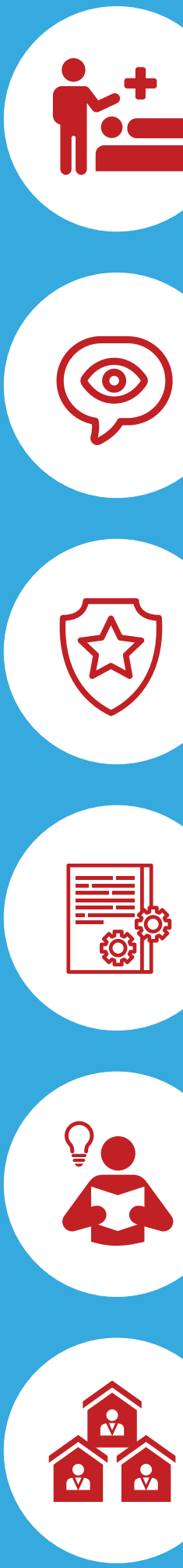
# Behavioral Health Consortium

# THREE-YEAR ACTION PLAN

BHC+

Behavioral Health Consortium

May 2018



# TABLE OF CONTENTS

# A Special Thank-You

We would like to express our appreciation and gratitude to all of the individuals who shared their personal stories with us over the last six months. Your courage, spirit, and drive to make a difference inspire us all.

To the nearly 600 Delawareans who took part in the concept-mapping process in all three counties — including those in recovery, family members of those who have lost their battle, providers, law enforcement, researchers, elected officials, and interested community members — we thank you for your ideas, suggestions, and feedback. Your input helped lay the groundwork for this first report.

To all of the Consortium members and stakeholders who have been a part of this process from the beginning, we thank you for your dedication and passion to make change and save lives.

Thank you to the multiple agencies, divisions, and partners that helped provide leadership and support to us throughout the last six months:

---

- **Delaware Division of Public Health**
- **Delaware Division of Substance Abuse and Mental Health**
- **Delaware Department of Services for Children, Youth, and Their Families**
- **Delaware Department of Safety and Homeland Security**
- **Concept Mapping Systems, Inc.**

---



## Governor Carney,

**Bethany A. Hall-Long, PhD, RN**
*Lieutenant Governor*
*Chair, Behavioral Health Consortium*

As chair of the Behavioral Health Consortium, I respectfully submit to you this initial report, which details and outlines the recommendations addressing both the addiction epidemic and behavioral health in Delaware.

We are tragically reminded every day of the effects of this epidemic, as our death toll continues to rise. Each year, the number of deaths attributable to overdoses of opioids and heroin is higher than the last. Delawareans are exhausted and exasperated by a system that does not serve them efficiently or effectively. The efforts of our state agencies have not been able to keep pace with the rapidly growing devastation this disease has caused. Uncoordinated efforts have left families and communities without direction or assistance — or any help at all.

As you noted in your ***Action Plan for Delaware***, our citizens need a statewide integrated plan for addressing the prevention and treatment of mental health and addiction. We know that we cannot do it alone. We realize we have to approach this with the understanding that addiction is a disease and is directly related to a person's overall wellness and behavioral health. We also understand that any meaningful solutions are going to require the engagement of our full community. We cannot rely on state officials alone. We need a coordinated and comprehensive plan that includes all the stakeholders in this fight.

Since the first meeting, the Behavioral Health Consortium has held community forums throughout Delaware. During this time, we have engaged over 600 community members representing those in recovery and their families, community and civic leaders, educators and law enforcement, and health officials and practitioners. Each told us their story of how both addiction and behavioral health have impacted their lives. Consortium members listened and learned as parents described learning of their child's addiction and the harrowing journey of trying to get them treatment. They listened as law enforcement described responding to the same individual for overdosing for the 14th time.

It is time to put ideas to action. The recommendations included in this initial report come directly from the community. They are based on the direct feedback of those with firsthand experience dealing and living with addiction and mental health, and navigating a fractured system of treatment available in Delaware. These recommendations are an initial roadmap to address this epidemic and the long-term behavioral health challenges our state faces. It will help build a solid and sustainable future for our state and improve health outcomes.

Sincerely,

Bethany A. Hall-Long

**Bethany A. Hall-Long, PhD, RN**
*Lieutenant Governor*
*Chair, Behavioral Health Consortium*

# Executive Summary

## BACKGROUND

The formation of the Delaware Behavioral Health Consortium was first proposed by Governor John Carney in his Action Plan for Delaware, and signed into law on July 16, 2017. The Consortium, created by the passage of Senate Bill 111 under the leadership of Lt. Governor Hall-Long, Senator Townsend, and Representative David Bentz, was formed to tackle Delaware's challenging and complex issues around addiction and mental health. In Delaware, like in many states across the nation, the statistics paint a troubling reality. Over 30,000 adults, 9,000 adolescents, and more than 82 percent of our prison population struggle with mental illness or substance use disorder. Nationally, 11 is the average age of onset of a behavioral health disorder, and 22.5 percent of the general population are struggling with mental illness. Unfortunately, far too many Delawareans do not seek treatment, do not know where to turn for help, or do not have the resources available to get the help they need.

## PURPOSE

Since the first meeting in October 2017, the Consortium has focused on creating a streamlined approach to improving Delaware's behavioral health system by tying together the numerous public and nonprofit bodies, efforts, initiatives, and commissions that are currently in place and creating both short-term and long-term strategies to save lives and expand access to services.

The 25-member Consortium and multiple stakeholders have met a total of five times and conducted a series of statewide community listening forums, which will be referenced in greater detail throughout this report. The Consortium, through a number of public meetings and focus-group settings, has worked with the local community to identify the most pressing issues currently facing the state in the behavioral health arena.

## NEXT STEPS

Within this first report, a multiyear strategy will be outlined, which highlights the need to combat addiction, increase integration of services, develop a strong workforce pipeline, eliminate the stigma of behavioral health, and prevent future Delawareans from struggling with addiction and a lack of needed services. The Consortium members are dedicated to this work and are eager to recommend a plan of action that will focus on systemic change, improved quality integration, and the continued evaluation of outcomes and improvement to Delaware's behavioral health system.



# Understanding the Issues

## COMMUNITY LISTENING FORUMS

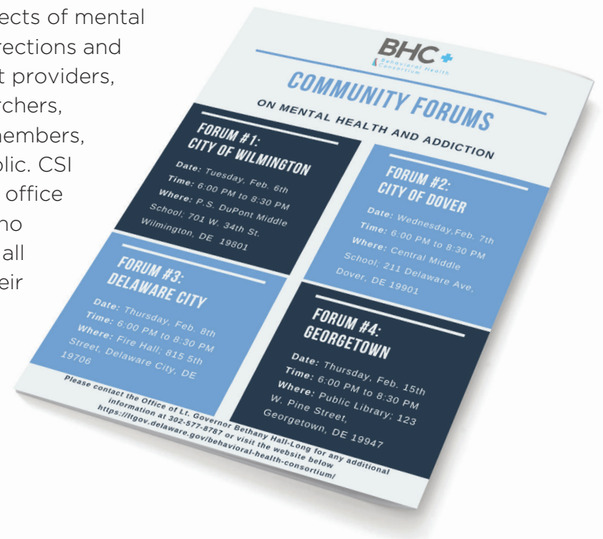
To better understand the issues and needs of communities throughout Delaware, the Behavioral Health Consortium convened and hosted four statewide community listening forums in Wilmington, Dover, Delaware City, and Georgetown during the month of February 2018. Concept Systems, Inc. (CSI), a social research and community action organization, supported the meetings, and hosted a two-question internet survey and an email link to elicit additional feedback from those who may not have been able to attend a session.

The two questions that individuals at the forums were asked to focus on, and that made up the survey, were:

1. **When you think about mental health and addiction (behavioral health), how behaviors affect health, and how people feel about their health where you live, what is happening in your community?**
2. **What is the most important thing we in Delaware can do to deal with mental-health-related issues and the issues we are facing in behavioral health that we talked about in Question #1?**

Over 600 people attended statewide grassroots sessions and were asked the guiding questions above. The sessions generated over 1,000 responses to each of the questions. Data collected in response to Question #1 contained more than 520 individual items. Data collected in response to Question #2 contained over 600 individual comments and recommendations.

Attendees included community members who have suffered loss or have experienced the effects of mental illness or addiction in their own lives, corrections and law enforcement professionals, treatment providers, elected officials, educators, clergy, researchers, counselors and advocates, Consortium members, and other interested members of the public. CSI and the staff of the lieutenant governor's office were assisted by volunteer facilitators, who helped support the process by engaging all attendees and eliciting descriptions of their experiences and knowledge of the issues of what is happening in the communities of Delaware.

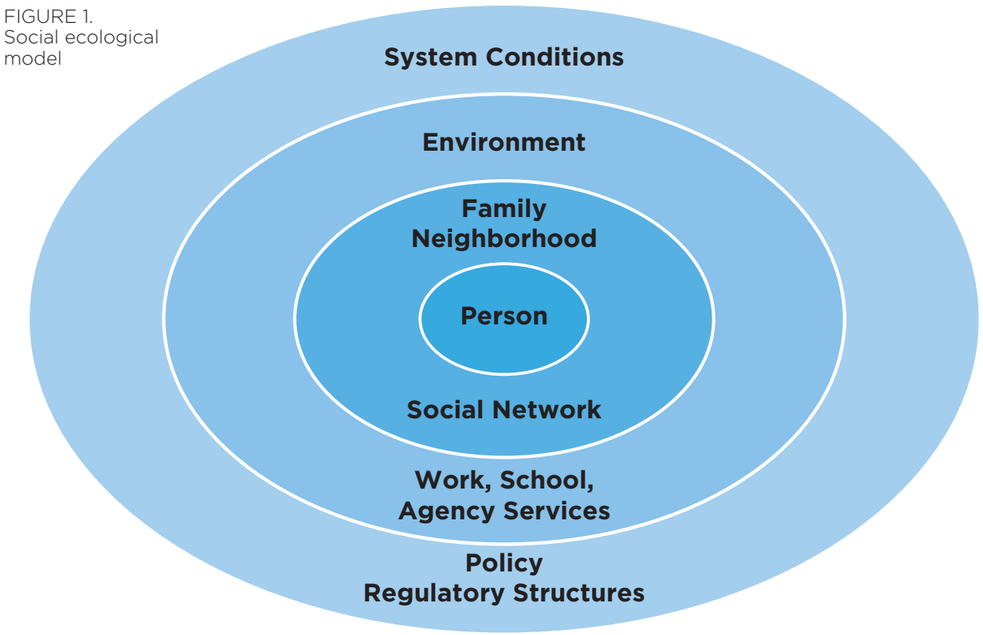


# Community Forum Finds

## Question #1: What Is Happening in Your Community?

A qualitative content analysis and topic identification of all items collected was conducted in response to the first question. To organize the many ideas and issues described by community members and representatives of related organizations, the feedback is framed in the context of the Social Ecological Model for public health.[1] Figure 1 is a basic social ecological model.

FIGURE 1.
Social ecological model




The picture that attendees painted of the issues they see in their neighborhood included elements that are specific to the personal experience of an individual and the conditions that exacerbate a person's ability to manage their environment and its challenges. Family, neighborhood, and community influences are present, as are those that are related to a higher social and enterprise structure, including work, school, and systems of support. Community members also clearly described system conditions, systemic embedded elements, and policy-related issues.

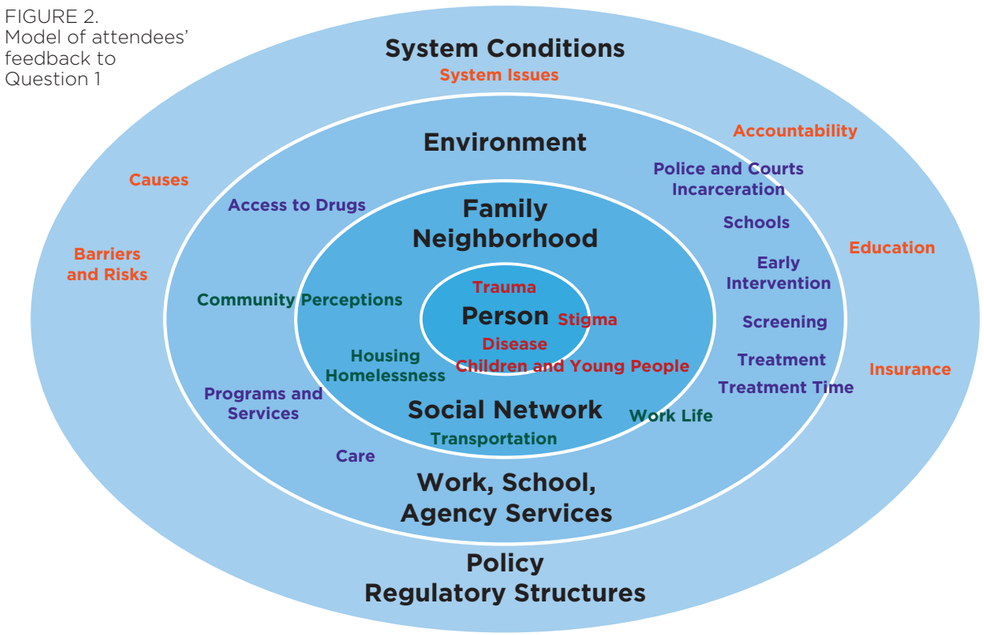
[1] Adapted from the Centers for Disease Control and Prevention (CDC), The Social Ecological Model: A Framework for Prevention, http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html.



## The Behavioral Health Issues Model

The picture below in Figure 2 shows the array of topics discussed at the Community Listening Forums, which describe what is going on in the attendees' communities. Some topics overlap areas of the framework, to show their presence in more than one part of the picture. In the following section, the focus is on each part of the model, describing the topics that, from the data collected, expressed attendees' concerns about that area.

FIGURE 2.
Model of attendees' feedback to Question 1

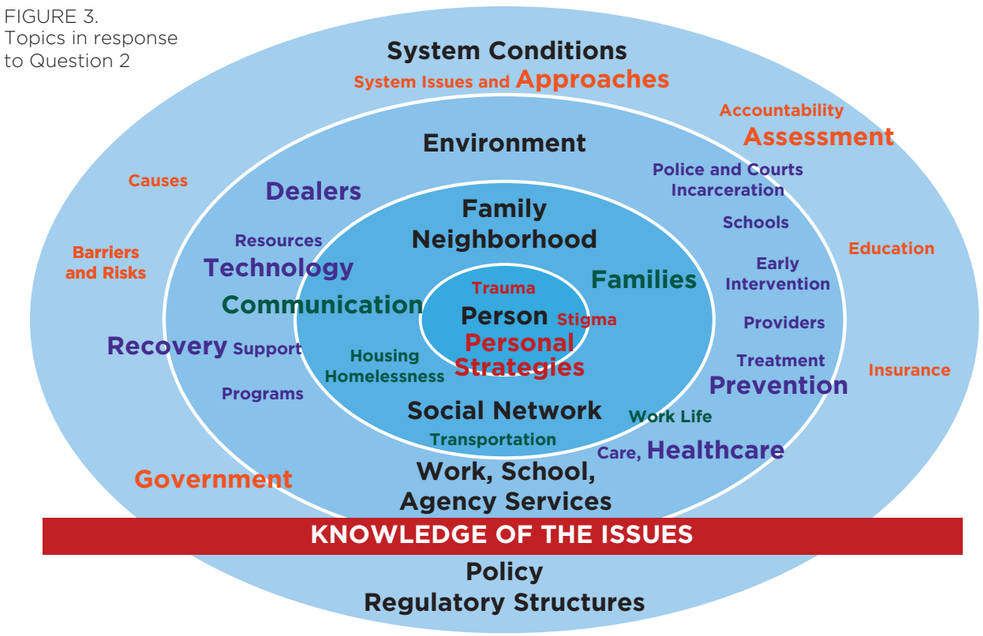


# Community Forum Finds

**Question #2: What is a specific thing we in Delaware can do to deal with the issues we are facing in our state's behavioral health, including mental-health-related issues and addiction?**

As previously mentioned, Question 2 produced over 600 action recommendations that address many of the issues raised in Question 1. Figure 3 is a model similar to the one used on the last page, indicating what topics the feedback touched upon, and that are the same as those on page 9.

FIGURE 3.
Topics in response to Question 2




Issues were then rated and sorted by members of the community to determine both the importance and feasibility of the recommendations. Those recommendations and action items will be broken out by topic area and time frame in the following sections of the report.



# THREE-YEAR ACTION PLAN

## ACCESS AND TREATMENT

## CHANGING PERCEPTIONS AND STIGMA

## CORRECTIONS AND LAW ENFORCEMENT

## DATA AND POLICY

## EDUCATION AND PREVENTION

## FAMILY AND COMMUNITY READINESS

"As an ER doc, I have seen the impact the opioid crisis has taken on families and communities. It's been enlightening and exciting to bring the stakeholders to the table to discuss what's most important. There are so many aspects we are addressing, from providers' prescribing habits to finding new treatment avenues."

**SANDY GIBNEY, MD,** *Emergency Room Physician, St. Francis Hospital*

**Ensuring adequate resources, capacity, and high-quality treatment should be a top priority for every behavioral health system across the state. Looking to expand treatment resources, which increase access for individuals, is critical.**

*State entities are listed as responsible parties. Note that private and nonprofit partners are critical to the success of many of these actionable items.

| Insurance, Regulations, and Reimbursement | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Support mental health parity.<br>• Facilitate mental health parity legislation. | Office of the Lt. Governor, General Assembly, Behavioral Health Consortium, Department of Insurance | Year 1 |
| Educate the public on insurance availability and options.<br>• Link to public awareness campaign under education and prevention campaign. | Behavioral Health Consortium, Department of Insurance, Medicaid | Year 1 |
| Reduce disparity between cost of Medication Assisted Treatment (MAT) for Medicaid vs. private insurance. | Department of Insurance, Medicaid, Behavioral Health Consortium | Year 2 |

| Insurance, Regulations, and Reimbursement (Cont.) | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Reduce disparity between cost of medications/psychopharmacology for Medicaid vs. private insurance. | Department of Insurance, Medicaid, Behavioral Health Consortium | Year 2 |
| Adopt pay-for-value initiatives in opioid use disorder treatment, including bonuses and penalties for quality metrics and payment methodologies that reward positive outcomes within Medicaid population. | Behavioral Health Consortium, Medicaid, DSAMH | Year 2 |
| Explore and develop revolving loan repayment program for treatment services. | Behavioral Health Consortium, Office of the Lt. Governor, DSAMH, Division of Public Health | Year 2 |
| Evaluate and change reimbursement strategies for behavioral health, including therapy and counseling services. | Behavioral Health Consortium, Department of Insurance, Medicaid, DSAMH, DSCYF | Year 2 |

| Access and System of Care | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Implement Centers of Excellence for rapid intake and assessment, treatment with medication and counseling, peer-mentorship services, and access to chronic-pain management. | Department of Health and Social Services | Year 1 |
| Create an "Overdose System of Care." | Office of the Lt. Governor, General Assembly, Behavioral Health Consortium, Department of Health and Social Services, First Responders | Year 1 |
| Create and conduct geriatric behavioral health or substance use disorder evaluation and needs assessment for treatment. | Office of the Lt. Governor, Behavioral Health Consortium, DSAMH, Division of Health Care Quality, Division of Services for Aging and Adults with Physical Disabilities, Department of Correction | Year 1 |

| Access and System of Care (Cont.) | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Increase the capacity of the substance use disorder treatment system along the full continuum of care to meet the needs of Delawareans, including residential beds, recovery residences, and outpatient services to ensure high-quality, individualized care. | Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF, Department of Justice | Year 1 |
| Conduct and create youth education and treatment evaluation/needs assessment.<br>• Analyze plan for Youth Educational Treatment & Recovery Academy. | Behavioral Health Consortium, DSAMH, Department of Education, DSCYF | Year 2 |
| Ensure all students have access to state-supported mental health services. | Behavioral Health Consortium, Department of Education, DSCYF | Year 2 |
| Advocate for and increase telemedicine psychiatry to increase access in rural and underserved areas. | DSAMH, Office of the Lt. Governor, Behavioral Health Consortium, Department of Insurance | Year 2 |
| Evaluate current efforts to increase access of behavioral health providers by expanding insurance and pay-for-service options. | DSAMH, Office of the Lt. Governor, Behavioral Health Consortium, Department of Insurance, Medicaid | Year 2 |
| Evaluate, pilot, and develop key recommendations to support primary care settings and to ensure that they are adequately reimbursed for integrated behavioral health. | DSAMH, Office of the Lt. Governor, Department of Insurance | Year 3 |

| Treatment Options | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Increase access to Medication Assisted Treatment (MAT).<br>• Increase educational opportunities for primary care physicians, obstetricians, providers, emergency departments, and other appropriate entities. | DSAMH, Department of Correction | Year 1 |





| Treatment Options (Cont.) | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Develop a statewide community health worker network, which will focus on behavioral health. | Office of the Lt. Governor, Family Cabinet Council, Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF | Year 1 |
| Develop a peer-to-peer program statewide. | Office of the Lt. Governor, Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF | Year 1 |
| Substance-exposed infants.<br>• Continue postpartum screening program. | Department of Health and Social Services, DSAMH, DSCYF | Year 1 |
| Expand access to naloxone. | Behavioral Health Consortium, DSAMH, Division of Public Health | Year 1 |
| Expand the syringe services program and access to fentanyl testing strips. | Behavioral Health Consortium, DSAMH, Division of Public Health | Year 1 |
| Provide more crisis intervention, including mental health first-aid training for first responders and communities.<br>• Expand and enhance 24-hour crisis hotline for point of entry and referral. | Behavioral Health Consortium, DSAMH, DSCYF | Year 1 |
| Expand detox facilities.<br>• Explore options for adolescent-exclusive detox. | Behavioral Health Consortium, Department of Health and Social Services, Department of Correction, DSCYF | Year 1 |
| Expand trauma-informed and trauma-responsive care programming in a substantial and systematic way.<br>• Build upon the first lady's Compassionate (Trauma Sensitive) Schools Program. | Behavioral Health Consortium, DSCYF, DSAMH, Family Services Cabinet Council, Department of Education, First Lady Program | Year 1 |

| Treatment Options (Cont.) | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Support chronic-pain care management. | Behavioral Health Consortium, Addiction Action Committee | Year 1 |
| Evaluate and develop statewide Veterans Response Training (VRT) program. | Office of the Lt. Governor, New Castle County Police Department, Department of Safety and Homeland Security, Behavioral Health Consortium | Year 1 |
| Ensure behavioral health resources meet the needs of those with intellectual and developmental disabilities, with a focus on evidence-based approaches. | Behavioral Health Consortium, Division of Developmental Disabilities Services, Medicaid, DSAMH, DSCYF | Year 2 |
| Examine and study harm reduction measures, including safe consumption sites. | Behavioral Health Consortium | Year 3 |

| Workforce Development | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Expand both psychiatric and other in-demand workforce residency programs. | DSAMH, Behavioral Health Consortium | Year 1 |
| Use mobile van(s) to promote educational development and better health outcomes in the community (e.g., clinics, community health workers). | Behavioral Health Consortium, DSAMH | Year 1 |
| Evaluate subsidized professional training and loan forgiveness programs for providers to practice in state.<br>• Evaluate support for higher education institutions. | Behavioral Health Consortium, DSAMH | Year 3 |



# THREE-YEAR ACTION PLAN

ACCESS AND TREATMENT

CHANGING PERCEPTIONS AND STIGMA

CORRECTIONS AND LAW ENFORCEMENT

DATA AND POLICY

EDUCATION AND PREVENTION

FAMILY AND COMMUNITY READINESS

"We have an epidemic of loneliness. That's the thing I fight. I lived behind the buses and on the buses. I hung out at the library. I was dying of loneliness and was actively addicted. We have to invite the outcasts to the table. We have to have goals. We want to empower them — give them somewhere to go. Now they are nowhere. They are invisible. No one wants to help them. We look at them as pointless. We need acceptance."

**JIM MARTIN,** *Community Advocate*

**The barrier that stigma presents is one of the most challenging obstacles for an individual in recovery. This was regularly communicated both in the Behavioral Health Consortium's regular meetings and throughout the statewide community forums. The below recommendations are set forth to combat that stigma and work toward changing perceptions.**

*State entities are listed as responsible parties. Note that private and nonprofit partners are critical to the success of many of these actionable items.

| Barriers | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Cultivate relationships with the business community for job employment for individuals in recovery. | Behavioral Health Consortium, Office of the Lt. Governor, Addiction Action Committee | Year 1 |
| Ensure behavioral health resources are culturally competent, utilizing evidence-based approaches. | Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF, Department of Education | Year 2 |
| Evaluate hiring policies in workplaces regarding the need to disclose behavioral health history. | Behavioral Health, Consortium, Department of Human Resources, DSAMH | Year 2 |
| Educate and provide support to individuals in recovery on ways to reacclimatize after active addiction. | Behavioral Health Consortium, DSAMH | Year 2 |

| Communication and Messaging | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Educate public officials and community leaders on the stigma associated with behavioral health, to better influence policy making. | General Assembly, Behavioral Health Consortium, Office of the Lt. Governor | Year 1 |
| Support and implement "Project Purple," a statewide awareness and stigma campaign. | Sussex County Health Coalition, Behavioral Health Consortium, DSAMH, Division of Public Health, Office of the Lt. Governor, Department of Justice, Department of Education | Year 1 |
| Increase awareness and use of HelpIsHereDE.com. | DSAMH, Division of Public Health, Behavioral Health Consortium, Department of Justice, Department of Education, DSCYF | Year 1 |
| Evaluate opportunities to ensure treatment information is available via cellphone, hotline, or other technology, to give family and consumers quicker access to care. | Behavioral Health Consortium, DSAMH, Division of Public Health, Department of Justice, Department of Education, University of Delaware, DSCYF | Year 2 |

# THREE-YEAR ACTION PLAN

ACCESS AND TREATMENT

CHANGING PERCEPTIONS AND STIGMA

CORRECTIONS AND LAW ENFORCEMENT

DATA AND POLICY

EDUCATION AND PREVENTION

FAMILY AND COMMUNITY READINESS



"Inmates aren't being correctly evaluated before they are incarcerated. They are evaluated on the crime, but not on their mental health. Someone living outside the law — for example, using substances — has to be evaluated for the mindset, not just the crime."

**DEION WILSON,** *Community Advocate*

**Our correctional officers, law enforcement, and first responders are often the first contact for individuals who are struggling with a behavioral health crisis. The old-school "tough on crime" mindset and initiatives of the 20th century, where harsh sentencing and imprisonment were believed to fix crime, has systematically failed. For example, 82 percent of the state's current inmate population have a serious mental illness and an underlying substance use disorder, which require treatment services. Currently, the Department of Correction is the largest behavioral health provider in the state.**

*State entities are listed as responsible parties. Note that private and nonprofit partners are critical to the success of many of these actionable items.

| Training and Partnership Opportunities | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Increase training for correctional officers to better deal with individuals with behavioral health needs within our prison and probation population. | Department of Correction, Department of Safety and Homeland Security, DSAMH | Year 1 |
| Develop and increase stronger partnerships and coordination between police departments, school districts, and school resource officers to offer trauma-informed training. | Department of Safety and Homeland Security, Police Chiefs Council, Behavioral Health Consortium, DSCYF | Year 2 |

| Sentencing and Re-entry | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Medicaid status should be shifted from “termination” to “suspension.” | Department of Correction, Department of Health and Social Services, Medicaid, DSAMH, DSCYF | Year 1 |
| Standardize post-prison discharge treatment and wraparound service as a bridge to society, including transitional housing. | Department of Correction, Department of Health and Social Services, Housing Alliance Delaware, Criminal Justice Council, Medicaid, Division of Social Services, DSAMH, DSCYF | Year 1 |
| Expand MAT within Department of Correction. | Department of Correction, Department of Safety and Homeland Security | Year 1 |
| Study potential post-arrest avenues that would restore the rights of an individual who has a behavioral health diagnosis, to increase access to medical services/medication and job/labor markets. | Behavioral Health Consortium, Department of Correction, Courts, Criminal Justice Council, Department of Labor | Year 2 |
| Examine the “drug diversion program” and the sentencing for individuals with behavioral health diagnoses to explore treatment vs. prison time. | Behavioral Health Consortium, Courts, Department of Safety and Homeland Security, Department of Correction, Criminal Justice Council, DSCYF | Year 3 |

| Community Supports | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Allocate funds specifically to detection and intervention programs, and law enforcement diversion programs (e.g., pilot TRUST, Angel Program, HERO HELP). | Behavioral Health Consortium, Office of the Lt. Governor, DSAMH, Delaware Police Chiefs Council, Department of Safety and Homeland Security | Year 1 |
| Evaluate and develop statewide Veterans Response Training (VRT) program. | Office of the Lt. Governor, New Castle County Police Department, Department of Safety and Homeland Security, Behavioral Health Consortium | Year 1 |



# THREE-YEAR ACTION PLAN

"Over the past several years, Delaware has displayed progressive ideas in finding solutions to what is the public health crisis of the 21st century. Those ideas have been transferred into lifesaving legislation with passage of the 911 Good Samaritan Law and access to naloxone. We have passed legislation requiring parity for treatment of behavioral health and substance use disorder by both private insurers and Medicaid. The Behavioral Health Consortium will build on those efforts in gathering additional data from the community that has been affected, to determine root causes and work toward ending the unnecessary deaths and loss of life."

**DAVID HUMES,** *Parent Advocate*

**The Data and Policy Committee oversees any legislative action, collects critical data, and ensures that all other committees are receiving all requested data.**

*State entities are listed as responsible parties. Note that private and nonprofit partners are critical to the success of many of these actionable items.

## Data

| Task/Activity | Responsible Party | Time Frame |
|---|---|---|
| Create a statewide MOU for state agencies to share critical data related to behavioral health. | Behavioral Health Consortium, Office of the Governor, Office of the Lt. Governor, Cabinet Secretaries | Year 1 |
| Create a statewide MOU for nonprofits and entities that contract with the state to better share critical data related to behavioral health trends and statistics. | Behavioral Health Consortium, Office of the Governor, Office of the Lt. Governor, Cabinet Secretaries | Year 1 |
| Assess and expand overdose fatality data and determine what critical resources are needed in specific ZIP codes. | Behavioral Health Consortium, Drug Overdose Fatality Review Commission, DSAMH, High-Intensity Drug Trafficking Areas (HIDTA) program, Division of Public Health, Department of Safety and Homeland Security | Year 1 |

## Data (Cont.)

| Task/Activity | Responsible Party | Time Frame |
|---|---|---|
| Explore funding of infrastructure cost for health care claims data (all payers), focusing on mental health parity cost and programs.<br>• Work to modernize 42 C.F.R. Part 2. | Behavioral Health Consortium, Delaware Health Information Network | Year 1 |
| Explore, analyze, and look to improve the Prescription Drug Monitoring Program. | Behavioral Health Consortium, Division of Professional Regulation, Department of Safety and Homeland Security, Delaware State Police | Year 1 |

## Policy

| Task/Activity | Responsible Party | Time Frame |
|---|---|---|
| Evaluate resources for families and individuals who need involuntary treatment resources. | Behavioral Health Consortium, Office of the Lt. Governor, DSAMH, Division of Public Health, DSCYF | Year 1 |
| Evaluate alternative therapies for individuals in active recovery. | Behavioral Health Consortium, Addiction Action Committee, DSAMH, DSCYF | Year 1 |
| Support legislation that would ban powdered alcohol. | General Assembly, Behavioral Health Consortium, Office of the Lt. Governor | Year 1 |
| Explore options for funding, ranging from federal applications to settlements to state-based legislation (i.e., opioid assessment fee, etc.). | Behavioral Health Consortium, General Assembly, DOJ, Office of the Governor, Office of the Lt. Governor, Department of Health and Social Services | Year 2 |
| Conduct assessment of behavioral health and substance use disorder commissions and agencies to study any gaps or overlapping between entities. | Behavioral Health Consortium | Year 2 |

# THREE-YEAR ACTION PLAN

ACCESS AND TREATMENT

CHANGING PERCEPTIONS AND STIGMA

CORRECTIONS AND LAW ENFORCEMENT

DATA AND POLICY

**EDUCATION AND PREVENTION**

FAMILY AND COMMUNITY READINESS



"We're seeing the effects of trauma in children across the nation. They are responding with behavioral needs — and experimenting with drugs. Going in, we're having conversations across our state, getting a picture of what the true needs are. In the schools, we'll be able to reach as many children as possible, helping them connect with a caring adult — educators who are not just their teachers, but who have skillsets to better meet the students. My belief is if you can reach them, you can teach them."

**MICHELE MARINUCCI, EDD,** *Senior Director of Pupil Services, Christina School District*

**Providing education, prevention, and early intervention is critical to ensure that both mental and behavioral health issues are understood and addressed accordingly.**

*State entities are listed as responsible parties. Note that private and nonprofit partners are critical to the success of many of these actionable items.

| Partnership Opportunities | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Engage faith-based organizations to educate others about local resources and to provide a greater connection to services. | Behavioral Health Consortium, DSAMH, Healthy Neighborhoods Consortium, DSCYF | Year 1 |
| Implement the lieutenant governor's challenge to promote the improvement of physical and behavioral health for youth across the state. | Office of the Lt. Governor, Behavioral Health Consortium | Year 1 |
| Support and develop a "Green Alert" system for veterans in our community who are in crisis. | Behavioral Health Consortium, DSAMH, Veterans Commission | Year 1 |
| Support increased engagement of parents and guardians with schools through home mentors/community health workers and one-on-one interaction. | Behavioral Health Consortium, Local Education Agencies, Delaware Association of School Administrators, DSAMH, Department of Education, DSCYF | Year 2 |

| Training and Education | | |
|---|---|---|
| **Task/Activity** | **Responsible Party** | **Time Frame** |
| Implement and scale Botvin's LifeSkills Training and/or an alternative evidence-based curriculum for youth prevention. | Behavioral Health Consortium, DSAMH, Department of Education, Delaware Association of School Administrators, DSCYF | Year 1 |
| Promote a public campaign to increase education, prevention, and awareness around resources and stigma for suicide, addiction, mental health, alternative therapy, homelessness, and mindfulness. | Behavioral Health Consortium, Department of Health and Social Services, DSCYF, Office of the Governor, Office of the Lt. Governor | Year 1 |
| Implement evidence-based prevention strategies through the Healthy Neighborhoods Consortium. | Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF, Healthy Neighborhoods | Year 1 |
| Provide education on safer prescribing of opioids and improved pain management for the medical community. | Addiction Action Committee, Division of Professional Regulations, Division of Public Health, Behavioral Health Consortium | Year 1 |
| Offer basic behavioral health training to professional groups across the state. | Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF | Year 2 |
| Implement prescreening tools, which will assist with early detection of mental illness and substance use disorder. | Behavioral Health Consortium, DSAMH, Division of Public Health, DSCYF | Year 2 |
| Engage communities and provide education on the signs of behavioral health issues through community mentorship programs, peer-to-peer counseling, and training. | Behavioral Health Consortium, DSAMH, Division of Public Health, Healthy Neighborhoods, DSCYF | Year 2 |
| Evaluate "Helping the Helpers" program to provide counseling services for behavioral health workers who experience burnout and compassion fatigue. | Behavioral Health Consortium | Year 2 |
| Educate and provide training and resources for provider community to ensure better sucession planning to providers and caregivers. | Behavioral Health Consortium, DSAMH, DSCYF | Year 2 |



# THREE-YEAR ACTION PLAN

**Our families and communities play a critical role in supporting, educating, and fighting stigma for individuals who have a behavioral or mental health issue. Family and community readiness is what our families and communities need to better serve those experiencing an issue.**

*State entities are listed as responsible parties. Note that private and nonprofit partners are critical to the success of many of these actionable items.

## For the Families

| Task/Activity | Responsible Party | Time Frame |
|---|---|---|
| Collaborate with the Family Services Cabinet Council on behavioral-health-related programs. | Behavioral Health Consortium, Family Services Cabinet Council, Office of the Lt. Governor, Office of the Governor | Year 1 |
| Evaluate current efforts, review evidence, and offer educational programs to support families with a loved one in active addiction, with mental illness, or with other behavioral health issues. | Behavioral Health Consortium, DSAMH, Office of the Lt. Governor, Addiction Action Committee, Department of Education, DSCYF | Year 2 |
| Create a resource line for family members and caregivers that clearly outlines critical information, such as providers, insurance information, and potential cost. | DSAMH, Behavioral Health Consortium, Office of the Lt. Governor, Division of Public Health, University of Delaware, DSCYF | Year 2 |





## For the Communities

| Task/Activity | Responsible Party | Time Frame |
|---|---|---|
| With a focus on young people, identify arts, sports, culture, and recreation opportunities for community members — as well as safe places for community members to meet and participate in these activities. | Behavioral Health Consortium, Office of the Lt. Governor, DSAMH, Division of Public Health, Healthy Neighborhoods Consortium, DSCYF | Year 1 |
| Address issues around limited access to transportation. | Behavioral Health Consortium, Office of the Lt. Governor, Department of Transportation | Year 2 |
| Explore and provide holistic health-based programs, specifically targeting youth in areas of poverty. | Behavioral Health Consortium, Office of the Lt. Governor, Healthy Neighborhoods Consortium, DSCYF | Year 2 |
| Address and improve the safety and affordability of available housing for individuals in recovery. | Behavioral Health Consortium, Office of the Lt. Governor, DSAMH, Division of Public Health, Delaware State Housing Authority | Year 2 |

## Full membership list of the Behavioral Health Consortium:

| | |
|---|---|
| Bethany Hall-Long, PhD, RN | Lt. Governor |
| James Martin | Executive Director, ACE Peer Resource Center (Sussex Member) |
| Avani Virani | Medical Director, Highmark (Insurance Rep.) |
| Dr. Michele Marinucci | Director of Student Services, Woodbridge School District |
| Rebecca King | Nursing Director, Delaware Division of Public Health (New Castle Member) |
| David Humes | Board Member, AtTAcK Addiction (Nonprofit) |
| Dr. Emily Hauenstein | Senior Associate Dean for Nursing and Healthcare Innovation (Education Member) |
| Dr. Sandra Gibney | Emergency Department Physician, St. Francis Hospital |
| Tamera Fair | Chair, Wilmington HOPE Commission |
| Cheryl Doucette | Sussex County Health Coalition |
| Michael Bryson | Smyrna School District |
| Dr. Joshua Thomas | Executive Director, NAMI (Nonprofit) |
| Matthew Swanson | Chair, Delaware Center for Health Innovation (DCHI) |
| Susan Cycyk | Delaware Suicide Prevention Association |
| Dr. Terry Horton | Chief, Division of Addiction Medicine, Christiana Care Health System |
| Dr. Karyl Rattay | Addiction Action Committee |
| Wayne Kline | Police Chiefs Council |
| David Bentz | Delaware State Representative |
| Bryan Townsend | Delaware State Senator |
| Carolyn Petrak | Associate Executive Director, Ability Network of Delaware |
| Emily Vera | Executive Director, Mental Health Association of Delaware |
| James Ellison, MD, MPH, DLFAPA, | Christiana Care Health System |
| Elizabeth Romero | Director, Division of Substance Abuse and Mental Health |





STATE OF DELAWARE
BEHAVIORAL HEALTH CONSORTIUM

# ISSUES OUR COMMUNITIES EXPERIENCE THAT AFFECT BEHAVIORAL HEALTH, AND ACTIONS TO REDUCE BURDEN AND IMPROVE DELAWARE'S BEHAVIORAL HEALTH

**Executive Summary of Responses and Recommendations**

APRIL 20, 2018

Prepared for

Lieutenant Governor Bethany Hall-Long
Delaware Division of Substance Abuse and Mental Health
&
The Delaware Behavioral Health Consortium

by

Concept Systems, Incorporated

# EXECUTIVE SUMMARY OF RESPONSES AND RECOMMENDATIONS

On August 17, 2017 Governor John Carney signed legislation sponsored by Senator Bryan Townsend and Representative David Bentz to establish the Delaware Behavioral Health Consortium and the Addiction Action Committee. A coordinated plan for behavioral health, including the creation of the Consortium, is included in Governor Carney's Action Plan for Delaware. Lieutenant Governor Bethany Hall-Long chairs the Consortium and leads Delaware's efforts to identify priorities and improve behavioral health services.

The Behavioral Health Consortium will identify recommendations and policy proposals and consider organizational realignment opportunities for greater effectiveness and impact as the state works to change outcomes for Delawareans suffering with behavioral health issues. "Recommendations and actions steps will focus on systemic issues for improved quality integration and continued evaluation of outcome-based improvement across the State" (State of Delaware Office of the Lieutenant Governor Bethany Hall-Long, 2017).

To understand what Delaware residents and communities are facing relative to behavioral health, which includes mental health, opioid and other substance use and addiction, system issues and community issues, the Lieutenant Governor's office broadly publicized and convened four Community Listening Sessions. The meetings were also to gather residents' advice about what actions must or should be taken to change the current status of people and communities relative to behavioral health. Residents who were not able to attend had the opportunity to respond to a 2-question survey, or email responses. Over 300 people attended at least one session. 25 volunteer facilitators managed the discussions.

The two questions asked were:

1. When you think about mental health and addiction (behavioral health), how behaviors affect health, and how people feel about their health where you live, what is happening in your community?
2. What is the number 1 thing we in Delaware can do to deal with mental health related issues and the issues we are facing in behavioral health, that we talked about in question #1?

Data collected in response to Question #1 contained more than 520 individual items. Many redundancies exist in the set of comments, since they were collected at different events. Data collected in response to Question #2 contained over 600 individual comments; again, with redundancies. Concept Systems, Inc., the contracted research firm, was responsible for analysis of the information to yield a summary of responses to each question. CSI relied on the staff of the Lieutenant Governor's office to support the analysis with their feedback and guidance.

## Question #1: What is happening in your community?

The results of the responses to this question were mapped to a Centers for Disease Control *social ecological model,* which helps to show the effects on a person, family, community, agencies, and systems when conditions like addiction or dependence are present. The model below in **Figure E1** illustrates the main topics that individuals brought up. It was common to capture similar comments from different communities, indicating a widespread presence of the same issues throughout the state.





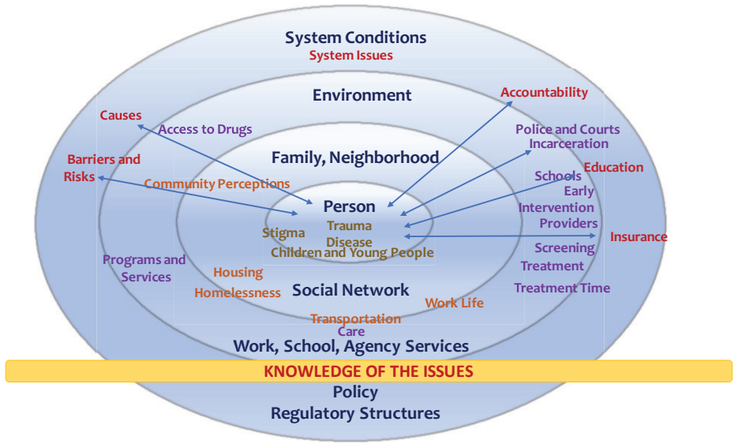



**Figure E1: Social Ecological Model of System Issues**

The figure contains the main topics that affect a community relative to behavioral health, that attendees raised in the listening sessions.

At the ***Person*** level, people experience trauma and co-occurring or difficult diseases that affect their resilience. Childhood trauma in particular was thought to be an influence. Individuals who are addicted and those who suffer from mental illness suffer stigma stemming from lack of knowledge and placing blame, according to attendees. The vulnerability of children and young people was especially called out.

At the ***Family and Neighborhood*** level, the breakdown of family and close relationships is noticeable. The emerging topics included *Community Perceptions, Housing, Homelessness, Transportation and Work Life,* and describe a person's security structure: work, home, and community.

*Community perceptions* of those with behavioral health issues, addiction, and mental health conditions reduce the ability of the person, the family and the neighborhood to rely on their own environment for support. "Not in my back yard" concerns contributed to lack of support. *Housing and Homelessness* indicates that those with addiction or behavioral health issues are destabilizing factors. Increased homeless means displacement and lack of access to care. *Work Life* challenges individuals; lack of jobs or opportunity, criminal background checks, and lack of access to only low paying jobs obstructs an individual's ability to recover. *Transportation* is related to self-determination and recovery.

At the level of the ***Environment***, or organizations and services either are effective or fail at integrating and ensuring the right services for the needs of the residents. Topics here include *Access to Drugs, Programs and Services, Treatment, Screening, Providers, Early Intervention, Schools, Police and Courts, and Incarceration. Access to Drugs* was a pervasive issue, described as everywhere in their communities; this includes increased use of fentanyl and over-prescriptions of legal drugs. *Programs and Resources* are undermined by lack of coordination, fragmentation and confusion for the person or family. Programs are short-sighted and not well enough funded for sustainability. Funds to tackle the issue are lacking. Specific populations thought to require help include children and parents who are

homeless, the elder population and veterans. Peer support, a potentially valuable program, does not exist in an organized way.

*Police and Courts* as a topic is critical to understanding the community's perceptions. Attendees said that police view an addict as a criminal; this is caused and compounded by lack of knowledge and tools for law enforcement to deal with those who are mentally ill or with addiction, or both. The court system is difficult to navigate and is not able to recognize addiction as an illness, so responds with jail sentences, which exacerbates and perpetuates the cycle that people experience relative to behavioral health. The effect of *incarceration* is devastating, and so pervasive as to be thought of as normal. For juveniles, incarceration can cause a spiraling effect.

*Schools* are counted on to provide mental health resources, guidance and interventions for children and their families. They are not equipped to manage these issues and have neither the resources or the training or staff to do so consistently. Early intervention is key.

*Providers* and *Care* are both limited; medical doctors, social workers and mental health professionals are not in sufficient supply in the state. Many are not sufficiently trained for the present issues; at the same time, caseload burden is high. Access to primary care or care continuum is lacking, causing individuals to "fall through the cracks" in the care environment.

*Screening, Treatment, and Treatment Time* describes the prevention and time-based treatment desires of the attendees, and the barriers associated with it. Insufficient opportunities to screen, emphasis on medication at the expense of positive behavior change, and medication without therapy were challenges. Medically Assisted Therapy is not universally available. Treatment access is uneven across the state, and lack of coordination for an individual's treatment creates missteps or misconnections, affecting the person's outcome. People experience significant wait times, an important barrier to improvement, and prescribed residential treatment is too short.

***System Conditions, Policy and Regulatory Structures***

The conditions that affect mental health and addiction at the system level are the *Causes, Barriers and Risks, Accountability, System Issues, Education* and *Insurance.* These high-level system conditions affect all levels of a person's experience. *Causes, barriers and risks* refer to social and societal issues, that, when not addressed, affect individuals and communities; such as accepted norms like bullying and greed, depression, drug or alcohol use. Deep social issues cannot be solved easily but must be recognized, and their impact on persons, families and communities must be understood. Systemic issues include poverty, gun violence, community trauma from disasters, man-made or natural. *Accountability* is lacking at all levels, from the person to the structural level. *Education* is the key ingredient to success but must be nurtured and provided fairly and fully. *Insurance* is a barrier to behavioral health; many who require treatment lack insurance or lack of specific coverage, denying access to timely and good quality treatment. *System issues* focused on what was called a fragmented system of red tape and disconnection.

***Knowledge of the Issues*** is a critical element in the topics that describe **what is happening in our communities.** Lack of knowledge troubled many attendees and included lack of formal learning about health and mental health, confusion about messages and how to decipher the truth from the array of conflicting information, lack of current and easily found information. Attendees expressed concern about accessing information, which might identify them as addicts or drug users.

As a bridge to Question #2 (what actions should we take?) ***Knowledge of Issues*** is a positive connector. Attendees felt that all must be educated about behavioral health, addiction and mental health in order to be able to affect the crisis: political representatives, educators, community leaders, neighborhoods, families and children.

The responses to Question #1 show the challenges facing individuals, families and communities in the current environment in Delaware, and highlight the issues that appear regardless of community. They are pervasive and critical to address. The next step in the process allowed us to then ask the question: what should we do?

## Question #2: What is a specific action we should take?

Ideas from the listening sessions and the electronic feedback processes produced over 600 specific ideas that answered the question: *What is a specific thing we in Delaware can do to deal with the issues we are facing in our state's behavioral health, including mental health related issues and addiction?* A qualitative synthesis produced a final set of 117 specific ideas that represented a wide range of feedback. To make a structured plan, we used Group Concept Mapping (Kane & Trochim, 2007), a well-regarded approach for participatory planning and prioritization.

About 150 people were invited to help organize and prioritize the 117 ideas, through individual sorting and rating. 46 people took part in the process. The *sorting* exercise allowed us to produce a *group concept map* of all ideas, a picture of all the ideas and their meaning relationship to each other. The idea map, or the *point map,* in **Figure E2** contains every idea; each idea's closeness to or distance from the other ideas is based on how the group of participants saw them as related, when their feedback was summed up.

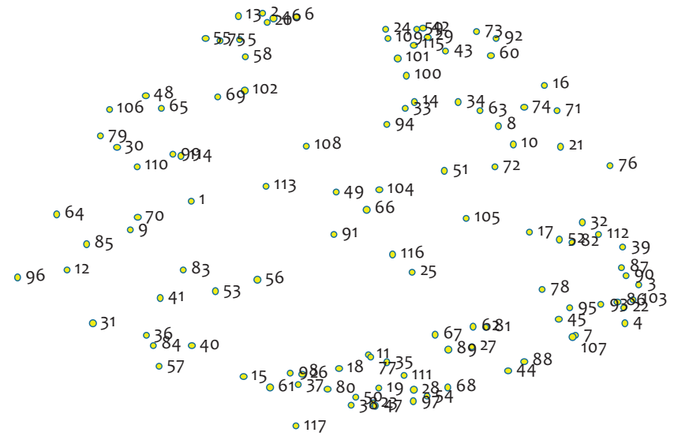


**Figure E2: The Point Map**

The *cluster map* in **Figure E3** shows the groupings of ideas by theme that the feedback produced.


**Figure E3: The Cluster Map with Labels**

The main concepts within the map, summed up from the ideas, are:

1. Our Children and Schools
2. Family Safety Network
3. Work Readiness
4. Legislation to Support Re-engagement
5. Regulations to Support Access
6. Resources
7. Treatment Access and Accountability
8. Treatment System
9. Changing Perceptions and Definitions
10. Education for Everyone
11. Readiness in Every Community.

Please note that the titles of these groups or ideas are to be finalized by the Consortium. The topics mirror the social ecological model, as do the themes related to Question #1. Personal, family and context issues, institutions and agencies, care and access, and policy are present in the group concept map, and show a system of thinking about action to change the current state.

To identify priorities and most-needed actions, an analysis of the ratings (Importance and Feasibility to Make Progress) was also conducted on each of the 117 ideas in the map, and averaged within each cluster or group. **Figure E4** is a picture of the ratings on Importance and Feasibility to Make Progress, and how they compare on each cluster.





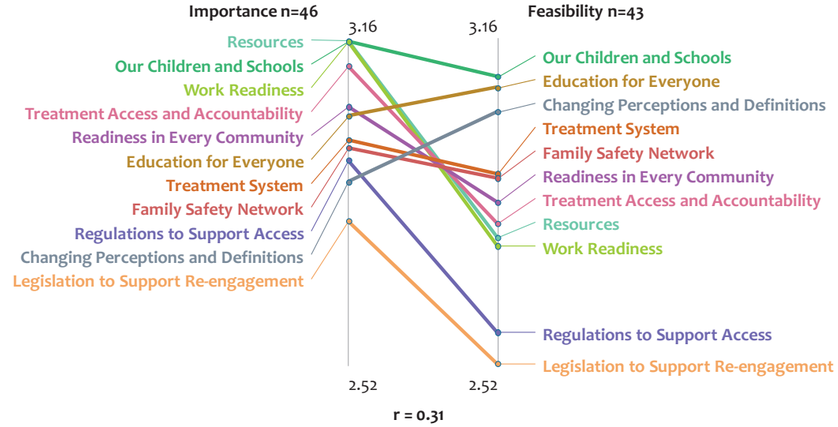



**Figure E4: Absolute Pattern Match Comparing Importance and Feasibility to Make Progress**

Concepts where Importance and Feasibility to Make Progress were similar in ratings include *Our Children and Schools, Education for Everyone, Treatment System, and Family Safety Network.* This tell us that participants thought that, on average, these major ideas were as feasible as they are important. Other clusters, or topics, that indicated a different alignment included some key areas, like *Resources and Work Readiness. Regulations to Support Access and Legislation to Support Re-engagement* were thought to be least feasible for progress.

For an action plan to be immediately applicable and effective, planners should review the values at an item by item level, within each group of ideas, looking at ideas that are *action-ready and action-critical.* Using the two ratings tells us what specific ideas or items are:

1. above average in both Importance and Feasibility to Make Progress,
2. lower than average in Importance but higher than average in Feasibility to Make Progress,
3. above average in Importance but lower than average in Feasibility to Make Progress, and
4. lower than average in both Importance and Feasibility to Make Progress.

These four lists are all included in the full report , on pages 31 through 35. Below we list only those that are above average in both Importance and Feasibility. This information provides important guidance to the Consortium, to consider where main opportunities to act exist, or could be developed. **Table E1** below, shows items that would likely demonstrate immediate progress.

| **Ideas by Cluster: Higher than Average Importance and Higher than Average Feasibility to Make Progress** | | | |
|---|---|---|---|
| **Cluster** | **Number. Idea** | **I** | **F** |
| **Our Children and Schools** | | | |
| | 2. Support schools to provide current information at the right levels for all grades, and for parents and guardians. | 3.39 | 3.31 |
| | 6. Work on prevention at all levels beginning with preschool through adulthood. | 3.54 | 3.26 |
| | 13. Provide age-appropriate education K-12 on decision making and life skills. | 3.23 | 3.26 |
| | 20. Begin intervention early in life with quality preschools that support, nurture and facilitate positive self-esteem, self-worth and conflict resolution skills. | 3.38 | 3.15 |

| | | |
|---|---|---|
| 58. Work with teachers and guidance counselors for students who are struggling with obvious issues, to help those students find proper health care. | 3.27 | 3.17 |
| 102. Provide early services for adverse childhood experiences and trauma. | 3.45 | 3.19 |
| **Family Safety Network** | | |
| 30. Increase training for correctional officers to better deal with population. | 3.00 | 3.07 |
| 79. Law enforcement and Emergency Department personnel need training on mental health issues, so it's not treated as a crime. | 3.27 | 3.31 |
| 99. Provide support to help families address things like enabling, co-dependency, treating the whole family and not just the addict. | 3.07 | 2.98 |
| 106. Ensure additional supports and training for alternative penalties for issues at schools instead of the disruption of expelling or suspending. | 3.07 | 2.95 |
| **Work Readiness** | | |
| 96. Require post-prison discharge plans as a bridge to society, including transitional housing. | 3.16 | 2.93 |
| **Legislation to Support Re-engagement** | | |
| 36. Allow non-violent felons to restore their rights, providing an incentive if they turn their lives around. | 2.84 | 2.56 |
| 53. Revamp the foster care system to include enriched mental health services for both child and family, such as multidimensional treatment foster care (MTFC). | 3.09 | 2.56 |
| 84. Urge judges to sentence addicts to treatment and not jail. | 3.13 | 2.79 |
| **Regulations to Support Access** | | |
| 18. Better process for regulating treatment agencies, including Medication Assisted Treatment providers and for-profit methadone clinics, to ensure they are achieving outcomes. | 2.78 | 2.79 |
| 37. Connect with nearby state licensing programs for mental health providers to increase ease for professionals to be licensed in Delaware also. | 3.18 | 2.90 |
| 98. Make credentialing quicker so that more providers would choose to practice in our state, thereby increasing access. | 3.14 | 3.05 |
| **Resources** | | |
| 11. Consolidate government resources for more effective use and better outcomes. | 3.27 | 2.90 |
| 19. Ensure programs are able to deliver the services they are promising, with more effective review. | 3.36 | 2.95 |
| 35. Ensure distribution of resources throughout the state, including downstate. | 3.27 | 3.02 |
| **Treatment Access and Accountability** | | |
| 81. Integrating services and resources for a comprehensive plan, to include a continuum of care system for the state. | 3.27 | 2.95 |
| **Treatment System** | | |
| 3. Ensure individuals have a solid plan for continuity of care with localized and continuous personal engagement. | 3.50 | 3.10 |
| 32. Include alcoholism identification and treatment as necessary components, since alcohol kills thousands per year. | 3.07 | 3.07 |
| 39. Build a toolbox of best practice strategies, using different treatment methods and activities that actually help, not enable. | 3.07 | 3.17 |
| 52. Integrate trauma-informed and trauma-responsive programming in a substantial and systematic way in order to keep problems from compounding. | 3.44 | 3.12 |
| 78. Provide advocates or treatment navigators to help and direct individuals and families in need of behavioral health services. | 3.09 | 2.98 |
| 86. Treat those who have problems with other drugs, including alcohol, in addition to opioids. | 3.13 | 3.26 |
| 90. Implement a systematic method for effective referral after screening for substance use. | 3.18 | 2.98 |
| 103. Be able to modify treatment models to meet individual needs. | 3.23 | 3.02 |
| **Changing Perceptions and Definitions** | | |
| 8. Communicate improvements as they occur and emphasize that care in-state is available and affordable so persons will seek care. | 3.07 | 3.12 |
| 10. Reorient conversations by elected officials and the media toward integrating mental health care with physical health care and the importance of screening. | 3.13 | 3.05 |
| 16. Ensure access to information through cell phone and other technology to promote 'help is here.' | 3.00 | 3.26 |
| 34. Provide training for how to deal with veterans. | 3.02 | 3.12 |
| 51. Mandate effective education to providers on pain management, addiction, and treatment to address inappropriate prescribing. | 3.24 | 3.20 |
| 74. Develop a guide to help with finding answers about services, money, insurance, facilities, and time requirements. | 2.91 | 3.12 |
| 76. Develop a website or phone line to act as a single point of entry to the system. | 3.07 | 3.23 |
| **Education for Everyone** | | |
| 24. Provide education for all on the signs of behavioral and mental health issues. | 3.20 | 3.27 |
| 29. Engage the community at all levels since this is a community issue. | 3.27 | 3.07 |
| 33. Recognize the link between homelessness, mental health struggles and substance abuse. | 3.22 | 3.46 |
| 42. Provide public education regarding the relapsing/remitting course of these illnesses and the science supporting the most effective treatments. | 3.11 | 3.07 |
| 59. Provide training to help people see the warning signs to reach people and reduce suicide. | 3.33 | 3.33 |
| 73. Continue and expand the messaging campaign to reduce stigma. | 3.07 | 3.29 |
| 109. Better education about mental health and substance abuse for the community, police, emergency personnel and professionals. | 3.35 | 3.48 |
| **Readiness in Every Community** | | |
| 104. Strengthen communities with more local services to address trauma, substance abuse, mental health, prevention and healthy behavioral supports in the environment. | 3.48 | 2.95 |
| 105. Provide more crisis intervention and early resources, including mental health first aid wherever needed. | 3.41 | 3.29 |
| 108. Implement pre-screening tools which are critical for early detection, including pediatric screening. | 3.25 | 3.10 |
| 113. Increase collaboration with state agencies, private sectors and non-profit organizations that focus on youth, through Delaware Youth. | 3.14 | 2.93 |
| 116. Develop a strong inpatient and outpatient rehabilitation program with work training and employment assistance. | 3.27 | 2.84 |

**Table E1: All Map Items High in Importance and High in Feasibility to Make Progress**

## Synthesis and Next Steps

Aligning the topics that Question #1 yielded with the group concept map structure (based on answers to Question #2) provides the Behavioral Health Consortium an immediately usable structure to consider what residents are experiencing, aligned with what actions can or should be taken, in an organized structure that can also serve as a committee and work group structure for the Consortium. **Table E2** below shows the topics aligned.

| Group Concept Map Cluster | Related Topics from Question #1 Feedback |
|---|---|
| **1. Our Children and Schools** | Children |
| | Person |
| | Personal strategies |
| | Schools |
| | Trauma |
| | Young people |
| **2. Family Safety Network** | Access to drugs |
| | Barriers and Risks |

| | |
|---|---|
| | Causes |
| | Environment /Context |
| | Families |
| | Programs/Services |
| | Support |
| **3. Work Readiness** | Work life/ Workforce |
| **4. Legislation to Support Re-engagement** | Housing |
| | Police, Court, Jails |
| **5. Regulations to Support Access** | Accountability |
| | Insurance |
| **6. Resources** | All |
| **7. Treatment Access and Accountability** | Disease |
| | Providers |
| **8. Treatment System** | Care |
| | Health care |
| | Screening |
| | Treatment |
| **9. Changing Perceptions and Definitions** | Community perception |
| | Data |
| | Knowledge about issues |
| | Stigma |
| **10. Education for Everyone** | Public awareness |
| | Public information |
| **11. Readiness in Every Community** | Early intervention |
| **All** | System, System Issues |

**Table E2: Cluster Map and System Issue Alignment**

This report can be readily used to support the Behavioral Health Consortium's planning and prioritization.

**The model that reflects responses to Question #1** provides the Consortium and the Administration with a current state, resident-authored description of conditions and experiences in Delaware that affect and hinder residents' behavioral health. The Question #1 section can be used to recognize the contributions of community members and to help related agencies in helping to focus their programs more effectively even in the short term.

**The Group Concept Map summing up Question #2** feedback is a solid, well-defined action framework for the Consortium and the Administration, and may guide other agencies to align on the issue. The clusters show a system of addressing the issue, and can help reduce the waste that siloed approaches often generate.

**The Value Ratings, comparing Importance and Feasibility to Make Progress** on every specific action idea, serves as a ready-to-use action agenda for each topic area and may suggest where more information is needed, or new partners required.





**We recommend** considering a committee structure that uses the map as the basis, combining clusters into topical regions to establish no more than 5 committees. A potentially useful arrangement might be as below:

- Children, Families and Neighborhoods (Clusters 1 through 3)
- Policy and Regulatory (Clusters 4 and 5)
- Care, Treatment and Services Integration (Clusters 7 and 8)
- Knowledge Development and Dissemination (Clusters 9 and 10)
- Resources (Clusters 6 and 11)

The Committees may then review all action items, with an emphasis on the high value ideas from the ratings feedback. Developing a time-based priority action agenda for each Committee would then allow systematic and manageable progress that would be easy to assess in terms of progress and impacts.

BHC+

Behavioral Health Consortium