Division of Substance Abuse and Mental Health

2014-2015 [DRAFT] Combined Behavioral Health Services Block Grant Application & State Plan

For Public Review

I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

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
Kevin

Last Name
Huckshorn

Agency Name
Division of Substance Abuse & Mental Health

Mailing Address
1901 N. Dupont HWY Main Administration Building

City
New Castle

Zip Code
19720

Telephone
302-255-9398

Fax
302-255-4427

Email Address
Kevin.Huckshorn@state.de.us

State CMHS DUNS Number

Number
134632624

Expiration Date

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

Agency Name

DRAFT DOCUMENT

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 CMHS Grantee of the Block Grant

First Name

Kevin

Last Name

Huckshorn

Agency Name

Division of Substance Abuse & Mental Health

Mailing Address

1901 N. Dupont HWY Main Administration Building

City

New Castle

Zip Code

19720

Telephone

302-255-9398

Fax

302-255-4427

Email Address

Kevin.Huckshorn@state.de.us

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

From

To

IV. Date Submitted

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

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Joseph

Last Name

Hughes

Telephone

302-255-9420

Fax

302-255-4428

Email Address

joseph.hughes@state.de.us

Footnotes:

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I: State Information

Assurance - Non-Construction Programs

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

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

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

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

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

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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

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I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

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

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

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

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

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

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

3. Certifications Regarding Lobbying

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

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

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Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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
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

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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

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.

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

DRAFT DOCUMENT

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I 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 I 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
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

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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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.

Name of Chief Executive Officer (CEO) or Designee	Kevin A. Huckshorn
Title	Director

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

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I: 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:

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II: 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.

Footnotes:

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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. Sixty-two percent of the state's population resides in New Castle County. The City of Wilmington, which is the state's largest city, is located within New Castle County and has a population of 72,195. 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 40% of the population. While the majority of Kent and Sussex counties are considered rural areas, the City of Dover, which is located in Kent County, is designated as an urban area.

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.

Based on the US 2010 Census population and updated estimates by the Delaware Population Consortium, the total state population is expected to reach 927,377 in the year 2014. 76.4% (708,516) of the population will be represented by individuals ages 18 and over, and 23.6% (218,860) of the population will be represented by children and youth (age 0 - 17). African-Americans will comprise 21.9% and individuals of Hispanic origin will comprise 8.4%[1] of the total state population.

From 2000-2007 Delaware saw over a 10% population growth and much of it has been driven by increases in minority populations (Delaware Population Consortium 2007). Over the next decade from 2010 to 2020, there is an anticipated 6% growth in both the 0

[1] Data on Hispanic origin is based on US Census Bureau figures. 2007-2011 American Community Survey

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– 9 year old and 10 – 19 year old populations in the State of Delaware (Kids Count 2008). 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. Delaware's population as of 2008 includes 80,528 living veterans, 3,249 of whom are under 30 and served in recent oversees conflicts. 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 2010 was $59,317. Delaware's major businesses include chemical, banking and financial services, healthcare and pharmaceutical industries. The single largest employer in SFY 2011 was the State of Delaware, while the Services Industries as a group employed the largest number of Delawareans. More than half a million business entities have their legal home in Delaware including more than 50% of all U.S. publicly-traded companies and 60% of the Fortune 500. Delaware maintained an unemployment rate of 7.7% as of March 2011[2].

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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

[2] State of DE Office of Economic Development website; http://www.dedo.delaware.gov/dedo_pdf/NewsEvents_pdf/publications/DEDO_Data_Book_March_2013.pdf

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

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

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

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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.**

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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 six discrete units: two acute care units of 18 beds each; a 28 bed geri-psych unit for mostly medically complex individuals with a history of a serious mental condition; a longer stay, 32 bed all male unit for persons who have stepped down from forensic settings, are labeled as sex offenders or who may be considered aggressive; 32 bed unit for persons who have co-occurring disorders including MH, SA, intellectual disabilities, and personality disorders and who are hard to place in the community; and a 42 bed Level Five forensic program. The Delaware Psychiatric Center's average daily census was 146 clients for the period ending – 6/30/2012.

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.

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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

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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

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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.

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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.

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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.

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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.

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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.

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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

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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

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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.

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.

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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

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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.

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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.

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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 Problem Gambling (DCPG)

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

Needle Exchange Program

During calendar year 2008, the Department of Public Health (DPH) began a pilot program in the City of Wilmington, located in New Castle County. The concept of Needle Exchange Programs comes from the public health concept of harm reduction. By providing clean needles to intravenous drug users 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.

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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.

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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 appointed 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. 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 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

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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 represents 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 2013, Delaware will be in the fifth year of the cooperative agreement. The SPF SIG contracts with 11 community based agencies to implement substance abuse prevention services. The SPF SIG also has two evaluation contracts, one for community assessment and evaluation support, and one for the State Epidemiological Outcomes Workgroup (SEOW), otherwise

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known as the Delaware Drug and Alcohol Tracking Alliance (DDATA). The SPF SIG continues to work with statewide prevention staff to develop comprehensive prevention efforts and enhance Delaware's prevention infrastructure through training and development.

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.

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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.

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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.

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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

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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

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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.

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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

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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.

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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.

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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.

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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

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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

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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

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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.

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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

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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.

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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).

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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

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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

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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.

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II: Planning Steps

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

Narrative Question:

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

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

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

Footnotes:

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SECTION II

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 2014-15 Combined Behavioral Health Services Block Grant, other grants, and Delaware General Fund State dollars. Some areas will need to be addressed in the 2014 and 2015 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 new memorandum of agreement between the two organizations and a shared housing resource between the two agencies is largely responsible for the improved coordination since the last CBHSBG Application and State Plan.

  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

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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 nearly 36 months ago that is mobile and available to do in home or community agency assessments and make treatment and support recommendations and provide services to try and maintain current placements of these clients. A recent award from the Department of Housing and Urban Development, under the Section 811 program will provide new housing opportunities for disabled persons, some with serious mental illness in Delaware.

- Peer Support Programs are fully implemented and 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 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) community mental health clinics during this FY2013-14. The growth of "targeted care management" is a priority 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. For 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.

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- DSAMH has evaluated its overuse of provider managed representative payees and will be developing a plan to RFP this service to a stand alone, non provider agency in the near future.

- DSAMH is engaged in discussions 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 moves increasingly more towards smoke-free environments. 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.

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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.

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Unmet Needs and Gaps
There continues to be gaps in services throughout the state due to lack of data and substance abuse supports. 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.

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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)

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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:

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:

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

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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:

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        - 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

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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

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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

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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

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→ 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.

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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.

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Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area:

Priority Type: MHP, MHS

Population (s): SMI

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.

Strategies to attain the goal:

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.

Priority #: 2

Priority Area:

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, SED, TB

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

Strategies to attain the goal:

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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.

Priority #: 3

Priority Area:

Priority Type: SAP, SAT, MHP, 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.

Strategies to attain the goal:

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.

Priority #: 4

Priority Area:

Priority Type: SAP, SAT

Population (s):

Goal of the priority area:

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

Strategies to attain the goal:

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.

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Priority #: 5

Priority Area:

Priority Type: SAP, SAT

Population (s):

Goal of the priority area:

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

Strategies to attain the goal:

Priority #: 6

Priority Area:

Priority Type: SAP, SAT

Population (s):

Goal of the priority area:

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

Strategies to attain the goal:

Priority #: 7

Priority Area:

Priority Type: SAP, SAT

Population (s): 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.

Strategies to attain the goal:

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Priority #: 8

Priority Area:

Priority Type: SAP

Population (s): SED

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

Strategies to attain the goal:

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:

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, SED, HIV EIS, TB

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.

Strategies to attain the goal:

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.

Priority #: 10

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Priority Area:

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, SED

Goal of the priority area:

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

Strategies to attain the goal:

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

Footnotes:

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Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$4,219,475		$	$	$14,805,642	$	$
a. Pregnant Women and Women with Dependent Children*	$		$	$	$ 492,000	$	$
b. All Other	$ 4,219,475		$	$	$ 14,313,642	$	$
2. Substance Abuse Primary Prevention	$ 1,465,446		$	$ 2,216,724	$	$	$
3. Tuberculosis Services	$		$	$	$ 121,181	$	$
4. HIV Early Intervention Services	$ 315,829		$	$	$ 96,980	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$ 315,829		$	$	$	$	$
11. Total	$6,316,579	$	$	$2,216,724	$15,023,803	$	$

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* Prevention other than primary prevention

Footnotes:

The SABG Administration funds include DSAMH Administration as well as the 3% Enrollment set-aside.
As of January 1, 2014, Medicaid coverage will be expanded to include substance abuse services; DSAMH is currently working with Medicaid to identify the specific billing structure. However, at this time DSAMH is unable to report planned substance abuse expenditures for Medicaid.
Other federal funds include SPF SIG Year IV (SP015607) and SPE No Cost Extension (SP018655) funds.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$	$	$	$	$
6. Other 24 Hour Care		$	$	$	$	$	$
7. Ambulatory/Community Non -24 Hour Care		$ 843,741	$ 5,111,300	$	$ 64,542,700	$	$
8. Mental Health Primary Prevention		$ 23,000	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$ 47,649	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$ 38,590	$	$	$	$	$
11. Total	$	$952,980	$5,111,300	$	$64,542,700	$	$

* Prevention other than primary prevention

Footnotes:

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Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$843,741
Specialized Outpatient Medical Services			$	$
Acute Primary Care			$	$
General Health Screens, Tests and Immunizations			$	$
Comprehensive Care Management			$	$843,741
Care coordination and Health Promotion			$	$
Comprehensive Transitional Care			$	$
Individual and Family Support			$	$
Referral to Community Services Dissemination			$	$
Prevention (Including Promotion)			$	$23,000
Screening, Brief Intervention and Referral to Treatment			$	$

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Brief Motivational Interviews			$	$13,000
Screening and Brief Intervention for Tobacco Cessation			$	$
Parent Training			$	$
Facilitated Referrals			$	$
Relapse Prevention/Wellness Recovery Support			$	$10,000
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)			$	$

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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			$	$
Evidenced-based Therapies			$	$
Group Therapy			$	$
Family Therapy			$	$
Multi-family Therapy			$	$
Consultation to Caregivers			$	$
Medication Services			$	$
Medication Management			$	$

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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			$	$

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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			$	$

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Intensive Home-based Services			$	$
Multi-systemic Therapy			$	$
Intensive Case Management			$	$
Out-of-Home Residential Services			$	$
Children's Mental Health 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			$	$
Therapeutic Foster Care			$	$
Acute Intensive Services			$	$
Mobile Crisis			$	$
Peer-based Crisis Services			$	$
Urgent Care			$	$

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23-hour Observation Bed			$	$
Medically Monitored Intensive Inpatient (SA)			$	$
24/7 Crisis Hotline Services			$	$
Other (please list)			$	$

Footnotes:

DSAMH is unable to complete the SABG expenditures for this table due to current data collection and reporting structures by the provider network. DSAMH is working to develop reporting systems to collect expenditures by service.

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III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 4,219,475	
2 . Substance Abuse Primary Prevention	$ 1,465,446	
3 . Tuberculosis Services	$	
4 . HIV Early Intervention Services**	$ 315,829	
5 . Administration (SSA Level Only)	$ 315,829	
6. Total	$6,316,579	

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* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$ 175,854	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$175,854	
Education	Universal	$ 659,451	
	Selective	$ 102,581	
	Indicated	$ 14,654	
	Unspecified	$ 205,162	
	Total	$981,849	
Alternatives	Universal	$ 73,272	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$73,272	
Problem Identification and Referral	Universal	$ 14,654	
	Selective	$	
	Indicated	$	
	Unspecified	$	

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	Total	$14,654	
Community-Based Process	Universal	$ 73,272	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$73,272	
Environmental	Universal	$ 73,272	
	Selective	$	
	Indicated	$	
	Unspecified	$ 73,272	
	Total	$146,545	
Section 1926 Tobacco	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Other	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Total Prevention Expenditures		$1,465,446	
Total SABG Award		$6,316,579	
Planned Primary Prevention Percentage		23.20 %	

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III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 688,760	
Universal Indirect	$ 659,451	
Selective	$ 102,581	
Indicated	$ 14,654	
Column Total	$1,465,446	
Total SABG Award	$6,316,579	
Planned Primary Prevention Percentage	23.20 %	

Footnotes:

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Table 5c SABG Planned Primary Prevention Targeted Priorities

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
LGBTQ	þ
American Indians/Alaska Natives	þ
African American	þ
Hispanic	þ
Homeless	é
Native Hawaiian/Other Pacific Islanders	é
Asian	é
Rural	þ
Underserved Racial and Ethnic Minorities	þ

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Footnotes:

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III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 197,835	$	$	$197,835				
2. Quality Assurance	$ 52,756	$	$	$52,756				
3. Training (Post-Employment)	$ 178,052	$	$	$178,052				
4. Education (Pre-Employment)	$ 65,945	$	$	$65,945				
5. Program Development	$ 65,945	$	$	$65,945				
6. Research and Evaluation	$ 65,945	$	$	$65,945				
7. Information Systems	$ 32,973	$	$	$32,973				
8. Enrollment and Provider Business Practices (3 percent of BG award)	$	$ 189,497	$	$189,497				
9. Total	$659,451	$189,497	$	$848,948				

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Footnotes:

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III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$
MHA Administration	$ 10,000
MHA Data Collection/Reporting	$
Enrollment and Provider Business Practices (3 percent of total award)	$ 28,590
MHA Activities Other Than Those Above	$
Total Non-Direct Services	$38590
Comments on Data:	

Footnotes:

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IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their 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?

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SECTION IV - Narrative

Step C. – Coverage M.SUD Services

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

All services in Plan Table 3 will be Medicaid or QHP eligible activities. Delaware Division of Medicaid and Medical Assistance (DMMA) and the Delaware Department of Insurance (DOI) monitored QHPs will not deny any medically necessary condition.

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

Delaware has a quality management strategy currently established for the MCOs. The SPMI population will be carved out of that management strategy and carefully monitored as part of the oncoming management and monitoring of the Settlement Agreement between the State of Delaware and the US Department of Justice. QHP's will be monitored by the Delaware Department of Insurance as a separate process to what is managed and monitored by the State Division of Medicaid Services.

The Delaware Department of Insurance (DOI) views monitoring of access to M/SUD services through QHPs as a network adequacy issue. Network adequacy will be monitored as part of plan management of QHP Issuers and plans. At a minimum, the network will be required to meet the following statutory/regulatory standard:

All individual and small group plans sold inside and outside of the Exchange are required to comply with the Mental Health Parity and Addiction Equity Act (ACA § 1311(j)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578.

- Standard for QHP:

- Each QHP Issuer that has a network arrangement must meet and require its providers to meet state standards for timely access to care and services as outlined in the table, titled **Appointment Standards,** found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services. Issuers must have providers in the plan network that cover services in all ten essential health benefits or must submit justification for access to care at in-network rates and without balanced billing.

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1.1.1 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This requirement does not apply to Stand-alone Dental Plans
Statutory/Regulatory Standard

Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay (45 CFR 156.230(a)(2)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578.

3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

The Department of Insurance (DOI) has the responsibility for plan management functions and certification of the QHP. The plan will be responsible for ensuring that its provider panel meets the requirements of the adequacy requirements. The DOI will monitor the plans. Procedures are not yet totally developed.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

The Delaware Division of Substance Abuse and Mental Health (DSAMH) is the SMHA and the SSA. The Delaware Division of Substance Abuse and Mental Health (DSAMH) and the Division of Medicaid and Medical Assistance (DMMA) are sister-agencies under the Delaware Department of Health and Social Services (DHSS). Though no formal policy exists mandating operational procedure in reviewing complaints or violations, both agencies routinely coordinate to address complaints or violations if/when they are presented. DSAMH and DMMA are currently collaborating on several initiatives to streamline access to eligible Medicaid services throughout the state's Behavioral Healthcare system.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Delaware will expand Medicaid eligibility for adults up to 138% of the federal poverty rate, from 100% of the federal poverty rate. Delaware is establishing a partnership marketplace model with the federal government because Delaware doesn't have a population large enough to purchase insurance through the affordable insurance exchange and have a system that is financially sustainable once the administrative costs of operating and maintaining the system are factored into the equation. The cost of running the program would drive up costs to the individual's premium to a level that eligible consumers wouldn't be able to afford it. The Affordable Care Act's enabling legislation says the market place must be financially

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self-sustainable, thus this would not be a viable option in Delaware.

In addition, Delaware will adhere to all federal minimum requirements of the Essential Health Benefit (EHB) package to ensure the qualified health insurance package will meet federal coverage floors established by the Affordable Care Act.

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IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

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Footnotes:

SECTION IV - Narrative

Step D. – Affordable Marketplace

1. **How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?**

The Delaware Department of Insurance is still in the process of developing performance parameters. With the impending changes set to occur within the Delaware behavioral health system, the State of Delaware is making strides to enhance the lines of communication and inter-agency collaboration among each of the agencies involved with the Affordable Insurance Marketplace (DSAMH, DMMA, DOI, etc.). Communication and planning are integral to ensure the success of these programs and that Delawarean's receive appropriate and accessible care.

2. **How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?**

   The Navigator program will be a federally run and maintained program. As such, State agencies will have limited influence over the delivery of those services. The Department of Insurance (DOI) and the Department of Medicaid and Medical Assistance (DMMA) will ensure that the in-person marketplace assister programs will work with community partners to analyze the population as a whole. The marketplace assisters will also work to serve special populations, including those with behavioral health consumers to identify specific outreach opportunities as well as provide application and enrollment assistance.

3. **How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?**

   Delaware will utilize grants funds to pay for behavioral health services on a "payer of last resort" basis meaning all other eligible funding sources including Medicaid, CHIP, QHPs and private insurance must have been exhausted before Block Grant funds will be used to cover the services.

   All individuals seeking behavioral health services via the Division of Substance Abuse and Mental Health's continuum of care are required to complete an assessment of need determination that is conducted by the DSAMH Eligibility Enrollment. Part of that assessment will involve the determination of what existing insurance the client may have an/or getting the client connected with the affordable insurance marketplace to obtain coverage fitting the client's eligibility status.

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4. **How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?**

   There are specific guidelines relating to essential community providers and network adequacy. The specific guidelines are briefly listed above. The network adequacy aligns with Medicaid requirements and public health requirements. All plans are required to comply with the Mental Health Parity.

5. **Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.**

   Approximately 90% of DSAMH MH clients are uninsured and 100% AD clients are uninsured. The data was derived from unduplicated clients episodes obtained from State and Contracted Providers.

   Total MH uninsured clients served in SFY13 = 5,757 out of a total of 6,711. Total MH uninsured clients served in CY13 = 4,719 out of total of 5,171 (this data is from 1/1/2013 to 7/24/2013).

   Total AOD uninsured clients served in SFY13 = 10,251
   Total AOD uninsured clients served in CY13 = 7,995 (this data is from 1/1/2013 to 7/24/2013)

The DSAMH Behavioral Health Service System serves predominantly individuals that do not have private insurance or receive Medicaid Assistance. This is true of 100% of the SABG population, but a small percentage of ACT/ICM clients served via the MHBG do receive some services that are covered under Medicaid, and the DSAMH has been paying the services that were not Medicaid eligible. In preparation of the implementation of the Affordable Care Act requirements, Division of Substance Abuse and Mental Health and Division of Medicaid and Medical Assistance staff have enhanced lines of communication and coordination to better identify behavioral health services throughout the public behavioral health system in Delaware that are Medicaid eligible.

6. **Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.**

   At the present time this is a difficult number to capture. It's very difficult to capture because the DSAMH has historically only utilized Block Grant Funds to provide behavioral healthcare service to individuals that do not qualify for Medicaid and do not have private insurance. The division in certain some of the individuals that

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previously were not eligible to receive Medicaid are now eligible as Delaware Medicaid eligibility will increase to cover those at 138% of the Federal Poverty Level, up from the previous marker of 100%.

Exacerbating this issue is the fact that Delaware is currently adhering to terms and conditions established in an Olmsted Act Settlement Agreement between the State and the US Department of Justice. The DSAMH Division Director is currently working with the Court Monitor to establish a special population of individuals with Serious and Persistent Mental Illness (SPMI) that will be an identified group of persons that will be waivered from the Medicaid eligible population. These individuals would affect the population of persons served by the MHBG.

7. **For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.**

   Additional information is currently being pulled from State partners to respond fully to the guidance listed above. More information will be provided at a later date.

8. **Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.**

   Additional information is currently being pulled from State partners to respond fully to the guidance listed above. More information will be provided at a later date.

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IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (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 utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

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. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. 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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
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.
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?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
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?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

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SECTION IV - Narrative

Step E. – 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

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	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

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	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

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	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.

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IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

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. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

a) What information did you use?

b) What information was most useful?

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

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SECTION IV - Narrative

Step F. – Use of Evidence in Purchasing Decisions

1. Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices?	
ADULT BEHAVIORAL HEALTH SYSTEM:	Currently, there is no formal process for tracking or disseminating information regarding evidence-based practices for treatment services. Delaware continues to work on developing its Prevention of Substance Abuse Infrastructure, inclusive of tracking and disseminating information on evidence-based and promising practices. Currently, through the adult prevention provider network, BCCS implements Prime for Life, an NREPP recognized evidence-based practice. BCCS works with DSAMH to monitor and evaluate the success of this program and how to work with other providers to assess their communities and identify evidence-based and/or promising practices. Through the SPF SIG Initiative, DSAMH has developed an Evidence-based Practices (EBP) Workgroup, which is a subset of the Delaware Advisory Council (DAC). In FFY14, as the SPF SIG project begins working on sustainability efforts, the DAC will be merging with the Delaware Prevention Advisory Committee (DPAC), which is a larger Prevention Workgroup developed by the State inclusive of a variety of community based behavioral health agencies. DPAC will maintain the EBP Workgroup. Currently, the EBP Workgroup is in its infancy stage. The group has not yet developed a set of operating procedures for how they will work with the state and community to accomplish their goals. The intent of the EBP Workgroup is to have a governing body that works with community agencies with the identification and implementation of evidence-based and promising practices. As the prevention system continues to build the capacity at the community level to shift the paradigm into a

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	data-based delivery system, it is integral that community providers utilize data to implement appropriate services that target populations with the greatest need. DSAMH, in conjunction with the DPAC and the developing EBP workgroup, will work with the Center for the Application of Prevention Technologies to identify methods for success and operational strategies. By the end of FFY15, it is anticipated that the EBP workgroup will be fully functional.
CHILD BEHAVIORAL HEALTH SYSTEM:	Yes, currently we have an office of evidence based and or promising practices. Their roles are to identify gaps in our service delivery system, identify funding and write grants and applications that will strengthen our continuum. They train staff on evidence based practices and consult on implementation, program evaluation and data analysis.

2. Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions? What information did you use? What information was most helpful?	
ADULT BEHAVIORAL HEALTH SYSTEM:	Currently, DSAMH does not use information regarding evidence-based practices for purchasing or policy decisions for their adult treatment services. There are no formalized systems in place for using information regarding evidence-based practices within the adult prevention system; however, with the development of the EBP Workgroup, DSAMH is beginning to look at information on evidence-based practices for contracting purposes. DSAMH operates, directly or through contracts, with private agencies to implement a comprehensive substance abuse system of care, inclusive of primary prevention and treatment services. Following the State's procurement procedures, DSAMH utilized a competitive Request for Proposal (RFP) process for the identification of the current prevention providers. RFPs include requests that providers

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	implement evidence-based or promising practices within their of substance abuse prevention service delivery plan During FFY 14-15, Delaware intends to further develop the EBP Workgroup which would further aid in the identification and dissemination of information regarding selection and implementation of evidence-based practices, as well as for purchasing and policy decisions. The development of a data driven, evidence based behavioral health delivery system is important in enhancing the infrastructure of the behavioral health system. DSAMH will continue to make strides to enhance these efforts.
CHILD BEHAVIORAL HEALTH SYSTEM:	Currently, DPBHS does not use information regarding evidence-based practices for purchasing or policy decisions for their youth treatment services. In 2011 The DSCYF Division of Prevention and Behavioral Health Services released a Request for Proposals for the implementation of evidence-based substance abuse prevention programs, practices and policies for children and youth, ages 0-17 and their families, requiring applicants to work with a coalition(s) to implement comprehensive prevention strategies to address the substance abuse prevention priorities identified in the Delaware Substance Abuse Prevention Strategic State Plan for youth in Delaware. Applicants were required to submit proposals adhering to the five-steps of the Strategic Prevention Framework (SPF). The SPF is a structured, community-based approach to substance abuse prevention. The framework aims to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the individual's life span. This approach provides information and tools that can be used by States and communities to build an effective and sustainable prevention infrastructure. The SPF Implementation Principles provide broad guidelines that inform each step of the process, from strategic planning and capacity building, through evaluation

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	and sustainability. These principles are intended to promote a comprehensive, systems-oriented approach to prevention. As a result, DPBHS is able to fund programs, practices and policies that have a demonstrated evidence base and that are appropriate for the identified sub recipient communities/coalitions and have incorporated environmental strategies into the development of their comprehensive plans. Environmental strategies are based on the belief that substance abuse is a product of multiple environmental conditions and circumstances. Environmental strategies incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems, and policies. More specifically, environmental strategies seek to: (1) limit access to substances, (2) change the culture and context within which decisions about substance use are made, and/or (3) shift the consequences associated with substance use.

3. How have you used information regarding evidence-based practices? Educating State Medicaid agencies and other purchasers regarding this information? Making decisions about what you buy with funds that are under your control?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH has not used information regarding evidence-based practices to educate Medicaid or other purchasers regarding this information. In FY 14-15, DSAMH will work with Medicaid, as well as other agencies, to educate each other on service and operational needs.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS has not used information regarding evidence-based practices to educate Medicaid or other purchasers regarding this information. DPBHS leadership believes that as we gain more knowledge in this area we will be better prepared to share information on the type of EBP's being used with Medicaid providers.

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IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

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SECTION IV - Narrative

Step G. – Quality

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

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1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

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Section information pending

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IV: Narrative Plan

H. Trauma

Narrative Question:

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?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any 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?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

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SECTION IV - Narrative

Step H. - 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?

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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

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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.

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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.

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IV: Narrative Plan

I. Justice

Narrative Question:

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 abuse 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. [42,43] 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 utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. 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 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 answer the following questions:

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?

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

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?

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

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?

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 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.

44 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.

Footnotes:

SECTIONIV - Narrative

I. 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.

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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.

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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

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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.

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IV: Narrative Plan

J. Parity Education

Narrative Question:

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

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SECTIONIV - Narrative

Step J. – Parity Education

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.

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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.

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IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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 rewarded to coordinate 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 answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

    a. heart disease,

    b. hypertension,

    c. high cholesterol, and/or

    d. diabetes.

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SECTIONIV - Narrative

Step K. – Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?	
ADULT BEHAVIORAL HEALTH SYSTEM:	Delaware is currently pursuing Medicaid coverage expansion to include individuals up to 138% of the federal poverty rate; implementing a partnership with the federal government to establish an affordable insurance marketplace, the continued implantation of specialized service delivery for the USDOJ target population of individuals with severe and persistent mental illness; and redesigning the service delivery process for individuals receiving substance use treatment and prevention services
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS continues to work with the **Division of Developmental Disabilities Services, Department of Education, and the Division of Medicaid and Medical Assistance** to develop a collaborative service approach.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?	
ADULT BEHAVIORAL HEALTH SYSTEM:	At this time the State is concentrating predominantly on the Affordable Care Act initiatives, but the State is actively adhering to the terms of a Settlement Agreement between the US Department of Justice around Olmsted issues. These activities impact the type and manner of service delivery to a specialized group of individuals with the adult behavioral health service system, therefore they too are a coordinated care initiative.
CHILD BEHAVIORAL HEALTH SYSTEM:	At this time there are no coordinated care initiatives that our state is pursuing for youth.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – the Division of Substance Abuse and Mental Health is implementing system wide changes to the behavioral health system, State agencies are making strides to enhance the inter-agency lines of communication and coordination. These efforts have enhanced relationships with FQHCs, Community Health Centers and primary care practices and behavioral health providers. This enhanced communication is

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	essential to the successful implementation for the Affordable Care Act initiatives in the state.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS is currently strengthening our relationship with primary care organizations and associations. One example to note is through our Garret Lee Smith Grant (GLS) we are providing training to all primary care physicians and associations to reduce suicide.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.	
ADULT BEHAVIORAL HEALTH SYSTEM:	DHSS/DSAMH has operated smoke free facilities since 2008 via an effective smoking cessation initiative instituted that year. As a result of this initiative consumers cannot smoke on the grounds of the state-operated behavioral healthcare facilities.
CHILD BEHAVIORAL HEALTH SYSTEM:	DSCYF/DPBHS behavioral health facilities for youth are all non- smoking.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.	
ADULT BEHAVIORAL HEALTH SYSTEM:	DHSS/DSAMH does not currently screen, assess and address smoking amongst clients beyond operating state-run service sites that are smoke free.
CHILD BEHAVIORAL HEALTH SYSTEM:	DSCYF/DPBHS does not regularly screen, assess and address smoking with youth. However, the Division of Public Health Tobacco Prevention and Control program continues to support the SYNAR enforcement programs, further reducing the percentage of youth from accessing tobacco products and reducing tobacco addiction.

6. Describe how your behavioral health providers are screening and referring for: a. heart disease, b. hypertension, c. high cholesterol, and/or d. diabetes	
ADULT BEHAVIORAL HEALTH SYSTEM:	At this time DSAMH providers are not screening and referring for heart disease, hypertension, high

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	cholesterol and or diabetes.
CHILD BEHAVIORAL HEALTH SYSTEM:	At this time DSCYF /DPBHS providers are not screening and referring for heart disease, hypertension, high cholesterol and or diabetes. However many providers do integrate health and wellness into their milieu. Our Department does provide resources to state-wide agencies through competitive mini-grants to enhance services and address health and wellness.

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IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to 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).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

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SECTIONIV - Narrative

Step L. – 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.

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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

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- 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.

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IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. 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?

6. 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?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must 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 actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

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supportive community?

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SECTIONIV - Narrative

Step M. – Recovery

1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – The Adult Behavioral Health System's set of values and principles are contained in the Division of Substance Abuse and Mental Health's Strategic Plan.
CHILD BEHAVIORAL HEALTH SYSTEM:	YES- The Children System has both system of Care Values and Guiding Principles that have been vetted with key stakeholders and Delaware's children and families. **System of Care Values** • Child-centered and family focused with the needs of the child and family dictating the types and mix of services provided • Community-based services, integrated with intensive care management • Culturally competent, with services that are responsive to the Cultural, racial and ethnic differences of the population served **Guiding Principles** • Engage children, families and communities as full participants in all aspects of service delivery • Provide services from pre-school to age 18 in the least restrictive, clinically appropriate setting • Consider the role of trauma exposure in children, families and communities in service provision • Strengthen community capacity through leveraging resources and partnerships • Use data to drive service system decisions that maximize evidence based practices and positive outcomes

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

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ADULT BEHAVIORAL HEALTH SYSTEM:	YES
CHILD BEHAVIORAL HEALTH SYSTEM:	YES

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – Person centered planning is at the center of Delaware's Adult Behavioral Health System's recovery based philosophy for recovery, which also includes hope as a vital component to the recovery process. Each participant in the adult Behavioral Health System works with their therapist to develop and maintain their individualized care plan to meet their needs throughout the recovery process.
CHILD BEHAVIORAL HEALTH SYSTEM:	Yes-strategies that involve the use of person-centered planning and self-direction is weaved throughout our continuum. As it relates to Prevention our coalition plans and address the need of our communities. As it relates to treatment all of our youth have treatment goals and objectives. Our providers in our continuum also use a person-centered planning approach. Additionally we actively engage our youth and families to identify their needs and direct their care. As it relates to participant-directed care our wrap around teams mentioned in our application is a great example of participate-directed care.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – Delaware's plan indicates a variety of recovery supports that meet the holistic needs of system participants. The Adult Behavioral Health System includes peer specialist, navigators, self directed care, consumer/family education and involvement in the recovery process, respite care, supported employment, and housing among the host of services available throughout the Continuum of Care.
CHILD BEHAVIORAL	Yes- Delaware's children portion of the plan presents a

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HEALTH SYSTEM:	culture of available and accessible services that promotes recovery and resilience for Delaware's children, youth and families.

5. 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.

6. 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?	
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. The most recent offering for administrative and executive staff was April 1, 2013.
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.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?	
ADULT BEHAVIORAL HEALTH SYSTEM:	YES – DSAMH does not have an official accreditation or certificate program for peers, but DSAMH does have established standards for peer-run services. In addition, all peers receive training provided by DSAMH before providing peer assistance services at any of the state supported behavioral health service sites.
CHILD BEHAVIORAL HEALTH SYSTEM:	**No**

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8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, 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:	Exemplary activities in the realm of the adult behavioral include a completely revamped community mental health service delivery system that was developed and implemented with respect to the Olmsted Act Settlement Agreement between the State and the US Department of Justice. The transformation of the MH service system in Delaware is well documented, the details of which were contained in the previous State Plan. DSAMH is on schedule with the achievement of all the previous performance markers associated with the transformation of the MH service system. Another exemplary activity is DSAMH's creation of 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. The State agencies collaboration in coordination efforts to fully implement Delaware's Affordable Insurance initiatives has been bearing fruit in the development and implementation of the Affordable Care Act's mandated programs, and the efforts have led to the ongoing open-communication of several state agencies such as Department of Insurance, department of Medicaid and Medical Assistance, Department of Correction and the Division of Substance Abuse and mental health that is helping each of the agencies eliminate service gaps and increase efficiency and the effectiveness of service provision not necessarily related to the ACA initiatives. Similar to the transformation of the MH system which began two years ago, the SA system is now undergoing

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	transformation. DSAMH desires to build upon the groundwork of the MH system transformation by utilizing technical assistance consultation by the same individual who provided TA for the MH system. To assist with the transformation and technical assistance, DSAMH has requested support from SAMHSA. The technical assistance and transformation of the SA system of care will include the identification of appropriate recovery supports to be developed and written specifications for each.
CHILD BEHAVIORAL HEALTH SYSTEM:	The following are some exemplary activities and initiatives related to recovery support for Delaware's children, youth and families. **Prevention**: o Expanded services in all 3 counties and in the City of Wilmington, o Strengthened the Promoting Safe and Stable Families Program (PSSF) to include a domestic violence prevention component, o Supported the Fatherhood Coalition and the Delaware Prevention Coalition to assume responsibility for ongoing operations and activities, o Kicked off the anti-bullying campaign, o Addressed violence, bullying, suicide in conjunction with the expansion of community center hours and funding of the curfew centers in Wilmington, o Funded several spring-summer activities in Kent County to increase positive youth opportunities. **Community-Based Treatment Services:** o Expanded services – ✓ Three (3) new providers added, ✓ All nine (9) of the previous providers were awarded contracts, ✓ Of the nine, six (6) providers expanded their services, ✓ Three (3) maintained their level of service. o Expanded services in Kent and Sussex Counties. **Early Childhood Services:** o Finalized contracts for four (4) new Early

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	Childhood Mental Health Consultants with the new Race to the Top funds. o BEST success- ✓ Continue to provide Parent Child Interaction Therapy (PCIT) training for licensed clinicians and to children and their families via home-based services, ✓ Hired a PCIT Trainer, ✓ Continue to sponsor monthly Family Partner's Peer to Peer Support Groups, ✓ Produced Delaware's B.E.S.T. video with collaboration from family members, ✓ Mental Health Awareness activities reached over 140 Early Childcare and Educations Programs and outreached to 800 individuals through the Rita's Water Ice event. **Residential Treatment Services**: o Completed the final phase of RTC staff training and implementation of Collaborative Problem Solving. o Completed a facilities review of state-operated RTCs and made key decisions regarding the current configuration of facilities and related lease renewals, o The Residential Best Practices Committee was formed to identify and recommend best practices for the in-state RTCs and to provide information that will shape the future Request for Proposals for RTC services. The committee is in the final stage of its assignment. **K-5 Early Intervention:** o Added two (2) contracted K-5 Family Crisis Therapists (FCTs), o Launched first middle school Mental Health Consultants program. **Suicide Prevention:** o Awarded Garrett Lee Smith (GLS) Suicide Prevention Grant, o Crisis Team led DE's effort to address youth

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	suicides in Kent and Sussex Counties, o Worked with consultants and the Centers for Disease Control (CDC) to evaluate our response to the teen suicides and to identify possible root causes. PBH and the Crisis Team received positive feedback. o Implemented Lifelines, the suicide prevention curriculum, funded through the GLS Suicide Prevention Grant, o Presented suicide prevention information at the 2012 Spring Retreat of Delaware Chief School Officers Association. **PBH FY 13 budget**: o $2.1 million deficit correction for contractual treatment services plus $1.5 million in salary funding, o $200,000 ongoing funding for community center extended hours, o Allocation of $4.2 million from Department of Education to DPBHS for K-5 services, o $80,000 for the Richardson Park pilot, o $58,000 to fund additional services in southern DE resulting from the HJR 7 Report, o 1% increase for contracted service providers.

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Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?	
ADULT BEHAVIORAL HEALTH SYSTEM:	As a primary proponent of consumer recovery and full inclusion in the community, DSAMH will take further steps in 2013 to provide consumer employment opportunities, and engagement in planning activities. DSAMH has in the past assumed a role in the development and evaluation of services provided by the CCCPs by contracting with the University of Pennsylvania's Center for Mental Health Policy and Services Research. Throughout the ACT/ICM and CMHCs, consumers increase the skills of daily living and social functioning of consumers and are encouraged to expand their role in community life, particularly in the areas of social

	relationships, work and school. Recovery plans that are monitored in 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,

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	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.

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2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH attempts to include consumers and/family members in organizational planning meetings that involve the development of service provision In addition, 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.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS attempts to use our Advocacy and Advisory Council. Currently we are sponsoring and partnering with Family Voices. This is a newly created family run organization in the State of Delaware.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?	
ADULT BEHAVIORAL HEALTH SYSTEM:	The inclusion of consumers and/family members in organizational planning meetings that involve the development of service provision, along with person centered recovery plans that are developed by the consumers throughout the adult behavioral health system the method DSAMH employs to ensure consumers are presented with opportunities to participate in shared decision making activities and direct their ongoing care and support.
CHILD BEHAVIORAL HEALTH SYSTEM:	DPBHS system of care is child centered and family focused. Parents and or guardians are treated with respect and encouraged to engage and to participate in their child's recovery planning and treatment.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?	
ADULT BEHAVIORAL HEALTH SYSTEM:	DSAMH supported the development of the consumer-run Rick Van Story Resource Center. The Division is actively working to open a consumer arts program. DSAMH continues to expand the number of Peer Specialist throughout the Behavioral Health System. DSAMH is adding Peer Navigators to the enhanced list of peer resources throughout the adult behavioral health system.
CHILD BEHAVIORAL HEALTH SYSTEM:	Currently DPBHS is supporting a State-wide family run organization that strengthens advocacy for Delaware families, support networks and recovery-orientated services.

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Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?	
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.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?	
ADULT BEHAVIORAL HEALTH SYSTEM:	Through strict adherence to the voluntary Settlement Agreement between the State and the US Department of Justice, all new housing opportunities for persons served must be in a manner that is needs-appropriate and least restrictive within the community. As such, non-integrated community housing placements require a waiver from the Court Monitor assigned to monitor compliance with the Settlement Agreement.
CHILD BEHAVIORAL HEALTH SYSTEM:	As previously discussed under service system 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

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	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.

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IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data 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?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

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SECTIONIV - Narrative

Step N-1. – Evidence Based Treatment Approaches SABG

ADULT BEHAVIORAL HEALTH SYSTEM

Use of Data

Delaware began its review of indicators with the establishment of its State Epidemiological Outcomes Workgroup (SEOW), known in Delaware as the Delaware Drug and Alcohol Tracking Alliance (DDATA). DDATA was instituted as part of an SEOW contract with CSAP through Synectics, prior to Delaware being awarded a SPF-SIG. In 2009 when Delaware received their SPF SIG, the SEOW was maintained as a part of the project. The SEOW was formulated to and continues to have active participation from most state agencies that have access to data on substance use and abuse and its consequences. DSAMH's Prevention Team continues to work with the SPF SIG, the SEOW, as well as community partners to collect and assess substance abuse data- inclusive of consumption and consequence patterns and trends.

The SEOW develops an Epidemiological Profile annually which is intended to outline the needs data for the state. DSAMH utilizes this information to identify state priorities, inclusive of areas of high need. DSAMH continues to work with partners to close the gaps in the data collection and needs assessment system in order to identify the types of primary prevention services that are needed within the state.

With the paradigm shift in prevention continues which has moved into a data-driven system, DSAMH implements strategies to ensure appropriate prevention services are funded and implemented throughout the state. In 2010, DSAMH released Request for Proposals for the implementation of evidence-based substance abuse prevention programs, practices and policies for adults (ages 18 and older), requiring applicants to work with a coalition(s) to implement comprehensive prevention strategies to address the substance abuse prevention priorities identified by Delaware's SEOW. Based on a comprehensive assessment of the substance abuse consumption and consequences patterns in Delaware, the following substances were identified as Substance Abuse Prevention Priorities: (1) Underage Alcohol Use and Abuse; (2) Marijuana; (3) Prescription Drug Abuse including Opiates and Psychotropics; and, (4) Heroin Abuse. Adhering to the five steps of the Strategic Prevention Framework, SAPTBG providers are required to clearly define and understand the unique characteristics of the community they seek to serve by developing a profile of the population's needs, resources and readiness to address needs and gaps in service delivery. The use of the Framework has allowed SAPTBG funded community providers to develop strategic plans for the implementation of evidence-based programs, policies and practices based on actual local community level data to address the state priorities for Delaware's adult population.

Primary Prevention Programs, Practices and Strategies

As a result of this RFP, DSAMH contracted with two community providers to implement services, Brandywine Counseling and Community Services (BCCS) and the Latin

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American Community Center (LACC). These contracts fund comprehensive evidence-based strategies and interventions to: (1) Prevent the onset and reduce the progression of substance use and abuse for the adult population through the reduction of risk factors and increasing identified protective factors; (2) Provide primary prevention activities to prevent substance use and abuse through a comprehensive use of evidence-based strategies including education, information dissemination, environmental, community-based and alternative activities; and, (3) Build prevention capacity and infrastructure at the community level. Contracts are required to adhere to the five steps of the Strategic Prevention Framework to ensure the development and implementation of a comprehensive, culturally competent, and sustainable prevention system at the community level. These contracts will continue through FY14.

As a result of the expiration of these contracts, DSAMH will begin the development of a new RFP to solicit providers to implement substance abuse prevention services. Similar to the previous process, applicants will be required to utilize data to identify target populations and appropriate services.

Capacity Building

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 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, through the support of the SPF SIG, continues to assess current prevention providers as well as the prevention workforce at large to identify the capacity and needs of the professionals. This is integral as DSAMH continues to develop its prevention workforce infrastructure and enhance its prevention system.

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 intends to offer and or coordinate additional trainings on an annual basis to ensure access to professional development resources.

Outcomes and Evaluation

DSAMH monitors all providers through a variety of quality assurance measures to ensure grant compliance, as well as program integrity. Providers are required to submit monthly reporting documentation as well as participate in regular monitoring visits by both the

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Contract Manager and the Quality Assurance and Performance Improvement Team (QAPI).

In FY2011 DSAMH began working with DBPHS 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 through a contract with KIT Solutions, Inc., allowing for accurate, real time data collection. The KIT Solutions contract is funded out of DPBHS; however, it is intended to serve both the adult and youth prevention provider network.

DPBHS maintains a contract with the University of Delaware, Center for Drug and Alcohol Studies to provide evaluation of the effectiveness of substance abuse prevention activities for use in data-driven decision-making by the State. All evaluation and program assessment is done in a culturally competent manner in line with best practices. Through this evaluation contract, DPBHS and the University of Delaware work closely with DSAMH providers to evaluate the performance and outcome measures for their prevention programs and strategies. In addition to quality assurance measures, with the support of DPBHS and the University of Delaware, DSAMH is able to monitor program success as well as provide technical assistance where needed.

Community-based implementation of the Strategic Prevention Framework, Evidence-Based Practices and Environmental Strategies

DSAMH does not currently allocated state funds to support the implementation of primary prevention activities. Substance abuse prevention strategies are supported by the Substance Abuse Prevention Block Grant, the Strategic Prevention Framework – State Incentive Grant (SPF SIG), and the Strategic Prevention Enhancement Grant (SPE). DSAMH Prevention Staff works closely with the DPBHS Prevention Staff, the DSAMH Planning and Business Operations Units, as well as SPF SIG and SPE Staff to identify and establish best practices for supporting appropriate implementation of substance abuse prevention strategies following the Strategic Prevention Framework.

Between DSAMH and DPBHS, Delaware spends approximately 75% of the SABG prevention set-aside on community providers for direct service delivery; 20% on staff salaries and benefits (3 staff members); and 5% on administrative costs (travel, supplies), information technologies (KIT Solutions), and community resource/material distribution (Resource Center).

DSAMH still struggles with their providers to implement evidence-based practices for the adult population. Currently, contracts focus on best or promising practices for the implementation of prevention services. Providers implement a comprehensive array of services in congruence with the six CSAP prevention strategies. BCCS, a DSAMH prevention provider, implements Prime for Life, an NREPP recognized evidence-based practice. BCCS works with DSAMH to monitor and evaluate the success of this program and how to work with other providers to assess their communities and identify evidence-based and/or promising practices. LACC, another DSAMH prevention provider, has worked closely with the CAPT with their Service to Science program to move their parent education program, Prevention Promoters, to an evidence-based program recognized by NREPP.

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Through the SPF SIG Initiative, DSAMH has developed an Evidence-based Practices (EBP) Workgroup, which is a subset of the Delaware Advisory Council (DAC). In FFY14, as the SPF SIG project begins working on sustainability efforts, the DAC will be merging with the Delaware Prevention Advisory Committee (DPAC), which is a larger Prevention Workgroup developed by the State inclusive of a variety of community based behavioral health agencies. DPAC will maintain the EBP Workgroup. Currently, the EBP Workgroup is in its infancy stage. The group has not yet developed a set of operating procedures for how they will work with the state and community to accomplish their goals.

The intent of the EBP Workgroup is to have a governing body that works with community agencies with the identification and implementation of evidence-based and promising practices. As the prevention system continues to build the capacity at the community level to shift the paradigm into a data-based delivery system, it is integral that community providers utilize data to implement appropriate services that target populations with the greatest need.

DSAMH, in conjunction with the DPAC and the developing EBP workgroup, will work with the Center for the Application of Prevention Technologies to identify methods for success and operational strategies. By the end of FFY15, it is anticipated that the EBP workgroup will be fully functional.

In the upcoming RFP, DSAMH intends to hold providers to a higher standard in implementing evidence-based strategies. As the Evidence-based Workgroup develops their operating procedures, DSAMH will be able to utilize their expertise to provide guidance for the adult provider system to ensure the implementation of evidence based practices throughout the state.

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CHILD BEHAVIORAL HEALTH SYSTEM

Use of Data

In 2011 The DSCYF Division of Prevention and Behavioral Health Services released a Request for Proposals for the implementation of evidence-based substance abuse prevention programs, practices and policies for children and youth, ages 0-17 and their families, requiring applicants to work with a coalition(s) to implement comprehensive prevention strategies to address the substance abuse prevention priorities identified by Delaware's Epidemiological Outcomes Workgroup, also known as the Delaware Alcohol Tracking Alliance (DDATA). Based on a comprehensive assessment of the substance abuse consumption and consequences patterns in Delaware, the following substances were identified as Substance Abuse Prevention Priorities: (1) Underage Alcohol Use and Abuse; (2) Marijuana; (3) Prescription Drug Abuse including Opiates and Psychotropics; and, (4) Heroin Abuse. Adhering to the five steps of the Strategic Prevention Framework, SAPTBG sub recipients are required to clearly define and understand the unique characteristics of the community/coalition they seek to serve by developing a profile of the population's needs, resources and readiness to address needs and gaps in service delivery. The use of the Framework has allowed SAPTBG funded community providers to develop strategic plans for the implementation of evidence-based programs, policies

and practices based on actual local community level data to address the identified issue of underage drinking among the 0-17 population.

Primary Prevention Programs, Practices and Strategies

DPBHS funds comprehensive evidence-based strategies and interventions to: (1) Prevent the onset and reduce the progression of substance use and abuse for youth and their families through the reduction of risk factors and increasing identified protective factors; (2) Provide primary prevention activities to prevent substance use and abuse through a comprehensive use of evidence-based strategies including education, information dissemination, environmental, community-based and alternative activities; and, (3) Build prevention capacity and infrastructure at the community level. DPBHS will only fund programs, practices and policies that have a demonstrated evidence base and/or that are appropriate for the identified sub recipient communities/coalitions. By adhering to the five steps of the Strategic Prevention Framework, SAPTBG sub recipients are required to clearly define and understand the unique characteristics of the community/coalition they seek to serve by developing a profile of the population's needs, resources and readiness to address needs and gaps in service delivery.

Capacity Building

DPBHS continues to hold the Annual Prevention and Behavioral Health Forum. The Forum is a two-day conference that shares information and engages participants in best practices, evidence-based strategies, and policies pertaining to prevention in our statewide, local and regional communities. The Forum is attended by leaders and specialists in the fields of prevention, education, law enforcement, faith-based organizations, public health as well as youth groups and parents. The Forum will seek collaborative solutions in the prevention of substance abuse, child abuse, juvenile delinquency and violence and mental illness. The Forum is attended annually by approximately 400 participants from the 4 sub state planning areas: City of Wilmington, New Castle, Kent and Sussex counties.

DPBHS continues to contract with the Community Anti-Drug Coalitions of America to provide community-based coalition training and support to the evidence based prevention programs awarded through PBH for prevention services targeting youth aged 0-17 and their families and instruct program providers on how they can impact community problems, the creation and maintenance of partnerships, program sustainability, cultural competency, assessment, prevention planning, program implementation and evaluation.

Outcomes and Evaluation

In FY2011 PBH initiated 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 through a contract with KIT Solutions, Inc., allowing for accurate, real time data collection for SAPT'S NOMS by PBH on Delaware children, youth and their families.

DPBHS continues to contract with the University of Delaware, Center for Drug and Alcohol Studies to provide evaluation of the effectiveness of substance abuse prevention activities for use in data-driven decision-making by the State of Delaware and to provide

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technical assistance/consultative support to DPBHS Quality Management efforts. All evaluation and program assessment is done in a culturally competent manner in line with best practices.

Community-based implementation of the Strategic Prevention Framework, Evidence-Based Practices and Environmental Strategies

Currently (FY2012), approximately, 70% of the SABG prevention set-aside goes directly to community-based organizations for implementation of primary prevention programs and practices. DPBHS funds comprehensive evidence-based strategies and interventions to: (1) Prevent the onset and reduce the progression of substance use and abuse for youth and their families through the reduction of risk factors and increasing identified protective factors; (2) Provide primary prevention activities to prevent substance use and abuse through a comprehensive use of evidence-based strategies including education, information dissemination, environmental, community-based and alternative activities; and, (3) Build prevention capacity and infrastructure at the community level. DPBHS funds the following community based providers:

- West End Neighborhood House and Brandywine Counseling and Community Services who collaborate to form the Delaware Prevention Coalition (DPC). DPC is a statewide collaborative group designed to build and strengthen the capacity of community partners to create, safe, healthy drug-free communities by implementing a comprehensive statewide prevention effort to promote wellness and reduce alcohol, tobacco, and other drug abuse in the State of Delaware. In FY2012, DPBHS contracted with WENH and BCCS, requiring that the Strategic Prevention Framework be implemented to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors among youth ages 0 -17. To date, DPC has completed a Comprehensive Community Assessment of Delaware Alcohol Use Prevention Needs for Youth which informed a Comprehensive Strategic Prevention Plan. DPC is currently in the planning phase of their multi-year contract focusing on building the coalition's capacity to implement the Strategic Plan by strengthening existing partnerships and/or identifying new opportunities for collaboration; improving awareness of substance abuse problems and readiness of stakeholders to address these problems; and, improving organizational resources. DPC will enter the implementation phase of the project in the Fall of 2013.
- The University of Delaware Cooperative Extension for implementation of the Botvin Life Skills Program. Life Skills is a research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors.
- DPBHS contracts with Open Door, Inc. and the Greater Dover Boys and Girls Club as VetCorps host sites to assist coalitions with developing and carrying out a locally developed plan to increase services and support to veterans and military families focusing on access to health care and health care services, with an emphasis on substance abuse prevention, treatment and outreach.

In the past, DPBHS has funded the Step Up Campaign to Reduce Underage Drinking. Currently, the Division is seeking a community based provider to contract with for the

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implementation of a successful public awareness campaign to help adults recognize and change behaviors that facilitate underage drinking; provide ideas for effective "house rules" to help adults protect kids from underage drinking; encourage parents to block teens from access to alcohol; and to highlight the consequences of underage drinking to discourage alcohol use. And, as DPC moves toward its implementation phase in the Fall of 2013, the approved Strategic Prevention Plan includes the implementation of compliance checks as an educational and enforcement tool. The coalition will work to identify, warn and educate alcohol establishments about the consequences of serving underage patrons. The checks will also be used to enforce state criminal statutes and local administrative ordinances.

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IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

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SECTIONIV - Narrative

Step N-2. – Evidence Based Treatment Approaches MHBG

Five percent of the MHBG are being set-aside to provide funding for the implementation of evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. The Delaware allotment of MH funds does not constitute at least two percent of the total FY2014 state allotment, thus Delaware should not be required to implement a competitive sub-award process to issue the funding.

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IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

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 over 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.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with 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 answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with 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?

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SECTION IV - Narrative

Step O. Children and Adolescents Behavioral Health Services

Using the theme "supporting healthy minds" our vision is that all children and families are strong, resilient, and live in supportive communities.

Our mission, which is to develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care, drives us to continuously improve our services and reach our vision.

Multiple studies have shown that failure to meet the mental health needs of children has serious consequences such as: increased risk of suicide and substance abuse, school failure, contact with the juvenile justice system, poor employment opportunities and poverty in adult hood. Our Children deserve action so they do not experience these consequences.

As discussed in previous application "System of Care" we have made great progress toward Delaware's children's system of care. We have engaged our partners in a system of care service delivery approach. This approach operationalizes our commitment to think of the child first. The philosophy and core value of the system of care approach aligns with our strategic initiatives and goals.

At the core of this System of Care approach is a multi-disciplinary team that comes together around a child in crisis, to work seamlessly within and across agencies to emphasize the child's strengths, to involve the child's family as respected partners in service planning-to organize and deliver a wide range of services and formal and informal support systems, within the child's home community in a cultural sensitive manner. More importantly, it is proven to provide better outcomes for kids and their families.

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Planning Council Role

A DPBHS staff member participates as an appointed member of the Governor's Advisory Council. The DPBHS Community Advisory Council, described earlier in this section, collaborates with the GAC through the facilitative efforts of the Children's Committee a standing committee of the Governor's Advisory Council and the Advisory Council's Transition Committee.

Planning Process for Child Mental Health Services

The Department of Services for Children, Youth and Their Families (DSCYF), of which the Division of Prevention and Behavioral Health Services (DPBHS) is a part, has addressed many of the early challenges inherent in the implementation of an integrated children's services department and continues the process of refining, improving and expanding its system of care. DSCYF is focused on strengthening integration of its services, enhancing an interdivisional service continuum by maximizing resources, and increasing collaboration with families, advocates and other child-serving agencies. DPBHS planning activities are closely aligned with DSCYF planning processes.

Advisory Council. The DPBHS Community Advocacy and Advisory Council is comprised of parents, 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 quarterly and as scheduled by task-specific committees. Responsibilities include:

- Collaboration with DPBHS staff in review of service continuum, utilization, process and outcome reports.
- 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.

DPBHS-DSAMH collaboration. One DCMHS 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 DCMHS Advisory Council. There are also other representatives from the Children's Advisory Council that sits on the Governor's 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 collaborations, partnerships and networking.
- 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

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and their implications for program development. The DPBHS Leadership Committee and DPBHS director and deputy director represents the Division on the DSCYF leadership team and various DSCYF working groups to provide continuous input to 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 fulfill continuing education requirements and many have active roles in their professional organizations, providing additional sources of information for planning.

Training

DPBHS is committed to providing free training to Delaware providers. Theses trainings are chosen that will enhance our provider's knowledge working with Delaware's children and strengthening our continuum.

DPBHS has a scheduled training for clinicians, Trauma Focused Cognitive Behavioral Health (TF-CBT) which is offered bi-annually and our GAIN training is offered as needed as our substance abuse providers continuum grows.

Although those of the two scheduled evidenced based trainings our division offers multiple trainings statewide and two annual conferences which includes evidenced based and or promising practices skills workshops to Delaware's behavioral health work force, DOE, DFS, YRS and the Criminal justice system.

Some of these trainings include:

Mindfulness Training Motivational Interviewing
Prevention Behavioral Health Forum/conference
Suicide Prevention Training /Schools
Suicide Prevention Training / Staff and workforce
Fatherhood Conference

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Data Management System

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

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

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

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IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

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SECTION IV - Narrative

Step P. Consultation with Tribes

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

In the absence of 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.

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IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

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Step Q. Data and Information Technology

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

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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

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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.

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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. SAMH 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 FY14, DSAMH plans to utilize CORE Solutions for its transition towards the use of an Electronic Health Records system. 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 has not been utilized at its full capacity by funded providers, as well as state staff. In FY14, KIT Solutions will be providing technical assistance to Delaware. Delaware will increase efforts to monitor use and compliance of the system to ensure effectiveness.

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 when it is operational in

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2014. 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.

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Technical Assistance

There is currently a shortage of funding to support the development of information Technology and new systems to meet Federal reporting requirements and support the EHR initiatives required under the Affordable Healthcare act and under Medicaid requirements. DPBHS is seeking any additional funding and technical assistance regarding data and information technology that could be provided.

Barriers with Claims based approach to payment

DPBHS currently does not bill Medicaid on an encounter/claims based approach. Instead, DMMA, which is the state agency that runs Medicaid, pays PBH a "per child, per month" bundled rate for each child with Medicaid that receives any Medicaid eligible services from PBH in that given month. Therefore, any additional Medicaid eligible services for Medicaid eligible children would need to be incorporated into this "per child, per month"

rate. Challenges include:

- Financial systems are built to support the bundled payment approach. Moving to an encounter/claims based approach would likely require some changes in our system.

- Identifying what services are Medicaid reimbursable, updating the state plan to include these services, and working with Medicaid to figure out how to incorporate the addition of these services into our bundled rate.

- Children currently receive their initial 30 units of outpatient services a year through the Medicaid MCOs. When a child is being served by the MCO, PBH is not involved in their care or delivery of services. It would therefore be a challenge to figure out how to finance any additional services the child receives during that time when they are not involved in our "system".

In addition, DPBHS is currently working with DMMA to review and revise our payment methodology. At this time, the state is working with the federal government to clarify what our options are and move forward with making any required changes. At the same time, the state is implementing health homes for children with SPMI.

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IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

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SECTION IV - Narrative

Step R. 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

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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 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

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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.

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

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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

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- 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.

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IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

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State of Delaware Suicide Prevention Plan

July 2013 - July 2018

A Five-Year Strategy

Goal 1 **:**
Integrate and coordinate suicide prevention activities across multiple sectors and settings

Objectives	Strategies
1.1 Ongoing: Continue to hold regular suicide prevention coalition meetings designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public	1.1.1 Maintain relationships with relevant organizations 1.1.2 Engage organizations to disseminate information through their channels of communication 1.1.3 Encourage unrepresented stakeholders to support the Delaware Suicide Prevention Coalition 1.1.4 Ensure Governor's endorsement and gain legislative support
1.2 By 2015: Increase the number of both public and private organizations active in suicide prevention including the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities	1.2.1 Engage organizations in developing suicide prevention awareness messages and events 1.2.2 Encourage and collaborate with local government, professional, volunteer and other groups to include suicide prevention as a topic of analysis and discussion in their programs, training workshops, and other related activities

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1.3 By 2015: Establish a comprehensive Suicide Prevention Network to help implement the objectives of the Delaware Suicide Prevention Coalition statewide plan and implement the *National Strategy* as applicable	1.3.1 Engage organizations dedicated to implementing the National Strategy. 1.3.2 Convene quarterly to plan and implement community-based suicide prevention activities 1.3.3 Provide technical assistance to the Suicide Prevention Network 1.3.4 Engage relevant partners in suicide prevention activities Increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities 1.3.5 Communicate with partners through meeting minutes, coalition member newsletters and News Journal inserts to provide information and to increase involvement in suicide prevention projects
1.4 By 2015: Support faith-based communities who have adopted institutional policies promoting suicide prevention and increase by 10% the number of faith-based communities who address suicide prevention.	1.4.1 Continue to provide Lifelines and safeTALK trainings to local faith-based groups. 1.4.2 Encourage local faith-based groups to include suicide prevention as a topic of analysis and discussion 1.4.3 Collaborate with faith-based groups to develop plans to assist their members in identifying risk factors, encouraging treatment for depression, increasing protective factors, and offering support and guidance to individuals

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Goal 2:
Implement research-Informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objectives	Strategies
2.1 Ongoing: Support the Get Right Side Up public education campaign that increases public knowledge of suicide prevention to Delaware's Youth	2.1.1 Maintain the Get Right Side Up website which provides information, support services and warning signs 2.1.2 Involve youth in identified activities related to Get Right Side Up
2.2 By 2015: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	2.2.1 Participate in statewide conferences and special-issue forums on suicide and suicide prevention 2.2.2 Advertise1-800-273-TALK hotline number 2.2.3 Use national suicide prevention resources for technical and material support

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***Goal 3*:**
Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objectives	Strategies
3.1 By 2015: Increase number of individuals that view mental and physical health as equal and inseparable components of overall health to reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders. Promote the understanding that recovery from mental and substance use disorders is real and possible for all.	3.1.1 Publish related articles in News Journal insert 3.1.2 Disseminate articles and public service announcements that educate about and highlight suicide prevention strategies 3.1.3 Develop public awareness campaigns to transform public attitudes and build on existing efforts 3.1.4 Enhance school health curricula to ensure that mental health and substance abuse is appropriately addressed 3.1.5 Collaborate with medical professionals to reduce the stigma of mental health related issues within the medical community and to encourage mental health treatment 3.1.6 Provide information to the pediatric and primary health care community to educate them about the signs, symptoms and available resources regarding suicide 3.1.7 Promote educational programs about trauma-informed care
3.2 Ongoing: Promote effective programs and practices that increase protection from suicide risk.	3.2.1 Encourage and support community groups (i.e. schools, faith-based and social organizations) to provide avenues that enhance connectivity among citizens

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Goal 4:
Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Objectives	Strategies
4.1 By 2018: Establish a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness in the media	4.1.1 Convene a group that includes representatives from the state Public Communications Officers, the News Journal, CN8, local TV channels 22 and 8 and other affiliates of the Delaware Suicide Prevention Coalition (DSPC) 4.1.2 Support adherence to guidelines for the responsible portrayal and reporting of suicides and suicide attempts in media and entertainment outlets 4.1.3 Promote education on responsible reporting and encourage instruction on targeting stories using the reporting guidelines
4.2 By 2018: Increase the number of journalism departments in local colleges and universities that adequately address reporting of mental illness and suicide in their curricula	4.2.1 Convene a group that includes representatives from journalism departments in local colleges and universities and the Division of Child Mental Health Services (DCMHS) as well as liaisons to DSPC liaison and other affiliates of the DSPC

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Goal 5:
Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objectives	Strategies
5.1 By 2015: Increase the number of agencies and organizations with comprehensive suicide prevention plans that coordinate across government agencies	5.1.1 Collaborate and coordinate with local agencies that deliver services in public health (injury prevention, mental health and substance abuse) 5.1.2 Provide technical assistance for agencies and organizations in developing goals, objectives, timetables and actions to be taken 5.1.3 Provide agencies and organizations with national and state resources related to evidence-based programming for suicide prevention 5.1.4 Encourage all plans to be culturally competent according to the guidelines and criteria developed by SAMHSA
5.3 By 2016: Increase the number of correctional institutions and detention centers housing either juvenile or adult offenders, with best practices and evidence-based suicide prevention programs	5.3.1 Provide training and technical assistance in evidence-based programs (e.g., Lifelines, safeTALK) 5.3.2 Provide fidelity guidelines to correctional institutions and detention centers to achieve the program outcomes 5.3.3 Encourage the criminal justice system to develop criteria by which the program can be evaluated

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5.4 By 2016: Define and implement screening guidelines for schools, colleges and juvenile justice system, along with guidelines on linkages with service providers	5.4.1 Research Best Practices and existing guidelines Include assessment tools and criteria, protocols, algorithms for assessing risk status, referral guidelines and evaluation measures in mental health and substance abuse screening

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Goal 6:
Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Objectives	Strategies
6.1 By 2018: Increase the number of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks	6.1.1 Identify a screening tool for primary care clinicians, other health care providers, and health and safety officials to assess the presence of lethal means in the home 6.1.2 Identify guidelines on how to talk to family members about the presence of lethal means in the home 6.1.3 Educate individuals and families about firearm storage and access, and about appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications and poisons used for household purposes
6.2 By 2018: Advocate for firearm safety, safer methods for dispensing potentially lethal quantities of medications and methods for reducing carbon monoxide poisoning from automobile exhaust systems	6.2.1 Support and sponsor legislative efforts in the improvement of technologies to prevent suicide by lethal means 6.2.2 Remain knowledgeable of current topics and support national advocacy efforts in this area 6.2.3 Work with military agencies to establish special projects in an effort to reduce violence with guns
6.3 By 2018: Expose a large number of households to public information campaign designed to reduce accessibility of lethal means	6.3.1 Educate individuals and families about limiting access to lethal means 6.3.2

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	Use multiple strategies to communicate the message through posters and pamphlets, videos, bus signs and billboards, and/or other media

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Goal 7:
Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objectives	Strategies
7.1 By 2016: Increase the number of employers who include workforce development training in the assessment and management of suicide risk and the identification and promotion of protective factors	7.1.1 Teach agencies and organizations to incorporate evidence-based training of professional staff in programs 7.1.2 Offer evidence based training to large employers (e.g. ASIST, safeTALK, QPR)
7.2 By 2016: Increase the number of clergy who have received gatekeeper trainings in identifying and responding to suicide risk and behaviors	7.2.1 Engage clergy and faith-based communities regarding Applied Suicide Intervention Skills Training (ASIST), Question Persuade Refer (QPR) Training, and other gatekeeper trainings 7.2.2 Provide training and technical assistance to clergy 7.2.3 Encourage gatekeeper training methods and techniques to be used in the faith-based communities
7.3 By 2016: Increase the number of education programs available to family members and community members of all ages	7.3.1 Organize and integrate public awareness workshops in locations (school meetings, libraries, churches) convenient for families and community members
7.4 Ongoing: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk	7.4.1 Encourage the providers to take advantage of workshops offered on suicide-related topics

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behavior and the delivery of effective clinical care for people with suicide risk	7.4.2 Partner with providers of training to deliver education on suicide-related topics

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Goal 8:
Promote suicide prevention as a core component of health care services

Objectives	Strategies
8.1 By 2016: Increase the number of persons treated for self-destructive behavior in emergency departments, hospital settings, Federally Qualified Health Centers, primary care offices and other health care related locations that pursue a mental health follow-up plan	8.1.1 Develop guidelines for hospitals and health delivery systems that ensure adequate resources to confirm of mental health follow-up appointments 8.1.2 Collaborate locally to establish processes that increase the number of patients who keep follow-up mental health appointments after discharge from emergency departments and other hospital settings 8.1.3 Ensure that a guardian of the youth patient receives the proposed mental health follow-up plan
8.2 By 2017: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings	8.2.1 Encourage coalition members to share protocols 8.2.2 Consider coalescing protocols into a document that can be shared with Delaware agencies 8.2.3 Promote the use of least restrictive settings in coalition-related literature
8.3 By 2017: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts	8.3.1 Discuss outcome measures with Healthcare Commission 8.3.2 Consider offering specific training for quality improvement staff relative to suicide prevention and related indicators

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Goal 9.
Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objectives	Strategies
9.1 By 2016: Start using standardized guidelines for assessment of suicide risk among individuals receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers	9.1.1 Develop standardized suicide assessment guidelines 9.1.2 Identify those who need training and technical assistance in using suicide assessment guidelines 9.1.3 Provide training and technical assistance to personnel in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers 9.1.4 Promote effective assessment services to personnel in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers
9.2 By 2016: Increase the number of persons treated for self-destructive behavior in emergency departments and hospital settings that pursue the proposed mental health follow-up plan	9.2.1 Develop guidelines for hospitals and health delivery systems that ensure adequate resources to confirm of mental health follow-up appointments 9.2.2 Collaborate locally to establish processes that increase the number of patients who keep follow-up mental health appointments after discharge from emergency departments and other hospital settings 9.2.3 Ensure that a guardian of the youth patient receives the proposed mental health follow-up plan

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9.3 By 2016: Increase the number of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse	9.3.1 Develop protocols to provide post-trauma psychological support and mental health education for patients 9.3.2 Ensure proper follow-up and after-care treatment for patients
9.4 By 2016: Develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans	9.4.1 Collaborate with managed care and insurance providers to develop uniform operational definitions for suicidal behaviors and related terms in quality care/utilization management guidelines
9.5 By 2016: Facilitate an understanding of healthcare reform initiatives as they relate to suicide prevention and treatment of suicide survivors	9.5.1 Develop public awareness campaigns to transform public attitudes regarding stigma related to mental health disorders 9.5.2 Develop a public information campaign describing the role of medication in the treatment of persons with mental or substance use disorders (such as bipolar disorder, schizophrenia, dual diagnosis) 9.5.3 Collaborate with local and state agencies to decrease barriers for ethnic and cultural groups such as lack of health insurance 9.5.4 Encourage regular risk assessment at individual healthcare homes
9.6 By 2016: Increase the number of mental health service providers in Kent and Sussex Counties.	9.6.1 Provide advocacy to policy makers 9.6.2 Collaborate with Delaware Healthcare Commission to support mutual efforts

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	9.6.3 Collaborate with Division of Public Health provider recruitment programs
9.7 Ongoing: Promote the safe disclosure of suicidal thoughts and behaviors by all persons	9.7.1 Provide ongoing support for safe disclosure by consistent messaging, promotion, and training of evidence based practices
9.8 By 2017: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs	9.8.1 Establish a temporary ad hoc group to work with emergency departments to accomplish this
9.9 By 2017: Develop guidelines on the documentation of assessment and treatment of suicide risk, and establish or identify resources to provide a training and technical assistance to assist providers with implementation	9.9.1 Research guidelines that have been vetted by American Association of Suicidology (AAS) and other experts 9.9.2 Consider bringing AAS and other expert resources to Delaware to assist with implementation

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Goal 10.
Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objectives	Strategies
10.1 By 2016: Define state guidelines for effective comprehensive support programs for suicide survivors	10.1.1 Develop guidelines and offer peer leadership training for facilitators of suicide survivors support groups
10.2 By 2016: Increase the number of providers who are prepared to deliver effective services to suicide survivors	10.2.1 Provide training and technical assistance in suicide survival to professionals and other service-oriented individuals (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors and clergy) 10.2.2 Arrange for suicide survivors to speak at seminars on topics such as recognizing and managing the personal impact of suicide to first responders
10.3 Ongoing: Increase the number of suicide survivors who are attending educational and support programs	10.3.1 Increase awareness of available support groups 10.3.2 Encourage availability of groups in all three counties 10.3.3 Create new supportive programming in psychiatric and medical facilities, high school wellness centers, community organizations and faith-based communities
10.4 Ongoing: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief	10.4.1 Provide training to clinical programs on trauma treatment and care for complicated grief

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	10.4.2 Identify standards of care for programs who provide trauma treatment and care for complicated grief
10.5 Ongoing: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups	10.5.1 Encourage participation in Mental Health Association groups as well as other applicable agency groups 10.5.2 Provide information to DSAAPD for inclusion in their resource guide
10.6 By 2015: Adopt, disseminate, implement, and evaluate guidelines for Delaware to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation	10.6.1 Work with Division of Public Health, Center for Disease Control, and other State entities to develop these guidelines 10.6.2 Establish an ad hoc group to focus on this objective

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Goal 11.
Increase the timeliness and usefulness of surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objectives	Strategies
11.1 By 2018: Encourage the development of standardized protocols for death scene investigations	11.1.1 Collaborate with first responders to review emergency medical services protocols for suicide scene procedures and revise as needed 11.1.2 Support the provision of training to emergency medical technicians, medical examiners, fire fighters, police and coroners in gathering evidence from a suicide scene
11.2 By 2018: Increase the number of jurisdictions that regularly collect and provide information for follow-back studies of suicides	11.2.1 Determine if a local jurisdiction regularly completes follow-back studies on completed suicides; if not, advocate for follow-back studies 11.2.2 Support already-existing initiatives (e.g., Child Death, Near Death and Stillbirth Commission; Morbidity and Mortality Committees)
11.3 By 2018: Increase the number of hospitals that collect uniform and reliable data on suicidal behavior by coding external causes of injuries	11.3.1 Advocate for mandated coding of external causes of injury by all hospitals
11.4 By 2018: Increase the number of state survey instruments that include questions on suicidal behavior	11.4.1 Advocate for separate questions for suicidal behaviors in state surveys 11.4.2 Task a coalition member to identify the number and contact persons for state survey instruments.
11.5 By 2018: Encourage the development of a statewide violent death reporting system that includes suicides and collects information not currently available from death certificates	11.5.1 Review current practices and ensure that nationally recognized reporting systems are in line with state practices

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11.6 By 2018: Increase the number of annual reports on suicide and suicide attempts	11.6.1 Review current practices and ensure that nationally recognized reporting systems are in line with state practices 11.6.2 Encourage state health agencies to produce reports on suicide
11.7 By 2018: Support pilot projects to link and analyze information on self-destructive behavior from various distinct data systems	11.7.1 Link data systems from law enforcement, emergency medical services, hospitals and other public health agencies 11.7.2 Eliminate barriers with respect to data linkage including difficulties in obtaining access to various data sets, maintaining databases and issues of confidentiality 11.7.3 Analyze linked data systems to provide more comprehensive information about youth suicide and suicide attempts

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Goal 12:
Promote and Support Research on Suicide Behavior and Prevention

Objectives	Strategies
12.1 By 2018: Develop a statewide suicide research agenda with inputs from survivors, practitioners, researchers and advocates	12.1.1 Include research on aspects of prevention, intervention or postvention, including basic, applied, clinical, evaluation, community-based intervention and media-based research
12.2 By 2018: Increase funding (public and private) for suicide prevention research, research on translating scientific knowledge into practice, and training of researchers in suicidology	12.2.1 Apply for public and private funding through collaboration with federal, state and local stakeholders 12.2.2 Leverage existing resources to maximize funding for suicide prevention research
12.3 By 2018: Establish and maintain a Delaware registry of prevention activities with demonstrated effectiveness for preventing suicide or suicidal behaviors	12.3.1 Review existing research to gather findings that have the most potential for application in community and clinical settings 12.3.2 Make the registry available to individuals or communities so they can apply them or build upon them in developing local youth suicide prevention initiatives
12.4 By 2015: Disseminate the national suicide prevention research agenda	12.4.1 Research how to add electronic access to suicide prevention research guide on coalition members' websites 12.4.2 Consider including national suicide prevention research agenda to other document dissemination that the coalition creates

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Goal 13.
Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objectives	Strategies
13.1 By 2016: Develop a comprehensive data collection plan that regularly obtains and analyzes state and county suicide rates and suicide attempts in a coordinated and integrated method	13.1.1 Discuss the National Outcome Measures and encourage the coalition membership organizations to collect data on specific measures 13.1.2 Evaluate state-level achievements based on established National Outcome Measures (NOM) 13.1.3 Define the goals and objectives of the data collection protocol 13.1.4 Agree on operational definitions and methodology for the statewide data collection plan 13.1.5 Ensure data collection (and measurement) repeatability, reproducibility, accuracy and stability in activities 13.1.6 Follow through with the data collection process as defined by the statewide data collection plan 13.1.7 Establish an ad hoc committee to concentrate on these strategies in order to achieve this objective.

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IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

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SECTION IV - Narrative

Step T. Use of Technology

ADULT BEHAVIORAL HEALTH SYSTEM

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

During the next two years, while DSAMH begins to assess the substance abuse treatment system, DSAMH plans to continue to utilize a variety of strategies to use ICTs to supplement treatment and recovery approaches. These strategies may include: Telepsychiatry; Common Ground Software; My Outcomes Software.

Delaware has taken the initiative by purchasing the product and making it economical for providers to use. The cost to providers will be much less if participating as part of the state project than if they purchased the products on their own. Delaware has made every effort to involve the providers early in the process and to communicate clearly the level of effort needed to participate as well as the benefits to both providers and clients.

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

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

Delaware plans to use the data collected from ICTs to evaluate programs at the client level. Use at the provider level remains uncertain at this time.

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

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changes can be detected in the annual consumer survey conducted by the state.

DSAMH providers utilize the KIT Solutions system for their data collection methodology in collaboration with DPBHS.

CHILD BEHAVIORAL HEALTH SYSTEM

In FY2011 PBH initiated 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 through a contract with KIT Solutions, Inc., allowing for accurate, real time data collection for SAPT'S NOMS by PBH on Delaware children, youth and their families. All 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.

For substance abuse treatment 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

DPBHS will roll out a new system and enhances enhanced FACT II system that 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

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- 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 substance abuse treatment more effectively and efficiently.

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IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

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Step U. Technical Assistance Needs

Delaware is currently receiving a variety of technical assistance services through SAMHSA/CSAT/CSAP.

During FY12-13, DSAMH received technical assistance focused on Needs Assessment and Women's Services. DSAMH has concluded with the technical assistance being received with regards to women's services; however, in FY 14, DSAMH will continue to implement the strategies suggested through that assistance in order to enhance the delivery of services for women, particularly for pregnant women and women with dependent children. In FY14, DSAMH will continue to work with SAMHSA/ CSAT to close out the needs assessment technical assistance as the State continues to review and develop better methods for collecting, analyzing, and utilizing data to make purchasing and policy decisions.

As a result of the 2012 SAMHSA/CSAT Core Technical Review, SAMHSA identified three areas of technical assistance that are needed for Delaware:

1. To strengthen understanding and management of the SABG requirements;
2. To enhance cultural appropriateness of services; and
3. To update fiscal management of the service delivery system

In FY13, Delaware began working with SAMHSA/CSAT to coordinate technical assistance on DSAMHs fiscal management system. Initial planning meetings will commence July 2013. This technical assistance may consist of on- and offsite assistance to help DSAMH develop or update its fiscal policy and procedures manuals, including SABG fiscal requirements. The TA might also focus on the minimum specifications/documentation requirements and records maintenance.

In order to strengthen understanding and management of the SABG requirements the SPO will provide the state SABG guidance and tools such as the following: Samples of contract language; Monitoring tools; PowerPoint slides; Sample memoranda of understanding; and s ample policy and procedures. These materials should include tools that SAMHSA and states have developed.

To enhance cultural appropriateness of services, DSAMH has requested on- and offsite technical assistance to develop a tool/process to conduct external reviews of available cultural competency programming available to and being used by DSAMH-funded providers; an assessment of the extent to which existing cultural competency training meets or exceeds DSAMH specifications; and tools that will enable state monitors to assess cultural competence of contracted providers.

In addition to the SAMHSA identified technical assistance, DSAMH requested technical assistance in the form of a consultant to provide a range of targeted TA through on- and off-site consultation to address the substance abuse treatment infrastructure, service array

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and protocols; and to assist with the coordinated TA efforts of all SAMHSA sponsored TA. This technical assistance was requested by DSAMH because Delaware's community substance abuse services system is inefficient, lacks coordination and expert oversight, and rewards process versus outcomes. DSAMH lacks internal expertise in designing and transforming from an acute care model to a recovery-oriented system, with emphasis on peer-driven recovery supports and long-term client engagement and retention. The system needs to be integrated with our community mental health system and primary healthcare to address co-occurring disorders. The array of services, treatment protocols and payment mechanisms need to be re-designed to allow for maximization of Medicaid reimbursement and the reinvestment of State/SAPTBG funds to support recovery, to prepare for state Medicaid expansion and ACA implementation. Further, Delaware is in need of guidance in developing meaningful and useful management information reports and 'dashboards' with contract incentives that reward efficient and effective recovery acculturation.

DSAMH will continue to receive technical assistance through FY14-15 as needed on these identified topics.

In addition to DSAMH identified technical assistance, DPBHS has identified that there is currently a shortage of funding to support the development of information technology and new systems to meet Federal reporting requirements and support the EHR initiatives required under the Affordable Healthcare act and under Medicaid requirements. DPBHS is seeking any additional funding and technical assistance regarding data and information technology that could be provided.

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V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work 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. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

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W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

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Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Sara Fishman	Others (Not State employees or providers)		Community Legal Aid Society, Inc. , 100 W. 10th Street, Suite 801 Wilmington, DE 19801 PH: 302-575-0690	sfishman@declasi.org
Anne Deming, PhD	Others (Not State employees or providers)		651 Beaver Falls Place Wilmington, DE 19808 PH: 302-999-1666	anneldeming@aol.com
Wesley Jones	Others (Not State employees or providers)		1901 South College Avenue Newark, DE 19702 PH: 302-369-1501	gjonesii@christianacare.org
Susan Phillips	Others (Not State employees or providers)		414 Evergreen Circle Milford, DE 19963	ss.phillips@verizon.net
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
Carol Harman	State Employees	Mental Health	Baratt Bldg, Suite 102, 821 Silver Lake Blvd Dover, DE 19904 PH: 302-739-8380	carol.harman@state.de.us
John Evans	State Employees	Delaware State Police	PO Box 430 Dover, DE 19903 PH: 302-739-5911	john.evans@state.de.us
Matthew Heckles	State Employees	Delaware State Housing Authority	18 The Green Dover, DE 19901 PH: 302-739-4263	matthew@delstatehousing.com
Dennis Rozumalski	State Employees	Department of Education	401 Federal Street, Suite 2 Dover, DE 19901 PH: 302-735-4273	drozumalski@doe.k12.de.us
Thomas Hall	State Employees	DHSS/Division of State Service Centers	1901 N. Dupont Hwy New Castle, DE 19720 PH: 302-255-9605	
Connie Hughes	Providers	DelARF	100 W. 10th Street, Suite 103 Wilmington, DE 19801 PH: 302-622-9177	CHughes@delarf.org
Lynn Fahey	Providers	Brandywine Counseling, Inc.	2713 Lancaster Avenue Wilmington, DE 19805 PH: 302-472-0381	lfahey@brandywinecounseling.org
James Larks	Providers	NET Centers	3315 Kirkwood Highway Wilmington, DE 19808 PH: 302-691-0140	jlarks@net-centers.org
			20505 DuPont Blvd., Unit	

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Bruce Lorenz	Providers	Thresholds	1 Georgetown, DE 19947 PH: 302-856-1835	blorenz@thresholdsinc.com
Charles Sygowski	Providers	Delaware Council on Gambling Problems, Inc.	100 W. 10th Street, Suite 303 Wilmington, DE 19801 PH: 302-655-3261	underdog@dcgp.org
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
Edie McCole	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		12 Hillside Road Claymont, DE 19703 PH: 302-793-1941	ediemccole@comcast.net
John 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
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
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
Florence Alberque	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		103 Delaplane Ave Newark, DE 19711 PH: 302-602-4486	floa49@yahoo.com
Daniel Hoeftman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1033 Governors Circle Wilmington, DE 19809 PH: 302-762-6205	gotodan@comcast.net
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

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Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

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		

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* 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?

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X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

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SECTION IV - Narrative

Step X. Improving Enrollment Processes and Provider Business Practices

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

• Outreach and enrollment support for individuals in need of behavioral health services.
• Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
• Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
• Third-party contract negotiation.
• Coordination of benefits among multiple funding sources.
• Adoption of health information technology that meets meaningful use standards.

Additional information is currently being pulled from State partners to respond fully to the guidance listed above. More information will be provided at a later date.

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Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) 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 BG 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 the Secretary of HHS.

Footnotes:

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