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Assessment #7

Mental Health Block Grant 101

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Mental Health Block Grant 101

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Document Overview

The purpose of this document is to provide the Pacific Jurisdictions with helpful suggestions that may assist staff with developing their Mental Health Block Grant applications and bi-annual Mental Health State Plans. This document is intended to be a resource guide only. Any language in this document that is not authorized by statute or in the Block Grant application guidance is merely a suggestion, intended to help Jurisdictions develop a more comprehensive application and mental health plan. This document is not official guidance nor does it supersede in anyway any program statute or official federal administrative policies.

This document is organized to follow the general format of the Community Mental Health Block Grant Application and State Plan.

- ☑ The section titles will be used instead of numbering as the numbers may change in the future.
- ☑ Since the requested sections of the Block Grant application may vary from year to year the document mainly focuses on the required sections. However, suggestions are provided for the requested sections.
- ☑ The first section is Quick Tips for Preparing the Block Grant Application with general, primarily administrative suggestions.
- ☑ The remainder of this document follows the headings in the block grant guidance with questions/observations/recommendations to assist planners in preparing a complete application that reviewers will find easy to follow. The recommendations included in this document are not required. They are only offered to help agencies organize and present a full picture of their mental health system of care.
- ☑ The Required Sections are addressed first in the order that they appear in the application guidance.
- ☑ The 5% Set Aside and Behavioral Health Advisory Council sections are required, but are addressed in the order that they are contained in the application guidance in the Requested Section. This format follows the WebBGAS format.
- ☑ The Requested Sections are addressed in the order that they appear in the application guidance.
- ☑ At the beginning of each section, the heading as it appears in the application guidance along with an excerpt from the guidance is presented in italics and quotation marks.
- ☑ The main body of this document is 28 pages long.
- ☑ The rest of the document includes appendices with charts, examples, and lengthier excerpts from the various jurisdictions that provide good examples of a specific section.

Quick Tips for Preparing the Block Grant Application

The Introduction to the Block Grant Application gives an excellent overview of the issues that SAMHSA identifies as being relevant to states' planning activities. Due to the size and political structure of the Pacific Jurisdictions, many of these issues may not be directly relevant. However, the underlying themes of prevention, integration of primary and behavioral health, parity in health insurance between physical health and behavioral health, data-driven planning, and use of evidence in providing/purchasing services are ones that should be given attention not only in preparation of your application but in the daily delivery of services.

Some general tips that may help in writing the application are as follows:

- ☑ Make sure that the administrative forms are completed with current information to avoid delays in getting grant funds.
    - The State Information page, the delegation letter, and the Assurances and Certifications must be complete and accurate – save yourself some grief and get them done early so that whoever needs to sign them has plenty of time. Make sure that the information for the authorized signing official and the planner are current on the State Information page.
    - To avoid last minute WebBGAS issues, make sure that your password and user id are working. Avoid submitting close to the deadline hour.
- ☑ In years that the bi-annual plans are due, start drafting the document 3-4 months in advance of the submission date.
- ☑ Step 1 has the most narrative information and probably changes the least from year to year. Get it in good shape early so that more time can be devoted to Steps 2-4 and the expenditure forms.
- ☑ A draft of the plan should be shared with the Planning Council 30 days in advance of the submission deadline so that they can meet their statutory obligation to review and approve the application.
- ☑ If your review process requires a lot of time, you should adjust the timeframes listed above to allow for extra time.
- ☑ You can also give the Planning Council members the citizen access code so that they can be looking at the application on WebBGAS as you complete the different sections.
- ☑ Work with your data people to collect necessary data for the needs assessment for the last complete fiscal year and year-to-date for the current fiscal year. Use the data in Step 2.
- ☑ Use Spell Check.
- ☑ Use descriptive material from other grant applications, site visit reports, and technical assistance documents as relevant, but make sure that they are up to date.

- ☑ Work with your Substance Abuse colleagues if you are not preparing a joint application to see how you might share information as relevant to your application.
- ☑ Use as few words as possible to accurately and completely cover the topic.
- ☑ Long documents that are referenced should be added as attachments instead of included in the body of the application.
- ☑ Short descriptions that are repeated in different sections should just be copied and pasted to avoid having reviewers jumping back and forth in the document.
- ☑ Think about linking one section to the other – Step 1 should clearly describe your system - Step 2 should identify systems needs based on data analysis and input from stakeholders – Steps 3 and 4 should logically follow with priorities, goals, strategies, and performance indicators designed to address the needs identified in Step 2. Basically, all of the steps of the plan should connect and tell a logical story.

Appendix 1 contains a comparison between the block grant guidance, the five statutory criteria, and the Substance Abuse and Mental Health Services Administration's (SAMHSA) block grant goals and aims and the Strategic Initiatives. The chart is a very broad overview of basic application checkpoints. It provides a way to make sure that the application requirements are met and to address SAMHSA priorities as they are relevant to your system.

Required Sections

"***Step 1 – Assess the strengths and needs of the service system to address the specific populations-***

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."

Each jurisdiction's application contains some or most of the information located below. It is not always organized in a way that makes it easy to follow. Since this section lays the foundation for the rest of the plan and contains the most descriptive information, it is important to organize it in a manner that is easy to prepare and to follow. It is also the section that will not change much from one year to the next, so getting it in good shape will only require updates in subsequent years. This is also the section where most of the five statutory criteria will be addressed. The following sections are suggested to help organize the material: SSA/SMHA, Service Providers, Services, Diversity, Geography/Population and Political Organization.

"Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems."

A. Single State Agency(SSA)/State Mental Health Authority(SMHA)

- ☑ Describe where in the government that the SMHA is located – It seems that Mental Health and/or Substance Abuse (MH/SA) Services are commonly located in the Ministry/Department of Health. It Is less clear exactly where in the Health Department MH/SA services are located and whether MH and SA services are combined or in separate administrative units. The same is true for children's MH and SA services – all in the same unit with adult or in a separate unit?

- ☑ Provide a general overview of the roles and responsibilities for each bureau, unit team or division responsible for delivering, managing or collecting data for children and adult mental health services.
- ☑ An organizational chart is helpful in making the location of the SSA/SMHA clear and the relationship between MH and SA and adult and child services.
- ☑ The organizational chart in **Appendix 2** is a made-up example of how the administrative structure could be shown.
- ☑ You can make a chart that shows your particular administrative structure. The chart and your narrative together should make the structure clear.

"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."

A. Service Providers

- ☑ Describe who provides direct services and prevention services – Are services provided only by jurisdiction employees? If so, how many are there with what qualifications? If services are sub-contracted to local programs or states, describe them. Are there differences between the adult and the children's service providers?
- ☑ Are block grant funds used in part to pay the salaries of the direct service/prevention staff? If so, the expenditure tables (Tables 2 and 3) should show that.
- ☑ Are there other governmental units that provide mental health services to adults and/or children? For example, are inpatient psychiatric services provided by a different division? A private hospital? Does the Youth Service Agency or the Social Service Agency (if different than the SSA/SMHA) provide services?
- ☑ Are there private providers who also provide services? Are the private providers individuals or agencies?

See **Appendix 3** for Guam's description of service providers. It describes services provided by the jurisdiction as well as other service providers.

See **Appendix 4** for Palau's description of its staffing pattern. This list makes it clear which staff provide child and adolescent and adult mental health services and which provide substance abuse services.

B. Services

☑ State the priority populations for the direct service delivery system – e.g. adults with serious mental illness, children with severe emotional disorders, and any others identified by your jurisdiction.

Example: Guam provides a clear description of its priority populations as follows:

"GBHWC will continue to address existing Block Grant requirements while working to create the system change that will be necessary as Health Reform approaches. Specifically, the plan will address SAMHSA-required areas of focus, including:

- Comprehensive community-based services for adults with Serious Mental Illness and children with Serious Emotional Disorders and their families;

In addition to these required populations, Guam's plan will address services for the following populations.

- Children, youth, adolescents, and youth-in-transition with or at risk for substance abuse and/or mental health problem;
- Those with a substance use and/or mental health problem who are:
    - Homeless or inappropriately housed;
    - Involved with the criminal justice system;
    - Military service members, veterans, or military family members; and/or
    - Members of traditionally underserved populations, including:
      Racial/ethnic minorities
      GLBTQ populations
      Persons with disabilities.

☑ State the priority populations for primary prevention services

☑ List the direct and prevention services provided by jurisdiction employees, e.g. general outpatient services, including evaluation, diagnosis, treatment, and case management services, and universal primary prevention services. Please make note of any Evidence-Based Practices (EBP). If inpatient psychiatric care is provided by another unit, describe how outpatient services are coordinated with that unit and are designed to reduce hospitalization.

☑ List the direct and prevention services that are provided by subcontract agencies.

☑ This is the section where you address the services listed in Criteria 1, 3, 4, and 5. For each of the following service types, state whether the service is provided and by whom and how it is coordinated with mental health services:

- services for dually diagnosed
- health
- rehabilitation
- employment

- housing
- education
- substance abuse
- medical and dental services
- services provided under Individuals with Disabilities Education Act
- case management (may be covered in the description of services provided by jurisdiction employees)
- a system of integrated social, education, juvenile and substance abuse services to treat children with multiple needs
- outreach to homeless
- how services will be provided in rural areas
- how emergency health providers are trained.

☑ Note any differences between the adult and the child mental health service delivery systems. If they are different, how are transitional age services coordinated?

☑ There are numerous topics to be addressed, but the description for each should be simple and as brief as possible.

☑ As you describe services provided by jurisdiction employees or sub-contract entities, think about whether they relate to any of the SAMHSA block grant goals/aims and the Strategic Initiatives. If so, a simple statement to that effect is sufficient.

See **Appendix 5** for the Commonwealth of the Northern Mariana Islands description of services. It addresses the majority of the requirements in Criterion 1 and 3.

"The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities."

A. Diversity

☑ The description of the geography and population will lay the foundation for this section. **For example**, the four states of Micronesia all speak different languages which require that services be delivered by staff who speak the local language as well as English.

☑ How are the needs of the Lesbian, Bi-sexual, Gay, and Transgender (LBGT) individuals met?

☑ Are the demographic characteristics of those who receive services similar to the overall demographics of the jurisdiction?

- ☑ Describe efforts to address the needs of diverse groups. For example, you may try to engage individuals through outreach, written material, representation on planning bodies, use of indigenous workers, etc.

See **Appendix 6** for Hawaii's description of services to special populations.

A. Geography and Population

The geography and population distribution in the islands is unique compared to the continental states and, in part, determines how the service delivery system is structured.

- ☑ Describe the geography of the jurisdiction – this description may already exist in Wikipedia, other grants, etc.
- ☑ Describe how travel between the islands is accomplished and how long it takes.
- ☑ Describe the various nationalities and ethnic groups and related languages existing in the jurisdiction.
- ☑ Describe the communication infrastructure between the islands or within the island. For example, are the following services readily available and reliable: land line phone service, cellular service, internet (email, Skype, etc.).

See **Appendix 7** for Palau's description of its service area.

B. Political Organization

Because the Pacific Jurisdictions are unique in their political organization and because it has a direct bearing on important topics such as the Affordable Care Act, Medicaid, and Medicare, a clear description of the political organization is important.

- ☑ State whether the jurisdiction is a territory or a Free Association State.
- ☑ State whether the jurisdiction receives Medicaid funding. If so, describe whether it is used to pay for mental health services – inpatient or outpatient.
- ☑ State whether the Affordable Care Act and the Parity Act apply to the jurisdiction.
- ☑ State whether the President/Governor appoints the head of the agency where mental health services are located. If so, say how long the current agency director has been in that position.
- ☑ State whether there are relevant political subdivisions in the jurisdiction e.g. the states in Micronesia.

Step 1 Summary:

By now, the reviewer should understand the geography of the islands and how it relates to service delivery, the political structure of the jurisdiction, where mental health services fall within the administrative structure of the jurisdiction, who provides which mental health services to both adults and children, how various support services are provided, and whether/how services relate to block grant goals/aims and the Strategic Initiatives. In addition, the reviewer will understand how the jurisdiction identifies and engages individuals from diverse backgrounds.

"Step 2 – Identify the unmet service needs and critical gaps with the current system-

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."

This section is where you bring together statistical data and input from the Planning Council and any other advisory bodies, feedback from other state agencies, and your experience to identify where the system needs to be improved. Step 2 can be addressed in three sections.

Unmet Needs and Critical Gaps

- ☑ What areas need to be improved based on the jurisdiction experience providing and/or contracting for services?
- ☑ Are there certain types of staff that you have difficulty attracting and retaining?
- ☑ Do you have a lot of approved, but unfilled staff vacancies due to recruitment/retention issues?
- ☑ Do you have difficulty getting necessary staff positions approved due to funding or politics?
- ☑ Are caseloads so high that individuals are not receiving services as frequently as needed?
- ☑ Are you able to provide evidence-based services with existing staff? Is more training needed and/or different types of staff?
- ☑ Do you need more staff or communication equipment to provide services to outlying locations?
- ☑ Do you need training in specific interventions? A number of jurisdictions indicated that their staff needed training in trauma-informed care.
- ☑ If your staff serve both adults and children, are they trained how to address the needs of each group?
- ☑ Is your data system sufficient to provide accurate and complete data on the people served (demographics, clinical characteristics) and the services they received (individual, group, case management, etc.) at the individual client level?
- ☑ Does the State Epidemiological Outcomes Workgroup address MH as well as SA data? What areas of need are identified?

Statistical Analysis

- ☑ Use the historical prevalence formulas (Uniform Reporting System (URS), Table 1) for estimating the number of adults with SMI and children with SED present in the population. Are there cultural differences that would suggest that the NRI estimates are not correct for the jurisdiction? If so, describe how these differences would make the NRI estimates too low or too high. Is your definition of SMI/SED different from the federal one? If so, how does that impact the estimates?
- ☑ Compare these estimates to those actually receiving services through jurisdiction employees and subcontractors.
  - Is there a difference between estimated need and number served that would require more staff, i.e. money, to serve?
  - Is the difference being served by other agencies or private providers to some extent?
  - What is the overall penetration rate for persons served compared to national rates or to that of similar territories/Free Association States?
  - **For example**, the NRI estimates might show 10,000 adults with SMI and 4,000 children with SED. You served 5,000 adults with SMI and 1,000 children with SED. That leaves a pretty big difference between need and served. However, other units/agencies serve an estimated 1,000 adults and 500 children. There is still a big gap in need versus served which will require more staff/funding to serve.
- ☑ What other sources of information point to unmet needs and critical gaps? Using your data system, do you need to serve more women, men, children, minority groups, etc. compared to their representation in the general population?

  For example, Micronesia analyzes the decline in total number served as follows:
  "As of this reporting period ending December 2013, there are a combined total of 445 active clients for substance abuse and mental health treatment. As you will see in the tables below, there are more mental health than substance abuse clients. That does not mean that we don't have substance use problems, but we are still in the process of improving our referral systems and screening tools to identify those individuals who need, and enrolling them in the proper service(s). We found a reduction of 171 clients in 2013, and an overall reduction of 447 from 2009 to December 2013 (Table 1). These data concern us because we believe the level of need has not changed, but the data do not reflect that. This reduction in reporting may be due to a range of factors, including stigma; cultural resistance; client compliance; transportation; accurate staff reporting and documentation; clients moving out of FSM (e.g., to US and Guam); client deaths; and clients refusing any

offered services. This will be a key focus area of our assessment and plan to more accurately capture the needs and service delivery."

- ☑ What does the data in SAMHSA's Behavioral Health Barometer show for the four indicators that they selected? Are there other indicators that are of concern to you?
- ☑ Are there local surveys or other national data sources such as the National Survey on Drug Use and Health or the National Facilities Surveys on Drug Abuse and Mental Health Services that highlight needs/gaps?

See **Appendix 8** for Alabama's description of data sources and prevalence estimates.
See **Appendix 9** for Palau's analysis of need.

Planning Council/Other Agency Input

- ☑ What needs have been identified during the Planning Council meetings? Are these based on general discussion? Formal vote?
- ☑ In working with other agencies, what requests for service are made that you cannot meet? What do they tell you that they wish could be done for the people they serve who have mental illness?
- ☑ Is there an interagency committee or council that comes together to identify needs including the need for mental health services? If so, what are the identified needs?
- ☑ Has there been external oversight/control over the system that dictated the focus of the system for the current planning cycle? If so, what are the gaps/needs identified in this process?

Step 2 Summary:

At the end of this section, the reviewer should clearly understand what your needs and service gaps are and what information you used to identify the needs and gaps.

"Step 3 – Prioritize state planning activities

"Using the information in step two, states should identify specific priorities that will be in the MHBG and SABG. The priorities must include the core federal goals and aims of the Block Grant programs: target populations (those that are required in legislation and regulations for each Block Grant) and other priority populations described in this document. States should list the priorities for the plan in Plan Table 1 and indicate the priority type (i.e., substance abuse prevention (SAP), substance abuse treatment (SAT), mental health prevention (MAP) or mental health services (MHS)."

- ☑ Identify clearly and concisely the top mental health priorities for your jurisdiction.
- ☑ Priorities are broad areas that reflect the issues of greatest concern/most immediate need.
- ☑ These priorities should flow from the areas of need identified in Step 2. For example, the Alabama Plan identifies 3 priority areas: self-directed system of care, community integration, and EBPs/best practices.

"***Step 4 – Develop objectives, strategies, and performance indicators***

For each of the priorities identified in step three, states should identify the relevant goals, strategies, and performance indicators over the next two years. For each priority area, states should identify at least one measurable goal/objective. For each goal, the state should describe the specific strategy that will be used to reach the goal. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, improving emotional health and prevention of mental illness, and system improvements that will address the goal."

- ☑ The goals are broad statements of desired outcomes that may have several strategies and performance indicators. **For example**, a priority is to improve access for children with SED. A goal (general description of what you hope to accomplish) for this priority is to serve a certain number of youth with SED or achieve a certain percentage increase in the number served from the prior year.
- ☑ A strategy (the means to reach the goal) for this goal would then be to hire 2 new Child and Adolescent Therapists or to train a certain number of existing staff to provide services to children and adolescents.

- ☑ The Performance Indicator (a measure of success on a yearly basis) for this strategy would then be the number of therapists hired or the number of staff trained and the number of children and adolescents served compared to the baseline.
- ☑ You should select indicators for which you can get a baseline number and numbers in the first and second years of the application. Sometimes a measure is not a number but could be something like a training held, a policy written, or an interagency agreement signed.

Example: The priority area is to improve services, the goal is to train staff using a proven clinical technique, the strategy is to implement trauma-informed care, the Year 1 Performance Indicators are to identify training resources and schedule the first training session, and the Year 2 Performance Indicators are 1) the number of staff trained and using trauma-informed care techniques and 2) the development of an intake protocol that assures that trauma is assessed during intake.

Example: In the Alabama plan, there is a broad goal for each of the three priority areas. The goals for the three priority areas noted in Step 3 above are as follows:

- "Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.
- Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.
- Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices."

Please note that the Alabama goals are directly related to the block grant aims and goals (home, health, purpose, and community) and to the following Strategic Initiatives: Recovery Support, Health Information Technology, and Data, Outcomes, and Quality.

See **Appendix 10** for an excerpt from Alabama's goals, strategies, and performance indicators.

Steps 3 and 4 Summary:

The priorities and the means for addressing them are described in these two steps. If you have a priority or goal that has not been mentioned in Step 1 or Step 2, you need to go back to those sections to add whatever is needed to support the choice of that particular priority/goal. Think about linking each section in a logical manner – here's our system (Step 1), here's where we need to improve (Step 2),

these are the highest priority areas (Step 3), and here's what we are going to do about it for the next two years (Step 4).

Tables 2, 3, and 6b

Plan Table 2: State Agency Planned Expenditures – the total under the MH BG should equal all planned expenditures for the year – direct services, prevention, and administration. If you can provide numbers in the other columns, please do so because it gives a clearer picture of the public mental health system. Table 2 is the only required table.

Plan Table 3: State Agency Planned Block Grant Expenditures by Service – In Step 1, you described service providers and services. To make this as simple as possible, you can use the major headings, e.g. Healthcare Home/Physical Health, Prevention, Engagement Services, etc. and not try to complete the more detailed lines under each major heading. If you use Block Grant funding to pay salaries of staff who provide Outpatient Services, you would put that amount in the Outpatient Services line and leave the sub-headings blank. Table 3 is not required, but it might be helpful to complete it in anticipation that the information will be needed for the Implementation Report.

Plan Table 6b: MHBG Non-Direct Service Activities Planned Expenditures – the total for this table plus the total for Table 3 should equal the total for Table 2. Table 6b is not required. However, similarly to Table 3, it may help you in the long run to put estimates in the application.

The chart on the next page shows how the three tables relate to each other.

Interaction Between Tables 2, 3, and 6b

Table 2 State Agency Planned Expenditure	Table 3 State Agency Planned block Grant Expenditure by Service	Table 6b MHBG Non-Direct Service Activities Planned Expenditures
2.b. MH Primary Prevention	Prevention	Technical Assistance Activities
5% Set Aside	Outpatient Services	Planning Council Activities
State Hospital	Out of Home Residential Svcs	Administration
Other 24 Hour Care		Data Collection/Reporting
Ambulatory		Enrollment and Provider Business Practices
Administration		Activities Other Than Those Above
Total	Total	Total

2.b Primary Prevention – The amount in this line may be the same as the Prevention line in Table 3 or the Activities Other Than Those Above in Table 6b depending on whether you consider Prevention to be a Direct or Non-Direct Service. It is also possible that you could have amounts in both Tables 3 and 6b.

5% Set Aside – Most of the jurisdictions indicated that they planned to use their funds to obtain Technical Assistance on EBPs. In that case, the 5% Set Aside amount in Table 2 should be the same as the Technical Assistance Activities amount in Table 6 b.

Other 24 Hour Care in Table 2 should equal Out of Home Residential Services in Table 3.

To keep it as simple as possible, the Ambulatory line in Table 2 should equal the Outpatient line in Table 3.

The Administration line in Table 2 should equal the sum of the Planning Council Activities, Administration, Data Collection/Reporting, and Enrollment and Provider Business Practices lines in Table 6b. You may not have an entry in all of these rows except Administration in Table 6b.

Requested Sections

With the exception of the section related to the 5% set aside for individuals with early onset mental illness and the section related to the Behavioral Health Advisory Council, the remaining sections are requested, not required. Much of the focus of these sections is on implementation of the Affordable Care Act and the Mental Health Parity Act and the priorities set by SAMHSA. These issues are important and deserve attention. However, they may not be consistent with or directly applicable to the current priorities of the jurisdictions. To the extent that you have information that addresses the recommended sections, you should include it. If you choose not to address a requested section, use a standard phrase such as "This section is not addressed".

"Coverage for M/SUD Services

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."

- ☑ This question is not directly relevant to the Free Association States. However, to the extent that private insurance exists within these jurisdictions, it is possible to advocate for coverage of MH services consistent with the Parity Act. If you have or plan to undertake such action, please describe.
- ☑ None of the territories elected to implement their own marketplace. Medicaid funding was increased instead. Medicaid funding in the territories does not appear to be used for MH services or to function in the same way that Medicaid does for the states. A brief statement about how Medicaid funds, including the increase, are used would be helpful here. Guam is exploring billing for MH services under Medicaid.

"Health Insurance Marketplaces

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services."

- ☑ This question is not directly relevant to the Free Association States.
- ☑ The SMHA should describe whether the increase in Medicaid funding will be used to expand eligibility, to increase payment for existing services, to add new services, or some combination of these possibilities. Describe any efforts by the SMHA to advocate for increased coverage for MH services and to assist its consumers in accessing health care services provided with Medicaid funding

"Program Integrity

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.. "

- ☑ This question is not directly relevant to the Free Association States.
- ☑ While there is not an Essential Health Benefit per se for the territories, there is an opportunity to work within the government to advocate for coverage of mental health services and to educate those who implement the Medicaid program about the special considerations for confidentiality of mental health and substance abuse medical records. Any efforts in this area should be described.

"Use of Evidence in Purchasing Decisions

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."

- ☑ Include a description of any evidence-based practices currently in use and how that use is communicated to policy makers and/or other agencies
- ☑ This question presents a great opportunity to tell SAMHSA what you need in order to implement or expand use of evidence-based practices – training, funding, modification to meet different cultural norms, etc.

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."

- ☑ The Behavioral Health Barometer is available on SAMHSA's website. If you use the Barometer to establish your priorities, please describe or cross-reference to Step 2 or 3.

"Trauma

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma."

- ☑ Several of the jurisdictions indicated the need for more training on addressing trauma in the assessment process and provision of services. If that is true for your jurisdiction, say so here.

"Justice

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."

- ☑ To the extent that you described care coordination with the justice system in Steps 1 or 2 of the application, you should cross-reference that description here.

"Parity Education

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity."

- ☑ While the Mental Health Parity Act may not be applicable in your jurisdiction, it provides a basis for approaching insurers and legislators to advocate for better coverage of MH services. If you expect to undertake such advocacy, please describe.

"Primary and Behavioral Health Care Integration Activities

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."

- ☑ To the extent that there are efforts to integrate primary and behavioral health care, please either describe or cross-reference to any description in Step 1.

"Health Disparities

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."

- ☑ The narrative in Step 1 should address diversity in the population to be served, and the analysis in Step 2 should identify populations that are underserved. You should cross-reference those sections here.

"Recovery

SAMHSA encourages states to take proactive steps to implement recovery support services."

- ☑ To the extent that recovery support services have been addressed in previous sections of the application, you should cross-reference here or provide a brief summary of your efforts/plans to implement recovery support services.

☑ Describe any training efforts that have been conducted on recovery services.

"Evidence-based Early Intervention Treatment Approaches for Youth and Young Adults experiencing first time mental illness the MHBG (5% Set Aside)

States are required to use their 5 percent set-aside of their Mental Health Block Grant (MHBG) allocation to support "evidenced-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders."

☑ The amount of the 5% set aside is small for each jurisdiction. Most indicate that they plan to use the funds to train staff in an evidence-based practice, perhaps pooling funds with other jurisdictions for a central training.

"Children and Adolescents Behavioral Health Services

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 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. ….SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs."

☑ The extent to which your Child and Adolescent MH Services are provided through a System of Care should have been described in Step 1. You can cross-reference the relevant section here.
☑ If your jurisdiction is receiving or has received a System of Care Grant provide an overview of progress made as a result of the funding and the impact the grant has had on transforming or improving children services.

"Consultation with Tribes

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)."

☑ The jurisdictions do not have tribes as defined in the guidance.

"Data and Information Technology

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."

- ☑ The information requested here should be included to some extent in Step 2. You can cross-reference relevant sections or provide a brief update to your 2012-13 application.

"*Quality Improvement Plan*

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)…. In an attachment, states must submit a CQI plan for FY 2014/2015."

- ☑ If you have a FY2014-15 CQI Plan, include it as an attachment.

"Suicide Prevention

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."

- ☑ Include your most recent Suicide Prevention Plan as an attachment
- ☑ If the plan is due for an update, say when you expect it to be updated.

"Use of Technology

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."

- ☑ If you addressed use of ICT elsewhere in the application, cross-reference it here.
- ☑ If not, state whether there has been any change from what was described in the 2012-13 application.

"Technical Assistance Needs

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."

- ☑ This is your big chance to pull together in one place all the TA needs mentioned throughout your application.
- ☑ Going into detail here will help SAMHSA allocate TA resources to the areas of greatest need and might increase the chance that you will get what you need.

"Support of State Partners

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."

- ☑ Collaboration with state partners should have been described in Step 1. You can cross-reference here.
- ☑ Letters of Agreement, Contracts, or Memoranda of Understanding can be listed and/or included as attachments.

"State Behavioral Health Advisory Council

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder…… 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. "

- ☑ In addition to a narrative description of the Advisory Council's roles and responsibilities, it is useful to include the Advisory Council's By-laws as an attachment.
- ☑ The way in which the Application is reviewed by the Council and the way in which comments and suggestions are incorporated in the final draft should be clearly described.

- ☑ The forms should be completed. It seems that some jurisdictions had a significant number of vacancies on the Council. If so, please describe your plans to fill the vacancies.

"Comment on the State BG Plan

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."

- ☑ Describe how the application is made available for public review and comment.
- ☑ Include any comments received prior to submission of the application.

For example, Micronesia describes its process for public comment as follows:
"It is usually in April every year, the FSM Planning Advisory Council will call for a meeting to review the grant application, sharing information as lessons learned, invite the State SAMH Coordinators and the state council members for an update reports and comments. Discussion on the grant application is always done at the states level to give the people from that respective state the opportunity to make any comments. The announcement will be put out on the radio, posted up on the bulletin boards, put up banners and mouth to mouth notifications to the individuals and people in the community. Almost everybody knows each other therefore; the notice will spread out quickly. The council meeting is open to the public. Now days, some people have access to the internet where the communication can be seen."

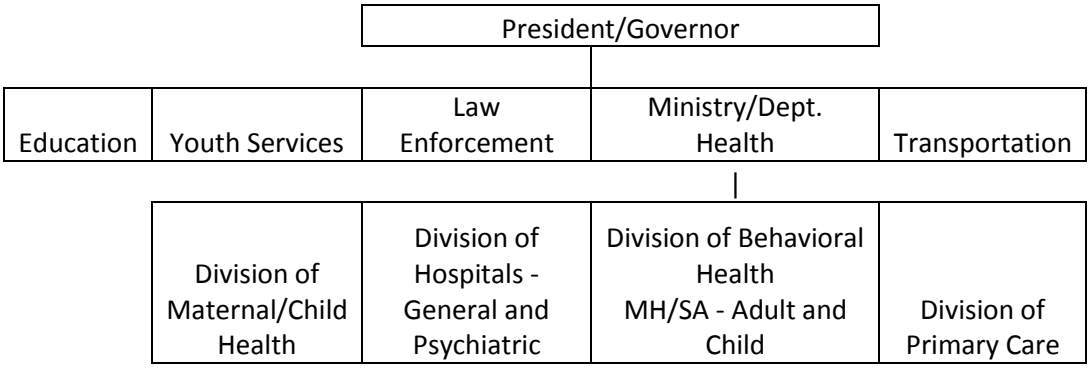
Appendix 1 MH Block Grant 101 – Comparison of Plan Requirements, Statutory Criteria, and SAMHSA's Block Grant Goals, Aims, and Strategic Initiatives

Plan Requirements	Statutory Criteria – Title 42, 300x-1(b) (1)-(5)	Block Grant Goals and Aims	Strategic Initiatives
Step 1: *Assess the strengths and needs of the service system to address the specific populations* – Describe the public mental health service system – State Mental Health Authority, regional/local providers, other agencies – how needs of diverse populations are addressed Address both child and adult systems	Criterion 1 – describe comprehensive mental health service system including services for dually diagnosed, health, rehabilitation, employment, housing, education, substance abuse, medical and dental care, and other support services to enable individuals to function outside a state hospital including services to be provided by local school systems under Individuals with Disabilities Education Act- Describe case management and activities leading to reduction of hospitalization Criterion 3 – provides for a system of integrated social, education, juvenile, and substance abuse services to treat those with multiple needs Criterion 4 - outreach to and services for individuals who are homeless and how services will be provided in rural areas Criterion 5 – describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan – provides for the training of providers of emergency health services *As you describe the service system, be sure to cover the required information under Criterion 1, 3, 4, and 5 (specifically, the training of providers of emergency health services)*		1. Prevention of substance abuse and mental illness 2. Trauma and Justice 3. Military families 4. Recovery Support 5. Health Reform 6. Health Information Technology 7. Data, outcomes, and quality 8. Public awareness and support *As the system is described in Step 1, there may be information relevant to one or more of the Strategic Initiatives listed above. If so, make sure to reference the applicable initiative.*

Plan Requirements	Statutory Criteria – Title 42, 300x-1(b) (1)-(5)	Block Grant Goals and Aims	Strategic Initiatives
2. *Identify the unmet service needs and critical gaps with the current system* - identify data sources used for this analysis – use historically reported prevalence formulas for SMI/SED as well as other data sources for other populations – use Behavioral Health Barometer -	Criterion 2 – contains an estimate of the incidence and prevalence of SMI/SED and presents quantitative targets to be achieved in the implementation of the system described in Criterion 1 *Be sure to use the estimates provided by NRI. Compare the number you serve to the estimated number of individuals with SMI/SED to determine the gap, if any. Take into account the numbers who may be served by other state or local providers.*		*If the planning process has identified gaps or needs relevant to any of the Strategic Initiatives, it should be noted.*
3. *Prioritize state planning activities* – using information from Step 2, identify specific priorities – use core federal goals and aims of the block grant - use *Table 1* to list priorities *Your priorities should be clearly related to the description of needs and gaps identified in Step 2.* *In describing your priorities, note if any relate to SAMHSA's block grant goals and aims.*		BG goals are consistent with SAMHSA's vision for a high quality, self-directed, and satisfying life: A physically and emotionally health lifestyle (health); a stable, safe, and supportive place to live (a home); meaningful daily activities (purpose); and relationships and social networks (a community). Additional aims are: -Focus on everyone -Focus on prevention and wellness -Activities are data driven -Emphasis on access and availability - Emphasis on policy impact and support	*To the extent that the priority areas identified by the state relate to one of the Strategic Initiatives, it should be noted.*

Plan Requirements	Statutory Criteria – Title 42, 300x-1(b) (1)-(5)	Block Grant Goals and Aims	Strategic Initiatives
P49-53 Step 4 – develop goals, strategies, and performance indicators	Criterion 2 - quantitative targets to be achieved in the implementation of the system described in Criterion 1	*In writing your performance indicators, note if any relate to SAMHSA's block grant goals and aims.*	*To the extent that the goals/performance indicators identified by the state relate to one of the Strategic Initiatives, it should be noted.*
Tables 2, 3, and 6b – block grant expenditures	Criterion 5 – describes the manner in which the State intends to expend the grant		

Appendix 2 – Sample Organizational Chart



In this example, the Director of the Division of Behavioral Health reports directly to the Minister of Health. The Division of Behavioral Health provides only outpatient services with inpatient psychiatric care under the Division of Hospitals. The Division of Behavioral Health provides both mental health and substance abuse services to both children and adults. There could possibly be further cells in the chart. For example, under the Division of Behavioral Health, you could have an Office of Adult MH Services, an Office of Child Mental Health Services, and an Office of Substance Abuse Services (both adult and child).

Appendix 3– Guam's Provider Description

The Guam Behavioral Health and Wellness Center (GBHWC), formerly known as the Department of Mental Health and Substance Abuse, serves as the single state agency for mental health and substance abuse prevention and treatment services for the U.S. Territory of Guam (Public Law 17-21). GBHWC provide comprehensive inpatient and community-based outpatient mental health, alcohol and drug programs and services for the people of Guam, and to continually strive to improve, enhance, and promote the physical and mental well-being of the people of Guam who experience the life-disrupting effects of mental illness, alcoholism and drug abuse or are at risk to suffer those effects and who need such assistance and; to provide such assistance in an efficient and effective manner in order to minimize community disruption and strengthen the quality of personal, family and community life. GBHWC is the Single State Agency for mental health and substance abuse services in Guam and as part of public policy, encourage the development of privately-funded community-based programs for mental health, drug and alcohol abuse, in particular those programs that employ qualified local residents. As those services become developed and/or available in the Territory, the Government of Guam may gradually phase out of such operations.

GBHWC will continue to address existing Block Grant requirements while working to create the system change that will be necessary as Health Reform approaches. Specifically, the plan will address SAMHSA-required areas of focus, including: Comprehensive community-based services for adults with Serious Mental Illness and children with Serious Emotional Disorders and their families;

In addition to these required populations, Guam's plan will address services for the following populations.

- Children, youth, adolescents, and youth-in-transition with or at risk for substance abuse and/or mental health problem;
- Those with a substance use and/or mental health problem who are:
- Homeless or inappropriately housed;
- Involved with the criminal justice system;
- Military service members, veterans, or military family members; and/or
- Members of traditionally underserved populations, including:
- Racial/ethnic minorities
- GLBTQ populations
- Persons with disabilities

Child System Overview

The Child Adolescent Service Division (CASD) became a system of care site in 2003 with the development of I Famagu'on-ta (Our Children) through the Child Mental Health Initiative Cooperative Agreement. This led to CASD adopting the system of care philosophy, core values and principles, in all its practices. I Famagu'on-ta became locally funded when the grant funds ended in 2010.

Children and youth with severe emotional challenges are provided services through the wraparound process bringing agencies and other stakeholders together with the families to address the child/youth/family needs. Clients are linked to services such as substance abuse treatment, child abuse protection, vocational and other services. Clients aging out of CASD and needing adult mental health services are referred to the Adult Division where transition plans are being developed. A transition protocol is currently being developed to ensure that the young person does not fall through the cracks when they move from CASD to adult mental health. In 2009, the Early Childhood system of care for children from birth to age 5 was awarded to the Department of Public Health and Social Services. This Child Mental Health Initiative cooperative agreement, with a public health approach is in its 4th year.In 2011 CASD was awarded a one year Expansion Planning Grant with a no-cost extension ending September 2013. Just this July 2013, CASD received an Expansion-Implementation grant award for four years. This grant is to develop a unified system of care for children from birth to 21 years of age. The Child Adolescent Services Division (CASD) gradually merged with I Famagu'o-ta, Guam System of Care site, when the Child Mental Health Initiative funding ended and I Famagu'on-ta became locally funded. CASD has a general population focus whereas I Famagu'on-ta continues to focus on the SED and high risk population working in partnership with other child serving agencies such as Child Welfare/CPS, Guam Department of Education, Mental Health and Substance Abuse, other government agencies as well as private non-profit agencies. The adoption of the system of care philosophy and utilization of the wraparound approach is becoming an accepted practice among the child serving agencies working with children from birth to young adulthood.

Guam Behavioral Health and Wellness Center (GBHWC) in which CASD and I Famagu'on-ta falls under serves the whole population of Guam, being a small island geographically and population wise. GBHWC is the sole mental health agency on island with few private mental health providers accessible and mostly for individuals/families with private edical insurance. We serve a diverse ethnic and cultural group and although many speak English, there is a great need for qualified mental health interpreters and translators for those that do not speak English well, do not understand and are more comfortable with speaking their own language. Plans to develop a program to train and certify interpreters and translators is being considered and with the Expansion-Implementation funding and pooling funds from other sources, this is anticipated to happen before the end of fiscal year 2014.

Sexual gender minorities and youth transitioning to adult services are considered underserved population on island, and are two target groups that the Expansion-Implementation grant would be seriously assessing and developing linkages with. As a starter, we have invited the Gala organization to conduct presentations to our staff and we foresee a collaborative working relationship with them developing.

Strengths:

- Family Court Judge practices systems of care values and principles. He promotes wraparound process and values the work of the Wrap Teams.

- Court Judges are referring clients regularly to I Famagu'onta Wraparound.
- Ability to utilize evidence-based/best practice assessment tools to identify appropriate levels of care based on needs and strengths.
- I Famagu'onta has been sustained by local government funds since the end of the federal dollars.
- The 30th Guam Legislature has bought into the systems of care values and principles.
- Members of the legislature often use the systems of care and wraparound as examples of exemplary service in the community.
- Office is located in the community where the families prefer to access services and supports.
- National Association of Social Workers Guam chapter awarded I Famagu'onta/CASD with the Exemplary Service Provider Award and the I Famagu'onta/CASD Administrator was awarded the Lifetime Achievement Award
- The Rotary Club of Tumon Bay, a community civic organization, awarded I Famagu'onta/CASD with the Service Above Self award.
- Families are seeking more assistance; self-referrals and families referring other families to I Famagu'onta/CASD.

Needs:

- Procurement process often delays or prohibits timely access to funding.
- n-house counselors for CASD/I Famagu'onta, Children's Division. These are Psychiatric Social Worker I and II positions.
- Vendor attitudes continue to support the segregation of children and adolescents with serious mental health needs from their peers in the education system. Need technical assistance in addressing this with policy makers and Judges.
- There continues to be gaps in the continuum of care services for children and youth; such as home based services, school based mental health services, emergency/crisis response and local treatment facility/services for juvenile sexual offenders.
- Workforce capacity for the complex needs of children and youth with severe mental health challenges and their families.

Adult System Overview

GBHWC continue to be under the monitoring by U.S. District Court Judge Consuelo Marshall in March 2010. Until recently, GBHWC was appointed a federal management team that developed a Plan of Action (POA) to bring the agency into compliance with the court ordered Amended Permanent Injunction (API). POA addresses areas in community based living, treatment process, evidence based practices, quality assurance, etc. (see attachment "POA"). The POA still remains as one of the condition of the API and GBHWC also maintains Consultants to provide recommendations for compliance.

Strengths:

- GBHWC programs help individuals transition into community
- For some consumers, mental health programs are their only activities during the day.

- There are mental health programs that are "consumer driven" such as the Sagan Mami programs which consist of an enrichment center, peer support, supported employment and a drop in center for homeless SMI adults.
- Diverse and ethnically varied mental health professionals.
- Despite staff shortages, mental health programs are still provided.
- The implementation of Interdisciplinary Treatment Teams in GBHWC
- The development of transition protocols between the child and adolescent services and adults mental health system
- GBHWC participation in Strategic Planning Session for Service Members, Veteran, and their Families
- Increasing community partnerships through establishing more community-based
- programs.
- The Mental Health Court involves the court and mental health systems, handling cases involving persons with a mental illness in the criminal justice system.
- Focus on staff development through training from Transformation Transfer Initiative Funding

Needs:

- Transportation problems in accessing mental health programs.
- Staff shortages to implement program activities running programs.
- Increase focus on anti-stigma and anti-discrimination issues.
- Need for Quality Assurance, Data Infrastructure and Fee Schedule.
- Lack of workforce development (staff training and career enhancement) and a labor pool for mental health providers.
- Need for hiring and retaining psychiatrist and psychiatric social work counselors.
- Wages are low for mental health providers dealing with complex cases, despite long hours and demanding work schedule and commitments.

Mental Health Services provided through Entities other than GBHWC:

GBHWC collaborates with the following agencies and service providers for the following services, placements and collaboration:

• The Salvation Army's Lighthouse Recovery Center for men and OASIS Empowerment Center for women provides case management, medication monitoring, counseling and group for adults with SMI and substance abuse problems.

• Private clinics and providers offer psychiatric and psychological services, as well as counseling (Individual, Marriage, and Family Therapy) to adults with SMI.

• The court system provides forensic evaluations to adults with SMI.

• The Correctional Facility incarcerates individuals found NGRI (not guilty by reason of insanity). GBHWC collaborates with the Dept. of Corrections to ensure the incarcerated SMI adults receive the appropriate medication.

• Veteran's Administration Clinic (Naval Hospital) provides psychiatric services for SMI adults who are veterans.

• Sanctuary provides crisis intervention, counseling services, drug and alcohol

services and temporary shelter for troubled teens.

- Department of Youth Affairs (DYA) provides housing support for children with legal/behavioral problems, as well as provides counseling services and case management services.
- University of Guam provides counseling services, including suicide prevention services to students attending the university as well as counseling for the community through their Internship Program.

Appendix 4 – Palau's Provider Description

Behavioral health services for both children and adults are provided by the staff, there is little separation of duties for children and adults. Staff members travel by van, car, and boat to rural/outlying regions of the islands to provide services based on the continuum of care model. Staffing numbers are summarized below and include mental health and substance abuse program staff. Half of the staff is supported by U.S. federal funds.

Administration, Planning, & Evaluation Services:

- Administrator (1 FTE)
- Administrative Officer (1 FTE)
- Administrative Assistant (4 FTE)
- Epidemiologist (1 FTE)
- BRFSS Coordinator (1 FTE)
- SPE Coordinator (1 FTE)
- Data Specialist (1 FTE)

Clinical & Community Support Services:

- Medical Officer (Psychiatry) (1 FTE)
- Psychiatrist (1 FTE)(vacant)
- Inpatient Nurses (7 FTE)
- Outpatient Nurses (2 FTE)
- Social Workers (2 FTE)
- Clinical Addiction Supervisor (1 FTE)
- Recovery Counselor (1 FTE)
- Addiction Counselor Aide (1 FTE)
- Community Behavioral Health Worker (5 FTE)

Substance Abuse Prevention/Mental Health Promotion Services:

- Prevention Coordinator (1 FTE)
- Health Educator (1 FTE)
- Surveillance and Evaluation Specialist (1 FTE)
- Tobacco Control & Prevention Program Coordinator (1 FTE)
- Tobacco Program Social Marketing Specialist (1 FTE)
- Tobacco Program Assistant Manager (1 FTE)
- SEOW Coordinator
- Surveillance & Evaluation Specialist
- Community Behavioral Health Worker (2 FTE)

Appendix 5– Northern Mariana's Service Description

The State plan and annual budget revolve around the principle that individuals would all receive the best quality of care possible and be provided with services in the most clinically appropriate and least restrictive surroundings. The CGC (Community Guidance Center) administers services addressing mental health and substance abuse problems and consists of programs that include Behavioral Health Services, Addictions Services, Community Mental Health Services, and Prevention Services. Services provided at the CGC include individual, group, and family therapy; education; assessment; crisis response to community needs (i.e. following suicides or traumatic events); psychiatric, psychological, counseling services; and substance abuse prevention and treatment.

The Transitional Living Center (TLC), which is also part of the CGC, provides services to adults with SMI which include: community outreach, medication clinics, transitional living programs, respite programs, and a day program for both out-patients and in-patients with SMI. The TLC also provides psychiatric outpatient services such as psychiatric evaluation, pharmacotherapy, psychotherapy, case management, day treatment, assertive community outreach, education for consumers and families about mental illness, and symptom management. These services are administered by the Community Mental Health Services Team (CMHST), which is primarily housed at the TLC. In addition, the CMHST provides linkages between and referrals for primary health services, mental health counseling and substance abuse treatment, educational services, job training, vocational rehabilitation support, housing assistance, Nutrition Assistance Program, and entitlements such as Medicaid and Social Security Disability. Moreover, the TLC has specific groups focusing on leisure activities, training in skills of Activities of Daily Living (ADL), socializing outings, drug abuse awareness and prevention, anonymous-group-model recovery teaching, educational holiday celebrations, and medication management groups. Furthermore, the CMHST provides monthly outreach services to the consumers on the neighboring islands of Tinian and Rota. The status of consumers (adults with SMI and children/adolescents with SED) are communicated through the Health Centers on Tinian and Rota and the CMHST based on Saipan. Each trip to these islands is designed for a full workday, which serves approximately 10 consumers.

Although the CNMI does not have a separate, specialized children/adolescent mental health system, the CGC has a Child/Adolescent Team which shares staff with the Adult and Substance Abuse Teams. Staff members have taken courses and have received formal training in the treatment and evaluation of children/adolescents. The CGC assesses and makes recommendations with respect to the special education needs of children/adolescents and also consults with the Commonwealth Health Center (CHC) staff and receives referrals from the CNMI Family Court and the Division of Youth Services (DYS). In addition to this, assessment and consultation services are provided to the Early Childhood Intervention Program and other State agencies such as the Division of Youth Services (DYS), the Public School System (PSS), the Judiciary, Department of Public Safety (DPS), Division of Corrections (DOC), and the Office of Vocational Rehabilitation (OVR). The CGC collaborates with other key State agencies and

organizations in establishing a network essential to the delivery of mental health services to children/adolescents with SED residing in the CNMI.

Psychiatric inpatient services are provided at the psychiatric ward located at the Commonwealth Healthcare Corporation (CHCC), which is the main and only hospital located in Saipan, servicing people in the Commonwealth of the Northern Mariana Islands and some other islands in the Micronesian Archipelago. The psychiatric unit has an eight-bed, locked unit for individuals 18 years or older and provides in-patient services for adults with SMI directed towards diagnosis, stabilization, respite care, as well as educational services about mental health for consumers and their families during inpatient stays. Through the use of the available staff and physician(s) on call, the Emergency Departments at the respective health centers on Saipan, Tinian, and Rota provide 24-hour crisis services to persons with SMI or other acute mental health needs. The nursing staff of the psychiatric unit at the CHCC is available for additional consultation around the clock. In addition, a psychiatrist is on call 24 hours for related emergencies, as well as for psychiatric consultation to the Tinian and Rota health centers.

Currently, psychiatric inpatient care for children/adolescents with SED is provided on a very limited basis at the medical hospital; separated from the adult inpatient unit without the benefit of a secured, locked facility and trained mental health nurses and/or assistants.

Guided by its vision, the CGC finds that the networking of community services is a pivotal part of the mental health service system. The CGC collaborates with other State agencies and organizations to ensure a network of community services designed to assist individuals with mental illness. The CGC collaborates with the following State agencies and organizations:

- Office of Vocational Rehabilitation (OVR)
- Workforce Investment Agency (WIA)
- Department of Labor (DOL)
- Northern Marianas Housing Corporation (NMHC)
- Criminal Justice Planning Agency (CJPA)
- Court System
- Department of Public Health (DPH)
- Commonwealth Healthcare Corporation (CHCC)
- Tinian and Rota Health Clinics
- Public School System (PSS)
- Northern Marianas College (NMC)
- Division of Youth Services (DYS)
- Department of Public Safety (DPS)
- Division of Corrections (DOC)
- Northern Marianas Protection and Advocacy Systems, Inc. (NMPASI)
- Coalition for Anti-Stigma for Mental Illness (CAMI)
- Independent Living Center (ILC)
- Medicaid Office
- Karidat
- Ayuda Network

It is through these collaboration efforts with the agencies and organizations mentioned, the community mental health services program under the CGC, under the Behavioral Health Services, provides linkages between and referrals for clients/consumers seeking primary health services, mental health counseling, substance abuse treatment, educational services, job training, employment services, and housing assistance services.

System of Strategic Partnerships

All health services in the CNMI continue to be administered by the CHCC, which is headed by the CEO, who is hired by the Board of Directors of the hospital, and concurred with by the CNMI Governor. As a unit under the BHS, CGC continues to be responsible for the provision of comprehensive mental health and substance abuse services throughout the CNMI. Currently, CGC incorporates all out-patient mental health services and administers all Federal health programs in the CNMI related to mental health and substance abuse, as well as all other publicly funded mental health services. All mental health and substance abuse programs implemented at CGC are overseen by the Division of Behavioral Health Service Director, which is essential in ensuring that all program activities are closely coordinated with other related services. In addition, all services administered under the different programs implemented at CGC are overseen by program managers, who report directly to the Director, who in turn reports to the CEO.

Since the CGC is a unit under the Division of BHS, this supports and enhances a comprehensive, coordinated, and holistic approach to addressing the mental health, substance abuse, and primary healthcare needs of the consumers. This partnership extends the limited resources of the mental health system and promotes integrated treatment and the coordination of substance abuse and mental health interventions by combining them into a coherent, seamless service system. Furthermore, CGC collaborates with other key State agencies and organizations in establishing a network essential to the delivery of mental health services in the CNMI.

No single agency has been identified as the lead agency for case management and coordination of services. The Child and Family Services Committee, has worked closely with the Division of Youth Services (DYS), the Community Guidance Center (CGC), a community based psychologist, and others continue to plan yearly conferences focused on improving the case management skills of service providers. The unit primarily responsible for mental health services to children and adolescents is CGC. Services are integrated at CGC during weekly meetings with providers from each discipline to discuss new cases and coordination of services. In addition, a CGC intake coordinator and an intake social worker manage referrals and follow up with community and interagency contacts.

In compliance with the Individuals with Disabilities in Education Act (IDEA), the Public School System's Special Education Department (SPED) is responsible for ensuring that eligible students receive services as recommended on their Individual Educational Plans. Often this includes psychological services. It has been determined to be most effective and efficient to have not only a memorandum of understanding between agencies but also contractual arrangements for service provision. This arrangement ensures services not only for Special Education students

with severe emotional disturbance but also provides support for personnel who provide preventive services to Special Education students. The CGC also completed a Memorandum of Agreement (MOU) with the CNMI's Head Start Program in 2002 that also allowed for the delivery of mental health services for students aged three to five years with SED.

The Pacific Basin Interagency Leadership Council Conference incorporates service providers from the Pacific Region working in agencies that assist individuals with disabilities. One of the purposes of this conference is to promote interagency communication and cooperation. Participants include representatives from the Division of Youth Services, the CGC, the Public School System SPED Program, Early Childhood Intervention Program, Office of Vocational Rehabilitation, Department of Public Health, Northern Marianas College-University Affiliated Programs, the Developmental Disabilities Council, the CNMI Legislature, Pacific Regional Educational Laboratory, and the Children Developmental Assistance Center.

In Fiscal Year 2003, both public and private agencies collaborated to create the CNMI Interagency Juvenile Justice Task Force seeking to enhance interagency cooperation in dealing with juvenile concerns. The task force goal was to develop a comprehensive strategy specifically aimed at preventing juveniles from entering the justice system and establishing ways to rehabilitate youth offenders to ultimately reduce the rates of juvenile delinquency and recidivism. An MOU was entered into with various agencies including the Division of Youth Services, Community Guidance Center, CNMI Youth Alliance, Public School System, Department of Public Safety, Criminal Justice Planning Agency, Attorney General's Office, Public Defender's Office, Office of Youth Affairs, and a community representative. The task force claimed that individuals under the age of 18 commit 55-60% of all crimes in the CNMI and that the number, severity, and recidivism of juvenile crimes were increasing so a joint effort to curb this issue was developed. The MOU prioritized the following program objectives: study the juvenile delinquency problem in the CNMI, enhance pre and post-trial programs, advocate for the Juvenile Justice Act, develop and enhance public education and awareness on juvenile delinquency issues, and increase inter-agency communication.

All the clinicians at the CGC work with children and adolescents. Coordination of comprehensive services is managed individually, by the clinicians. Meeting together to discuss issues related to coordination will help to identify common problems and successful strategies. Interagency meetings (CGC, DYS, Family Court, and PSS) can be scheduled to follow-up on identified issues so that a collaborated effort can help resolve these issues. The PSS SPED contract has now been implemented for several years. Further evaluation and delineation of services and population (e.g. minors diagnosed with SED also receiving SPED services) under the contract is needed. In addition, these meetings can also be used to discuss problems and solutions to referral and coordination of services. Many referrals each year involve juvenile cases. Mental health services are provided by both CGC and DYS. Coordination of service delivery, assistance in case management, and consultation to the court is routinely managed by both service agencies. In addition, the Family Court requires timely information in order to expedite decisions and legal actions that can assist in the delivery of treatment and managing minors with Conduct Disorder and behavioral difficulties. The supplemental grant through

VOCA/DOJ supports two (2) FTES to prioritize counseling services for victims of crime services and participation in domestic and family violence advocacy and prevention activities. However, Federal Government sequestration has put this grant in jeopardy of losing one FTE. Currently, there are no exchange of information between agencies, and a lack of data base monitoring on the number of adolescents transitioning to adult services. Given that DYS services are discontinued after minors turn 18, a significant support service is lost to numerous individuals. Therefore, a gap exists for services for the youth, turned adult is a serious situation that requires a plan of action. A plan is needed so that the Office of Vocational Rehabilitation and the CGC can implement some type of transitional care so that individuals/ young adults who require such services will not fall through the cracks.

The Prevention component of the Behavioral Health Division of the Commonwealth Healthcare Corporation (CHCC) provides essential services throughout all three islands of the Commonwealth of the Northern Mariana Islands (CNMI). These services, which address issues such as underage drinking, drinking and driving, tobacco prevention, marijuana and prescription drug use and abuse, are universal and made available to Saipan, Tinian, and Rota, and are not exclusive to a particular population and/or groups. Special population groups include youth, parents, students, veterans, LGBT, all ethnicities, religion, and individuals with disabilities. There is also the capacity to serve individuals in the majority language groups that exist in the CNMI. A crucial component in providing prevention services throughout the community is the strong networking and collaboration of key partners which include government and nonprofit agencies, coalitions, and sub grant recipients. The prevention unit continuously develops its unique ways of operating and managing services that are mirrored by the communities it reflects. Prevention staff includes individuals who are either bilingual or trilingual and who are aware of and sensitive to shared traditions of the incredibly diverse cultural groups in the CNMI community. Their efforts ensure that all community populations are considered when addressing cultural competency concepts and while delivering community outreach, training and technical assistance, and project/program goals and objectives.

Following are strategic services that the CGC addresses and provides that require collaborative coordinated efforts:
Health Services – The CGC provides linkages and referral services to the Commonwealth Healthcare Corporation (CHCC) for all medical related care; private health clinics such as the Mariana Eye Institute, Marianas Visiting Nurses, Northern Marianas College (NMC) CREES program and CHCC dietician for nutrition.
Mental Health Services – The CGC provides Community Mental Health Services, Behavioral Health Services, and Addiction Services which include assessment/testing; individual, couples, and family counseling; individual and group addiction counseling; community mental health services; anger management and DUI classes; case management; consultation; and prevention and outreach.
Rehabilitation Services – The CGC provides rehabilitation services which include: individual and family counseling, group therapy, educational classes and activities, and referrals to specific treatment groups such as anger management or character building which incorporates substance abuse topics.

Employment Services – The CGC provides linkages and referral services to the Office of Vocational Rehabilitation (OVR), the Workforce Investment Agency (WIA), the Department of Labor, as well as volunteer positions within government agencies in the community.

Housing Services – The CGC provides linkages and referral services to the Northern Marianas Housing Corporation (NMHC) which provides HUD housing vouchers. In addition, the CGC Transitional Living Center (TLC) is a rehabilitation program for adults with SMI.

Educational Services – The CGC provides linkages and referral services to the Public School System (PSS), the Northern Marianas College (NMC), and the Office of Vocational Rehabilitation (OVR).

Substance Abuse Services – The CGC provides substance abuse services which include counseling services; individual, group, and family therapy; support groups; educational classes and activities; and referrals to specific treatment groups, such as anger management and/or character building.

Medical Services – The CGC provides linkages and referral services to the CHCC for medical services which is a unified medical center that has modern medical equipment for inpatient and outpatient services, emergency care, diagnostic services, and a wide range of public health services. There are 74 acute care beds available for medical, surgical, obstetrical, and pediatric patients and 8 beds for psychiatric inpatients; and serves as the primary referral facility for the Tinian and Rota Health Centers. The CGC also provides referral services to private health clinics.

Dental Services – The CGC provides linkages and referral services to the CHCC for dental services which include hygiene, corrections, fillings, prosthetics, and extractions.

Support Services – The CGC provides educational trainings and presentations, as well as linkages and referral services to family/consumer organizations such as CAMI (aka, NAMI), advocacy organizations such as the Northern Marianas Protection and Advocacy Systems, Inc. (NMPASI) which implements the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, as well as the Developmental Disabilities Council. Services provided by local school systems under the Individuals with Disabilities Education Act Services – The Public School System provides psychological testing by its educational psychologist; counseling services from school counselors; collaboration with teachers, the special education department, and behavioral psychologist to develop behavioral plans; as well as referrals to CGC and private practitioners for counseling and other mental health services.

Case Management Services – The CGC provides case management services which include assistance with Medicaid and disability benefits applications, as well as securing and maintaining housing, assertive community outreach, day-to-day follow-up and contact with consumers to enhance and prolong tenure, and assisting consumers in keeping appointments and attending other community-based activities and services. Services for Persons with Co-occurring Disorders – The CGC provides services such as evaluations, educational activities, individual and family counseling, group therapy, support groups, as well as referrals to specific treatment groups such as anger management and/or character building. Referrals to substance abuse services at the CGC are made for SED children/adolescents who are served by the outpatient program, the Public School System (PSS), and/or the Division of Youth Services (DYS), as well as those who are self-referred.

Maternal and Child Health Program

Specialized Services for Pregnant Women and Women with Dependent Children –

Prenatal care service is provided at the Women's Clinic located at the Commonwealth Healthcare Corporation, and Rota and Tinian Health Centers. It is also provided at the Adolescent Health Clinic located at Marianas High School. In addition, Medicaid enrollees can access prenatal care services at 4 Medicaid participating private health clinics. The first visit involves prenatal first visit intake/interview by nurse, physical exam (pap test), blood work, counseling, including HIV testing. The revisit exams include monitoring baby's growth and development and the mother's condition, and continue counseling and education. Case management is provided to pregnant women with pre-existing conditions such as hypertension, heart condition, diabetes and other medical issues. Follow-up is provided during postpartum care. The new Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program (HVP) provide home visiting service and coordination of services to families living in at-risk communities. Thus, the program will serve some higher risk, more vulnerable families, such as those where a parent has depression, a substance abuse problem, is at risk for abuse and neglect, and/or is experiencing family violence, either singly or in combination. The program also links with its partners such as CGC for early intervention and referral into professional services such as substance abuse treatment or mental health service. The HVP works with its partners to give attention to the implementation of strategies that will address the needs of higher risk families. The HVP also has an MOU with partners such as the Women's Clinic, Family Planning Program, Domestic Violence Coalitions, and other related stakeholders to update and shorten the medical history form to make it more user friendly when asking questions about alcohol, drug use (including cigarettes) and screening risks for domestic violence.

Victims Services - The Victims of Crime Act (VOCA) program, a supplemental grant through the CJPA, recipient of Department of Justice, is responsible for providing to the islands of Saipan, Rota and Tinian direct counseling and case management services to victims of crime, direct consultation, counseling assistance, outreach, psycho-education, including necessary presentations and training to all related social services agencies. VOCA Therapists participate with related Family Violence Task Force, Domestic Violence Coalitions, and other victims' services partnerships. Currently the CGC employs two (2) FTE Clinicians to prioritize counseling services to victims of crime.

Other Activities – The CGC provides mental health services in the most community-based, accessible (to the child and family) settings such as schools, detention units, homes, shelters, and at the CGC offices on Navy Hill.

Appendix 6– Hawaii's Description of Services for Special Populations

Mental Health Treatment in Jails and Prisons

According to national headlines[1], the rate of suicides over the last 10 years in jails across the country has mental health experts concerned about the care of inmates who are SMI/SPMI and the lack of supervision. In Hawaii, mental health treatment for inmates is provided through the Department of Public Safety (DPS) at all of the State's correctional facilities. Additional mental health staff are being hired and trained to assist in improving services to inmates with mental illness and expand mental health treatment programs for inmates, including coping skills and dealing with trauma. At times, inmates are transferred to the HSH by court order for more intensive mental health services.

On the policy level, administrators from multiple organizations form the Interagency Council on Intermediate Sanctions Committee (ICIS). Members of the Committee include the DPS, the Judiciary, the Department of Attorney General, the Department of Health, office of the Public Defender, Hawaii Paroling Board Authority, and the Honolulu Police Department. The ICIS meets monthly to discuss the reduction of recidivism and the prevention of future victimization by adult offenders. The group's goals are:

- Implement a system-wide application of standardized assessment protocols;
- Establish a continuum of services that match the risk and needs of adult offenders;
- Collaborate with communities in developing and implementing the continuum of services;
- Create a management information system capable of communicating among agencies to facilitate sharing of offender information; and
- Evaluate the effectiveness of intermediate sanctions in reducing recidivism.

Older Adults

There is renewed focus on adults aged 50-70 years old in the mental health system. Many elderly adults are on Medicare and experience difficulty finding a psychiatrist because this population tends to use the emergency departments more since physicians are less likely to accept them as patients. There's no easy fix for these types of situations in the islands. The coordination of care, coupled with the high cost living has become more essential. As Hawaii's population ages, the mental health system is now responding by training more people and working towards ensuring that mental health related resources are available for this age group. This has resulted in the 2013 legislature passing SB 310 SD2 HD2 CD1, which establishes an assisted community treatment program in lieu of the involuntary outpatient treatment program for severely mentally ill individuals who meet specified criteria. The Governor recently signed this bill into law.

[1] "Jail Suicides Worry Experts," New York Times, August 19, 2013.

Through the Hawaii Needs Assessment Report[2], seniors were reported as having the most hospitalizations due to short-term complications of diabetes and mental health hospitalizations. Specific needs of older residents are increasing due to the in-home needs and access to palliative care, in addition to mental health treatment. Therefore, Healthcare Reform will benefit this growing population while lowering premiums and providing better health coverage.

AMHD, in collaboration with the Executive Office on Aging, established the Oahu Geriatric Mental Health Hui (OGMHH). The OGMHH has applied for membership with the National Coalition on Mental Health and Aging, which is pending. This group has regular representation from the following entities:

- Adult Mental Health Division
- Executive Office on Aging
- Elderly Affairs Division
- Alzheimer's Association
- Neuropsychologist/Brain Rehabilitation Specialist
- Institute for Human Services (Homeless Shelter)
- Consumers and Advocates

Activities include:

- Collaborating with the Executive Office on Aging, who publishes a quarterly newsletter, dedicated an article in the press about Aging and Mental Health issues.
- Providing the impetus for the Executive Office on Aging to develop the first statewide plan on Alzheimer's disease and Other Related Dementia.
- With the Newsletter and the Dementia plan completed, focusing its efforts on the issue of "elderly wanderers in the community" and trying to develop a coordinated community response. Information and community input were gathered on a possible "Silver Alert" but based on community input, this was discontinued and other avenues are now being considered.

Veteran's Administration

The AMHD continues to collaborate with the Veteran's Administration on a quarterly basis. The availability of mental health services for veterans is becoming a higher profile issue with the increasing number of soldiers returning home from Iraq and Afghanistan. In an agreement between the Department of Health and the military, AMHD provides services to returning veterans. State funds are expended for services to veterans and the State does not bill the Federal government for these services. Although the Veteran's Administration has a robust mental health program, of special concern are the families of servicemen who may not take advantage of mental health services in the military hospitals due to stigma. Consequently, mental health services are also afforded this group when needed.

[2] HAH Healthcare Association of Hawaii, July 2, 2013.

Due to the high suicide rate among returning veterans, all four branches of the military are focused on suicide prevention. The Department of Defense recently shifted suicide prevention from a medical to a readiness issue under the category of Operational Health and Readiness. All branches now have "readiness" as a top priority and they are addressing the challenges that affect areas of a soldier's life. The military is reaching out to the civilian community to share resources, and collaborate to make sure soldiers can function and transition successfully into civilian life. Other interventions that are implemented are providing services to family members of active military, i.e., by putting therapists in the schools to be an available resource.

LGBTQ Community

AMHD has obtained a SAMHSA grant for implementing Trauma Informed Care. As such, an Advisory Council is being formed. Developing strategies for increasing sensitivity to the LGBTQ community will be addressed in that forum. Persons of diverse sexual orientation and gender identity are accepted at shelters and special accommodations are made to support them in those settings. As part of a LGBTQ's consumer recovery plan, if the consumer needs additional supports than are available in the AMHD service array, they are referred to local gay and transgender community support groups. At present, upon admission, a new consumer is asked for their preferences, (i.e. how they would like to be addressed, gender they identify with, types of treatment approaches that are preferred, etc.).

Racial and Ethnic Minorities

According to the 2010 U.S. Census, approximately 75 percent of Hawaii's population belongs to a racial or ethnic minority group, i.e. Hawaiians or Pacific Islanders, Black or African Americans, Hispanic or Latino, and Compact of Free Association (DOFA) migrants. The race/ethnic group most commonly reported as experiencing more health problems than average was Native Hawaiians, followed by other Pacific Islanders. It is noted that the rate of poverty is high among persons of certain race/ethnic backgrounds in the state. For the Native Hawaiians and other Pacific Islanders, the poverty rate is approximately 18 percent.

Mental health is also a clear area of need in Hawaii, and access to quality mental health care for racial and ethnic minorities remains an issue. According to the Healthcare Association of Hawaii Needs Assessment Report[3], two mental health indicators exhibit race disparities. The proportion of adults with a depressive disorder was highest for other Asians (16.6%), while the suicide death rate is highest for Native Hawaiian/Pacific Islanders (39.3 deaths/100,000 population). The Health Connector is reporting that there are 8 percent or 89,974 uninsured Hawaiians who may be eligible for health coverage. Since most Hawaiians and Native Pacific Islanders practice "pono pono" or holistic and naturopathic

[3] HAH Healthcare Association of Hawaii, July 2, 2013.

interventions, if they choose to pursue Western medicine, the Affordable Care Act will make it easier for them to get physical and psychiatric care. Due to pre-existing medical conditions is prevalent in this population, physicians and mental health providers will not deny them.

The AMHD served approximately 2,196 or 20% Native Hawaiians and Pacific Islanders (see page 21). With limited resources and staffing, the AMHD has focused on opportunities to integrate the needs of this population into existing programs, planning and policy efforts and by improving collaboration with other state and local partners to provide services for racial and minority groups.

Appendix 7 – Palau's Geography and Population Description

The Republic of Palau is comprised of more than two hundred islands forming an archipelago in the far southwestern corner of the North Pacific Ocean, 70 degrees north of the equator and 1340 west of the international date line.

The nation consists of high volcanic islands, raised limestone islands, barrier reefs and classic atolls extending nearly 700 miles on a northeast to southwest axis. Palau has a total land mass of 188 square miles and while there are over 200 islands that make up the nation, only 9 are permanently inhabited. The main island of Babeldaob comprises 14 of the 16 Palauan states. The 7.1 square mile island/State of Koror (located approximately 4,300 miles southwest of Honolulu) is currently the Republic's economic capital, with 75% of the population residing there or in the neighboring state, Airai, located on the southern tip of the island of Babeldoab. Babeldoab is the single largest island (land mass), and second in Micronesia only to Guam and is connected to Koror via bridge. The capital was relocated in October 2006 to the state of Melekeok (on Babeldaob). Majority of the population continue to maintain their livelihood in Koror for economic purposes.

The Southwest Islands, (comprising the two states of Sonsorol and Hatohobei), are located approximately 300 miles southwest from the main island group. They are sparsely inhabited, geographically isolated and in many ways culturally different from the rest of Palau. Given the geographic nature of the islands, access can pose a significant barrier to service delivery in Palau. Geographic constraints have been lessened over the past few years with the completion of the "Compact Road". This is a U.S. funded road that is 53 miles of paved road that circumnavigates Palau's largest island of Babeldaob. However, there are still five other island/states that remain accessible only by boat. Boat travel is dependent upon weather conditions, since traveling to several locales necessitates going outside the safety of the reef and into open ocean water. Ever-rising fuel prices also impact travel by any type of road or water vehicle. By U.S. standards, the entire nation of Palau is a rural area and impoverished.

Traditionally, Palau is a matrilineal society comprised of several competing chiefdoms. The society is characterized by a system of strong, ascribed hierarchal social ranking where the matrilineal descent determined social position, inheritance, kinship structure, residence and land tenure. Since western contact, dramatic societal changes have occurred, perhaps the greatest contributing factor being depopulation due to the introduction of western diseases. Only a tenth of the estimated original pre-contact population of 40,000 remained by the turn of this 19th century. Traditional society, however, continues to play an important function in the daily lives throughout the entire strata of the contemporary Palauan society. Service planning and service delivery on a daily basis takes into account the traditional, customary and cultural norms of the island people in their communities.

Appendix 8 – Alabama's Description of Data Sources and Prevalence Estimates

A combination of sources was used to identify critical service gaps. For years, DMH has monitored the utilization of public mental health services through analyzing service data reported to DMH. This data, in conjunction with periodic survey of the providers, allowed DMH to identify trends in service utilization by the consumers. Please refer to "Section IV-Narrative Plan Q. Data and Information Technology" (ACSIS, CDR, CARES, MICRS, Gateway, ABHAS).

Other sources of data utilized by DMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, DMH web-based housing inventory (MICRS), DMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets.

Another very valuable measure DMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting.

DMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, DMH worked with the Administrative Office of the Courts to match the DMH mental health database with mental health court participants.

In June, 2011, DMH released a Request for Proposals to seek a vendor to conduct a comprehensive behavioral health needs assessment in Alabama. This process was to determine the need for both mental health and substance abuse services for diverse populations. Proposals were received the contract for the needs assessment was awarded in June 2012 and Project Launch was initiated. A project work plan was developed that would be completed with a 9 month tenure. Due to the complexities of the process, the completion of the Needs Assessment to get into draft form was extended. The draft process was completed and submitted by the contractor in June 2013. DMH continues to work on final edits prior to moving to publications. Once this has occurred, DMH will utilize the data within our planning process (see attached draft Needs Assessment).

PREVALENCE

Community Programs

FY12

Overall Total Served (MI – Community and State Hospital) – 104,279
Overall Total Served (MI Community) – 102,035
SMI Adult (Contract Eligible) – 65,513
SED (Contract Eligible) – 25,321

The 2012 Uniform Reporting System (URS) Table 1 estimate of adults with serious mental illness (SMI) in Alabama is 197,841 and the estimate of children and adolescents with serious emotional disturbances (SED) is 69,555 people which is the upper limit of Level of Functioning equal to or less than 60.

The DMH definition of Serious Mental Illness is more restrictive than the federal definition in that the diagnostic categories are limited. The types of functional disability are similar between the state and federal definitions. The Alabama public sector's priority population is the SMI population that requires treatment and care outside the private sector. Many children and adolescents with serious emotional disturbance are served in the private sector, by the Department of Human Resources, by the Department of Youth Services, and by educational agencies. 27.9% of the total C&A served in Alabama compared to 28.3% nationally. 72.0% of total adults served in Alabama compared to 71.7% nationally. The FY12 Uniform Reporting System State Report shows Alabama with a penetration rate of 21.72 per 1,000 population compared to the national rate of 22.55. The community utilization rate is 21.25 per 1,000 population compared to 21.70 nationally. The penetration rate for adults with serious mental illness and children/adolescents with serious emotional disturbance exceeds the national rate in all age categories as follows:

00-17 years	Alabama 22.5 – National 17.6
18-20 years	Alabama 18.7 – National 15.0
21-64 years	Alabama 20.3 – National 15.9
65(+) years	Alabama 7.4 – National 4.1

Appendix 9 – Palau's Analysis of Need

Finally, the table created for the last planning activity continues to provide planning directions for existing services. It provides a summary of the current services that the division provides in collaboration with sister divisions and programs of the Bureau of Public Health, outlined throughout the lifecycle. Note that data from services provided at the hospital wards and other primary care clinics are not available at this time, nonetheless, there is continued service provision despite the challenges with the hospital data system to produce services rendered. In this table, a new row for the aging has been inserted at the bottom of the table. With regards to services for the elderly, planning actually took place this last year for this population.

LIFE DOMAIN	DATA ON NEEDS	PROGRAM & PARTNER	CLIENT SERVICES NEEDS	PROGRAM NEEDS
PRENATAL	60% (N=500) of pregnant women use tobacco/betelnut	Maternal Child Health (MOU)	Motivation for Change Stress management skills Cessation from ATOD	Effective social marketing, health education materials in local language based on research and data.
EARLY CHILDHOOD	Children with Special Health Care Needs N= 27	Maternal Child Health (MOU)	**Students** – Social & Emotional Skills **Families** – Parenting Skills **Staff** – Skills & Environmental Strategies	Effective program for early childhood that promotes social and emotional development
EARLY CHILDHOOD (HEADSTART)	HEAD START: Students N=500 Families N=500 Teachers/staff N=50	Head-Start (MOU)	**Students** – Social & Emotional Skills **Families** – Parenting Skills **Staff** – Skills & Environmental Strategies	Effective program for early childhood that promotes social and emotional development
YOUTH (Ages 6-18)	ANNUAL SCHOOL PUBLIC HEALTH SCREENING N=1300	SCHOOL HEALTH CENTER (MOU)	Effective program for indicated population	Revisit the existing program and elect a new program to strengthen the provision of indicated intervention
	SED – N=29	COMMUNITY MENTAL HEALTH	Comprehensive services including assessment, medication management, family therapy, social work, recovery and rehabilitation, home visit, outreach.	Ongoing training in behavioral health (MI/SA), technical assistance, behavioral health (MI/SA) resources, and consultation.
	SA: N=~16; F=~4; M=~12	Community Guidance Center	Anger Management, Adolescent Substance Use Intervention Program, Life Skills, Driving Under Influence, Support Group, recovery awareness.	Ongoing training in behavioral health, technical assistance, resources, and consultations.
YOUNG ADULTS (AGES 19-22)	COLLEGE/ADULT HIGH SCHOOL/GED N=200	COLLEGE STUDENT LIFE CENTER	Specific health education on mental, emotional, behavioral, substance use and abuse, life skills, and stress management	Revisit the existing program and elect a new program to strengthen the provision of indicated intervention
ADULTS (21+)	SMI: N = 136 66F, 70M MI/SA: N= 54 6F, 48M	Community Mental Health	Comprehensive behavioral health services including assessment, medication management, family therapy, life skills, social work, recovery and rehabilitation.	Ongoing training in behavioral health (MI/SA), technical assistance, behavioral health (MI/SA) resources, and consultations.
	SA: N=158, 13/F, 145/M	Community Guidance Center	Substance Withdrawal Addiction Treatment, Anger Management, Life Skills, Driving Under Influence, Support Group, social work, and recovery awareness activities.	Ongoing training in MI/SA, technical assistance, MI/SA resources, and consultations.
ELDERLY	N is unknown. Estimated persons in Palau over age of 60 is: - 2800 Male - 1900 Female	Dr. Sylvia Osarch, Geriatrician	Screening for risk, intervention, support in co-morbidities, social and spiritual health support, care taker support, etc.,	Program development for this population has to take place to address the increasing demand of referrals.

Appendix 10 – An Example of Alabama's Goal, Strategies, and Performance Indicators

Section II: Planning Steps –Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

PRIORITY AREA #1: Self-Directed System of Care
Priority Type: MHP, MHS
Populations: SMI, SED
GOAL: Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.
STRATEGIES: DMH will: • Continue to gather access data around age, gender, and racial/ethnic groups. • Maintain 80% or better of adult consumers and youth families reporting positive general satisfaction. • Maintain the percentage of adult consumers who report positively about function 77% or higher; and for family members of youth 67% or higher. • Hold annual Consumer Recovery Conference. • Maintain five consumer operated drop-in centers. • Continue to fund the peer services/trainings recommended by the MI Planning Council funded with Special Project dollars. • Maintain percentage of adult and child/adolescent consumers served in rural communities at 25% of the statewide total served. • Continue collaboration with Alabama Medicaid to pursue funding of peer services. • Implement state-wide use of an adult strength-based functional assessment tool. • Expand access to psychiatrist via telepsychiatry.
Annual Performance Indicators to Measure Goal Success
Indicator #1: • Maintain 80% or better of adult consumers reporting positively about general satisfaction **Baseline Measurement:** • Initial data collected during FY12. The numerator is the number of adult consumers who report positive about general satisfaction = 3,965. The denominator is the number of survey responses = 4,567. (87%) **First-year target/outcome Measurement:** • Maintain 80%

Second-year target/outcome Measurement:

- Maintain 80%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #2:

- Maintain 80% or better of youth families reporting positively about general satisfaction

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of youth families who report positive about general satisfaction = 805. The denominator is the number of survey responses = 925. (87%)

First-year target/outcome Measurement:

- Maintain 80%

Second-year target/outcome Measurement:

- Maintain 80%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results.

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.