South Dakota

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 07/31/2017 5.20.30 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 809587900

Expiration Date

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

Agency Name South Dakota Department of Social Services

Organizational Unit Behavioral Health Services

Mailing Address Kneip Building, c/o 700 Governors Drive

City Pierre

Zip Code 57501-2291

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Tiffany

Last Name Wolfgang

Agency Name South Dakota Department of Social Services

Mailing Address Kneip Building, c/o 700 Governors Drive

City Pierre

Zip Code 57501

Telephone 605-367-5236

Fax 605-773-7076

Email Address Tiffany.Wolfgang@state.sd.us

State CMHS DUNS Number

Number 809587900

Expiration Date

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

Agency Name South Dakota Department of Social Services

Organizational Unit Behavioral Health Services

Mailing Address Kneip Building, c/o 700 Governor's Drive

City Pierre

Zip Code 57501

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

First Name Tiffany

Last Name Wolfgang

Agency Name South Dakota Department of Social Services

Mailing Address Kneip Building, c/o 700 Governor's Drive

City	Pierre
Zip Code	57501
Telephone	605-367-5236
Fax	605-773-7076
Email Address	Tiffany.Wolfgang@state.sd.us

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

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Jennifer
Last Name	Humphrey
Telephone	605-773-3123
Fax	605-773-7076
Email Address	Jennifer.Humphrey@state.sd.us

Footnotes:

FY 2018-2019 Combined Behavioral Health Assessment and Plan

South Dakota

September 1, 2017

Table of Contents

20. Suicide Prevention
21. Support of State Partners – MHBG
22. State Behavioral Health Planning/Advisory Council and Input on the MH/SA Block Grant Application
**Letter by the Chair of the Behavioral Health Advisory Council*
*******Behavioral Health Advisory Council Members*
**Behavioral Health Advisory Council Composition by Member Type*
23. Public Comment on the State Plan

STATE OF SOUTH DAKOTA
DENNIS DAUGAARD, GOVERNOR

March 14, 2014

Division of Grants Management
Office of Program Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

To Whom It May Concern:

Please be advised the South Dakota Department of Social Services is designated to be administratively responsible for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant. State Secretary of the Department of Social Services, Lynne A. Valenti, is authorized to certify compliance with the requirements of 42 U.S.C. 300x et seq.

The Department of Social Services has been designated to be the recipient of both the SAPT and CMHS Block Grants. Secretary Valenti is authorized to certify, on my behalf, compliance with the requirements of 42 U.S.C. 300x et seq., or to make such other certification(s) as may be necessary to obtain and properly administer either the SAPT or CMHS Block Grants.

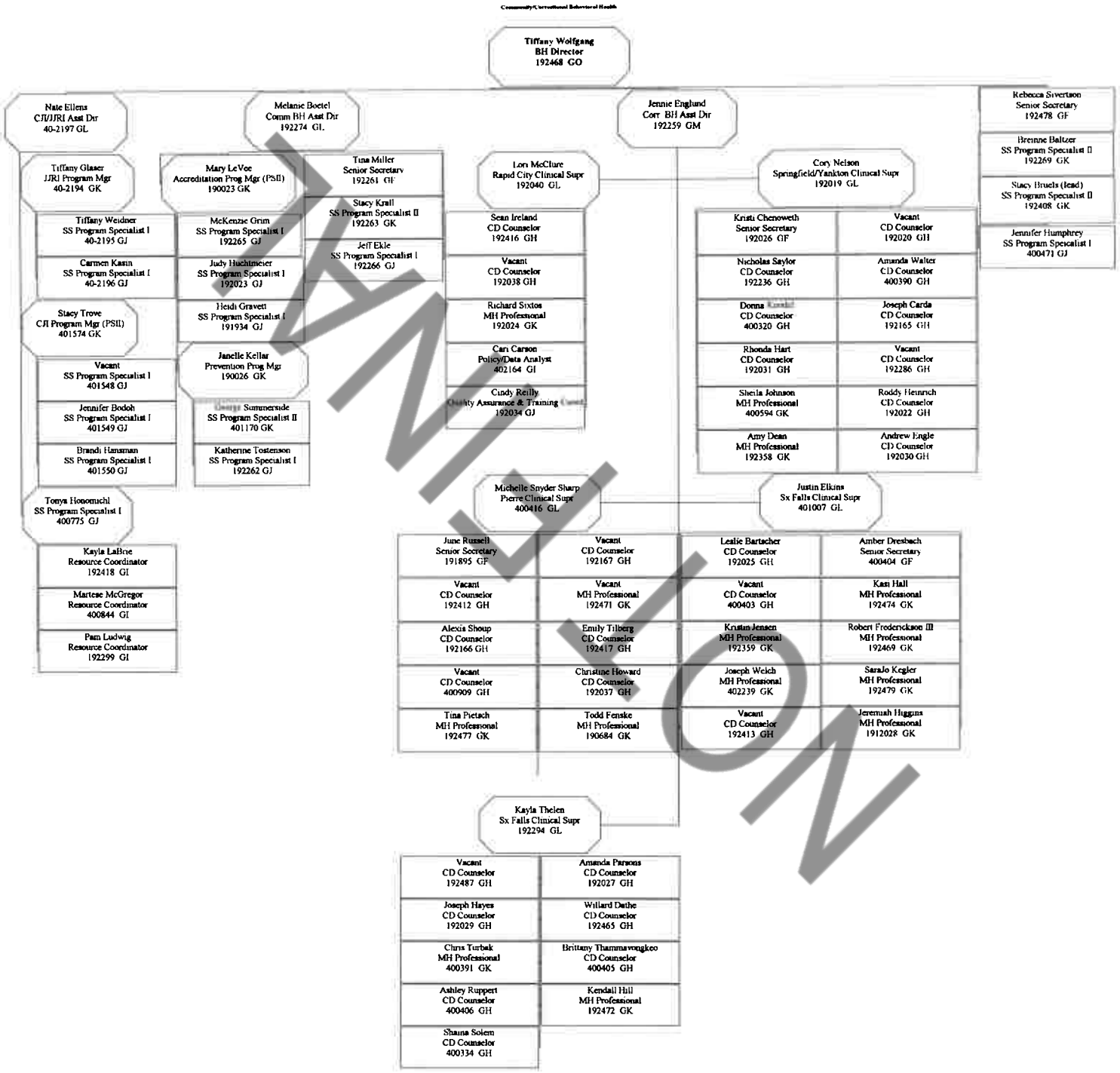
Sincerely,

Dennis Daugaard

Dennis Daugaard

DD:nn

STATE CAPITOL • 500 EAST CAPITOL • PIERRE, SOUTH DAKOTA • 57501-5070 • 605-773-3212



State Information

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

Fiscal Year 2018

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

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Lynne A. Valenti

Signature of CEO or Designee[1]: _____

Title: Secretary of the Department of Social Services

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Lynne A. Valenti

Signature of CEO or Designee[1]: _____

Title: Secretary of the Department of Social Services

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name
Lynne A. Valenti

Title
Secretary

Organization
Department of Social Services

Signature:

Date:

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

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

Organizational Structure

(Reference Organizational Chart)

State Level

Department of Social Services

Mission Statement

Strengthening and supporting individuals and families by promoting cost effective and comprehensive services in connection with our partners that foster independent and healthy families.

Department of Social Services (DSS) Strategic Plan:
http://dss.sd.gov/StrategicPlan.pdf

The Department of Social Services includes the following Divisions: Behavioral Health, Child Care Services, Child Protection Services, Child Support, Economic Assistance, Finance and Management, Legal Services, Medical Services (State Medicaid Authority), and the Human Services Center.

The Division of Behavioral Health (DBH) oversees the publically funded behavioral health services in South Dakota. Through a network of 33 accredited and contracted substance use providers, the DBH provides a full continuum of services including prevention, outpatient, intensive outpatient, day treatment, medically monitored intensive inpatient treatment, clinically managed low intensity residential treatment, clinically managed residential detoxification, and specialty programs including, gambling, relapse programs and methamphetamine treatment.

There are 11 private, non-profit Community Mental Health Centers (CMHCs) within South Dakota's community-based mental health delivery system. Each CMHC is governed by a local Board of Directors and each CMHC is responsible for providing services in a specific geographic service area. Primary populations include adults with serious mental illness and children with serious emotional disturbances and their families, including those with co-occurring mental health and substance use disorders

In addition, DBH is the direct provider of behavioral health services in the state's prison facilities.

The Division also oversees the following programs: Prevention Program, Resource Coordination Program, Accreditation Program, Criminal Justice Initiative Program and Juvenile Justice Initiative Program. The DBH employs 80 staff and is the Single State Agency for South Dakota providing both mental health and substance use disorder treatment services.

Behavioral Health Services

Mission Statement

Strengthening and supporting children and adults through community based substance use disorders and mental health services, psychiatric hospitalization, and services for offenders incarcerated in state correctional facilities.

Behavioral Health Services Workgroup

The Division of Behavioral Health utilizes recommendations from the Behavioral Health Services Workgroup 2012 Final Report to identify current service gaps and critical service needs. The recommendations include:

- Emphasis on services provided in the least restrictive environment which is appropriate for a person's care and safety.
- Creation of a regional approach to behavioral healthcare to ensure access to essential services.
- Expansion of community crisis intervention services to allow for earlier interventions that can prevent costly out-of-home placements.
- Expansion of supported housing services and supports, particularly for transition-age youth.
- Expansion of care coordination services within substance use disorder treatment.
- Streamlining of involuntary commitment laws to allow for better integration and reduction in barriers to treatment.
- Capacity development of community nursing facilities to better serve individuals with dementia and challenging behaviors.
- Modification of the intake process at the Human Services Center (HSC) to develop the capacity to allow senior individuals to be admitted directly to a geriatric unit.
- Provide psychiatric review and consultation services to nursing facilities by HSC staff to reduce inappropriate admissions to the HSC.
- Support behavioral health and wellness while reducing and treating substance use and mental health disorders by placing emphasis on a broad array of prevention services.
- Align prevention strategies at the state level while integrating prevention efforts within communities.

Behavioral Health Services Workgroup Final Report:
http://dss.sd.gov/docs/behavioralhealth/docs/behavioralhealthworkgroupreport-final.pdf

Administrative Rules of South Dakota Workgroup

In 2015, the Division of Behavioral Health (DBH) convened a workgroup of stakeholders and accredited agency representatives to review the Administrative Rules of South Dakota (ARSD) to align Substance Use Disorder (SUD) and Mental Health (MH) services where possible, remove redundancies in accordance with the Governor's Red Tape Reduction Initiative and update ARSD with current terminology, processes, and practices. DBH staff collaborated with the Division of Medical Services to revise rules related to Medicaid-funded SUD treatment. The updated ARSD for SUD and MH

services and Medical Services for Medicaid funded SUD treatment were effective December 5, 2016.

Behavioral Health Advisory Council

One of the essential roles of the Behavioral Health Advisory Council (BHAC) is to advise the Division of Behavioral Health (DBH) with the planning, coordination and implementation of the state's behavioral health services plan. BHAC members assist with the establishment of goals for the state plan while also monitoring and reviewing fiscal and programmatic information to evaluate the adequacy services for individuals with behavioral health needs. The BHAC also provides input towards potential services and/or funding expansion.

In 2016, a discussion was had regarding the future direction of the BHAC and how to ensure it meets the intended function and requirements, as well as being meaningful and productive for everyone involved. Discussion centered on the Prevention Program and the advisory councils they oversee for various projects and grants they administer. The advisory councils include the Partnership for Success, Youth Suicide Prevention Project, Screening Brief Intervention Referral to Treatment and State Epidemiological Outcomes Workgroup/Evidence-Based Project Subcommittee. Several BHAC members serve in some capacity on these councils and a consensus was reached to restructure each council into subcommittees under the umbrella of the BHAC. Coordinating the BHAC meetings with the related subcommittees meetings will allow the best use of time and travel as well as streamline the planning process of the state's behavioral health services plan.

Mental Health Initiative

In 2016, Chief Justice David Gilbertson, with the support of Governor Dennis Daugaard, created a Task Force on Community Justice and Mental Illness Early Intervention. The formation of the Task Force aligned with recommendations from the Behavioral Health Services Workgroup 2012 Final Report.

The Task Force consisted of representatives from all three branches of state government, local government, criminal justice and mental health stakeholder groups. Responsibilities included the following:

- Studying how individuals with mental illness encounter law enforcement and move through the court system, jails, and probation.
- Researching evidence-based practices and successful reforms from other states.
- Developing tailored policy options for South Dakota.
- Simulating the impact of proposed reforms.
- Exploring possible reallocation of potential savings into strategies that improve public safety and the evaluation/treatment of mental illness.

The goals of the Task Force were:

1. Improve public safety and the treatment of people with mental illness in contact with the criminal justice system through appropriate evaluation, intervention, diversion, and supervision.

2. More effectively identify mental illness in people coming into contact with the criminal justice system, through improved training in local criminal justice systems, better use of screening tools and skills, and expanded response and diversion options in communities for law enforcement and the courts; all while holding offenders and government more accountable.
3. Better allocate limited local resources in order to improve early intervention services and preserve limited jail and prison resources for violent, chronic, and career criminals.

The Task Force 2016 Final Report:
https://mentalillnesscommunityjustice.sd.gov/docs/Mental%20Health%20Task%20Force%20Report.pdf

Service System

Community Behavioral Health

Mission Statement

To ensure comprehensive statewide behavioral health services that foster individual opportunities for independence, productivity, community integration and quality services.

Fiscal Management

Mental health services are provided on a fee-for-service basis through Medicaid, Block Grant, and state general funds. Funding utilized for mental health services include direct services to individuals with serious mental illnesses and children with serious emotional disturbances as well as outpatient services, emergency services, and services through the Indigent Medication Program. The Indigent Medication Program assists individuals with serious mental illness and/or substance use disorders in purchasing psychotropic medications, related lab costs and medications for substance use disorders, with temporary funding, until longer term funding can be obtained.

Funding utilized for substance use services includes prevention, outpatient, intensive outpatient, day treatment, medically monitored intensive inpatient treatment, clinically managed low intensity residential treatment, clinically managed residential detoxification, and specialty programs including, gambling, relapse programs and methamphetamine treatment.

For both mental health and substance use disorder services, all clients undergo a financial eligibility process. Clients are found financially eligible based on 185 percent of the Federal Poverty Level (FPL). If a client's yearly gross income, minus allowable deductions, does not exceed 185 percent of the FPL for a family of comparable size, they are considered indigent and are automatically eligible for state funding for mental health and/or substance use services, when there is no other payer available. If a client's yearly gross income, minus allowable deductions, does exceed 185 percent of the FPL for a family of comparable size, they have the option of completing forms requesting a Hardship Consideration. This process takes into account any hardship that the client or family may have that would make paying for services an undue financial burden. The

Division of Behavioral Health is responsible for determining eligibility based on hardship considerations defined in provider contract requirements.

In addition, through the Children's Health Insurance Program (CHIP), South Dakota's Medicaid program expanded coverage to all families and children whose incomes are at or below 204% of federal poverty level. Each Community Mental Health Center informs clients and families on the eligibility criteria and application process for the CHIP, as well as the overall advantages to being involved in the program.

Accreditation Program

Mission Statement

Strengthening and supporting accredited agencies by promoting accountability using a strength-based review and technical assistance process.

The Division of Behavioral Health's (DBH) Accreditation team conducts onsite reviews of accredited mental health, substance use disorder treatment and prevention programs across the state. The review ensures compliance with provider contract requirements and Administrative Rules of South Dakota, Article 67:62 Mental Health and Article 67:61 Substance Use Disorders. The review encompasses areas of governance, fiscal management, personnel training/qualifications, statistical reporting, client rights, quality assurance, case record content, medication administration and consumer outcome/satisfaction reports.

The accreditation review is conducted by an evaluation of client charts and agency policies and procedures, and through interviews with staff and clients. The accreditation team developed tools to evaluate compliance with case record documentation and other requirements. It is the expectation that case records are strength-based, as unique as the client served, show evidence of client and family involvement and that goals/objectives are written so that both client and staff know when it is reached. The scoring tools are shared with the agency for transparency in the evaluation process and also to provide tangible feedback the agency can use for training and supervision purposes, along with a comprehensive feedback report. Based on the score of the onsite review, and the submission of an acceptable plan of correction when required, a program is granted a two or three-year accreditation period.

During the accreditation certificate period, the DBH may conduct follow-up calls and/or reviews with the agency for monitoring purposes and also provide technical assistance when needed, including a mid-point review for agencies with lower performance to assist them in evaluating the success of the implementation of their Plan of Correction to address identified areas of noncompliance.

Under South Dakota Codified Law 34-20A-2.1, the DBH recognizes national accreditation (Council on Accreditation, The Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities) and the Indian Health Service's quality assurance review in lieu of state accreditation for substance use disorder treatment agencies who request this recognition.

Additionally, the Department of Social Services, Finance Office, conducts audits based on a rotating schedule of state funded accredited programs. The Department of Health (DOH) conducts health and safety onsite reviews of all contracted mental health providers the year of their accreditation visit. Substance use disorder treatment providers who provide residential treatment are inspected annually by the DOH. The DBH also coordinates with the DOH on issues related to tuberculosis and any concerns related to safety and environmental issues.

In 2016 and 2017, the DBH worked collaboratively with tribal agencies, Indian Health Services and the Great Plains Tribal Chairmen's Health Board to inform and educate about opportunities for accreditation.

Criminal Justice Initiative Program

Mission Statement

To promote client change for the criminal justice involved client with behavioral health needs by providing evidence based programming through partnerships with the Unified Judicial System, the Department of Corrections, and community agencies.

During the 2013 Legislative Session, the Department of Social Services was approved funding for the establishment of the Criminal Justice Initiative (CJI) Program with the intention of improving outcomes for individuals with justice involvement.

The Division of Behavioral Health hired staff members for the CJI Program and selected providers for substance use services and criminal thinking programming through a Request for Proposal (RFP) process. Three reviewers from the Western Interstate Commission for Higher Education scored the RFPs. In total, 13 providers were selected to provide substance use services and four providers were selected to provide criminal thinking programming. There is a minimum of one substance use provider and one criminal thinking provider in each circuit court district with multiple substance use providers in the larger areas. Provider's participated in trainings on Cognitive Behavioral Interventions for Substance Abuse (evidence based practice for substance abuse treatment) and Moral Recognition Therapy (criminal thinking programming).

Due to further identified needs for substance use disorder and criminal thinking services, two additional substance use disorder and criminal thinking community providers were added to the CJI Program after the initial implementation.

The DBH offered on-going training and refresher courses to all CJI providers statewide. To enhance skill levels, Motivational Interviewing Training, which is considered a best practice, was offered to CJI providers with the opportunity for each provider to have their own trainer to allow for internal sustainability. Addiction Transfer and Technology Center provided training on Motivational Incentives to CJI providers and referral sources statewide. The majority of CJI providers are in the process of implementing the use of Motivational Incentives.

During the summer of 2013, a RFP was released for a rural pilot program; however, the Division of Behavioral Health (DBH) was unable to select a provider(s) based on the responses received. As a result, the DBH held meetings with potential providers to discuss expectations of the rural pilot. The RFP was reissued the summer of 2014.

In the fall of 2014, the DBH selected Volunteers of America and Lutheran Social Services through the RFP process for the rural pilot project. The project was 100% generally funded and initially targeted Regions one, five and six, which had been identified by the Behavioral Health Workgroup Final Report as the greatest areas of need.

Due to the success of the CJI Rural Pilot Program, in 2016, the program transitioned into providing substance use disorder treatment and criminal thinking services statewide. Services are being delivered through a technology platform which allows the client to access services through a personal device or a hub location.

CJI staff conduct quality assurance reviews on all services and CJI providers are expected to meet standards set forth by the CJI program. Outcome measure tools are collected by providers at the time of intake and discharge and CJI staff conduct follow-up surveys six months post completion of treatment. The Public Safety Initiative Oversight Council releases outcomes of the CJI Program annually.

FY16 PSIA Annual Report:
http://psia.sd.gov/PDFs/PSIA%202016%20Annual%20Report%20Document.pdf

CJI Workgroup Final Report:
http://psia.sd.gov/PDFs/CJI%20Report%20Draft%20Nov%202012%20FINAL%2011%2027%2012.pdf

Care Coordination

The Behavioral Health Services Workgroup final recommendations included the expansion of care coordination within substance use treatment. Care coordination is similar to case management and is currently provided with mental health services. However, this is not available with substance use services. Care coordination is considered part of the expansion for the Criminal Justice Initiative (CJI), and the Division of Behavioral Health is working with CJI providers to ensure care coordination is part of their services.

Juvenile Justice Reinvestment Initiative Program

Mission Statement

Promote change for at-risk youth with behavioral health needs by providing evidence-based programming through partnerships with Government and community agencies.

After reviewing the state's criminal justice system in 2013, which led to the creation of the Criminal Justice Initiative Program, Governor Dennis Daugaard and Chief Justice David Gilbertson initiated an assessment of the state's performance in juvenile justice.

At the time, South Dakota's juvenile violent crime arrest rate was one-third the national average, yet South Dakota was the second highest in the nation for incarcerating

juveniles. For most juveniles, commitment to the Department of Corrections (DOC) meant some kind of out-of-home placement. Costs associated with an out-of-home placement ranged from $41,000 to $144,000 per year, depending upon the program. Data indicated that 45% of youth released from an out-of-home placement returned to custody within three years of their release.

In 2014, the Juvenile Justice Reinvestment Initiative (JJRI) Workgroup convened to study the juvenile justice system and develop policy recommendations that advanced three goals:

1. Improve public safety by improving outcomes in juvenile cases;
2. Effectively hold juvenile offenders more accountable; and
3. Reduce costs by investing in proven community-based practices, while saving residential facilities for more serious offenders.

Over a period of six months, the workgroup analyzed juvenile arrests, dispositions, probations, out-of-home placements, and aftercare data. The workgroup also reviewed research on effective practices in juvenile justice and what works to reduce delinquency, including empirical, peer-reviewed studies about effective community-based practices and the use of residential treatment.

Meetings were held across the state with more than 200 individuals, including system-involved youth, parents of committed youth, victim advocates, Native American stakeholders, states' attorneys, judges, law enforcement, educators, county commissioners, youth care providers, defense attorneys, court services officers, juvenile corrections agents, and teen court representatives.

The Workgroup's analysis led to a set of key findings that were subsequently used to develop policy recommendations. The Workgroup found the following:

- Pre-court diversion is used inconsistently across the state.
- Most DOC commitments are for misdemeanor offenses, Children in Need of Supervision (CHINS) violations, and probation violations.
- Fewer youth are being committed to the DOC, but they are staying longer.
- Admissions to probation are declining but increasingly lower risk.
- Length of probation supervision is increasing.
- Evidence-based interventions for juvenile offenders are not sufficiently available in the community.

Based on the findings above, the workgroup developed 12 recommendations that focused expensive residential placements on youth who are a public safety risk, prevent deeper involvement in the juvenile justice system for youth committing lower level offenses, improve outcomes by expanding access to proven community-based interventions, and ensure quality and sustainability of reforms.

JJRI Final Report:
http://jjri.sd.gov/docs/JJRI%20WG%20Report_Final.pdf

The Division of Behavioral Health (DBH) has worked closely with the Unified Judicial System and the Department of Corrections to implement what has been determined in statute through the JJRI. The DBH released a Request for Proposal for Functional Family Therapy services and awarded contracts to ten out of the eleven Community Mental Health Centers and Lutheran Social Services. Providers completed training and services began in January 2016. Moral Reconation Therapy and Aggression Replacement Training services began in January 2017.

Resource Coordination Program

Mission Statement

Assist offenders with behavioral health needs to enhance their ability for a successful transition back to the community.

The Division of Behavioral Health has partnered with the Department of Corrections to ensure individuals with behavioral health disorders released from state operated correctional facilities have appropriate referrals to community providers. The DBH collaborates with many community agencies, including mental health and substance use disorder providers to facilitate improved discharge planning for individuals being released from correctional facilities. All agencies work together on discharge plans to ensure individuals being released, receive appropriate mental health and/or substance use services.

Correctional Behavioral Health

Mission Statement

To provide quality mental health and substance use disorder services to offenders committed to the Department of Correction's institutions using evidence-based practices to maximize opportunities for rehabilitation and recovery.

Through state general funds, services are offered at state correctional facilities operated by the Department of Corrections (DOC).

At the time of an offender's admission, an integrated behavioral health assessment is conducted, which identifies the level of need for both substance use disorder treatment and mental health services. If eligible, program referrals are made accordingly.

A mater's level clinician completes a full evaluation of offenders with a serious mental illness. The therapist works with the offender to develop a treatment plan, which includes coping with the prison environment, mental illness and release planning.

All offenders are able to request mental health services regardless of history. DOC staff and Department of Health staff may also refer offenders if a need is identified.

A master's level therapist develops a treatment plan for offenders identified as having on-going mental health needs. A master's level therapists also conduct suicide screenings, crisis intervention services and group therapy sessions.

All DOC facilities have implemented evidence-based substance abuse curriculum. Mental health and substance use staff see offenders with co-occurring issues jointly.

Prevention Program

Mission Statement

Create and sustain a statewide prevention system promoting behavioral health and preventing mental and substance use disorders through evidence-based programs / promising practices.

The Division of Behavioral Health (DBH) prevention infrastructure covers the entire state of South Dakota (SD) and maintains expenditures of not less than 20% of the Substance Abuse Prevention and Treatment Block Grant.

SD is divided into three main regions that the Prevention Resource Centers (PRCs) serve, ensuring coverage to all 66 counties of the state. The six identified primary prevention strategies are:

1. *Information Dissemination:* PRCs are responsible for providing knowledge and increasing awareness of the nature and extent of substance use, addiction and the effects on individuals, families, and communities. Each PRC has an identified catchment area, which ensures prevention resources are available to all 66 counties.
2. *Education:* Over 26 schools have substance use prevention programs that provide structured learning opportunities for substance use education.
3. *Community Based:* 23 community coalitions across the state provide the following services:
    - Building and sustaining alcohol, tobacco, and other drug coalitions.
    - Assisting with needs assessments and creating a prevention plan for alcohol, tobacco, and other drugs.
    - Providing resources for conducting community events related to alcohol, tobacco, and other drug prevention.
    - Ten of the 23 coalitions promote the Highway Safety campaigns targeted to prevent drunk driving in the state.
4. *Environmental:* Local community task forces provide the following services:
    - Assisting with the development and review of drug policies in schools.
    - Assisting communities to maximize enforcement procedures related to the availability and distribution of drugs.
5. *Alternatives: The* DBH supports the development and operation of community sponsored chemical free events for youth through contracts with the 10 community coalitions.
6. *Problem Identification and Referral:* The DBH contracts with 15 accredited prevention programs to offer structured prevention programming for high risk youth. These programs serve youth 18 and under and 19-20 year olds who are referred by law enforcement or schools due to alcohol and drug related behaviors.

The DBH Prevention Program received a federal grant through the Center for Substance Abuse Prevention that supported the development of a Statewide Strategic Plan. The

South Dakota Strategic Prevention Enhancement Grant (SD SPE) focused on expanding and enhancing the capacity to incorporate evidence-based prevention strategies across SD. The SD SPE addressed substance use and mental health issues utilizing the proven Strategic Prevention Framework. The SD SPE utilized epidemiologic approaches to identify high-risk substance use and mental health needs in communities in order to build the infrastructure of local and state response with evidence-based prevention programming. The result was a Comprehensive Strategic Prevention Plan created by a statewide collaborative of key stakeholders that is designed to prioritize and impact prevention indicators for the well-being of all SD citizens. The mission of the Statewide Strategic Plan is to "Create and sustain a statewide prevention system promoting behavioral health and preventing mental and substance use disorders through evidence-based programs/promising practices." The Plan's goals include:

1. Ensure access to a prevention system to support behavioral health and wellness and reduce substance use disorders.
2. Improve behavioral health through evidence-based programs/promising practices as determined by community needs.
3. Foster alignment of prevention strategies at a state level and systems integration at the regional and local levels.
4. Measure behavioral health outcomes of evidence-based programs/promising practices.

Prevention Program Strategic Plan:
http://dss.sd.gov/docs/behavioralhealth/docs/sddsspreventionsp.pdf

SD's Statewide Strategy for Suicide Prevention was created in 2005. The plan was updated in 2013 to reflect populations that have become most at risk for suicide, including youth, Native Americans, and military men/women and their families.

July 2013 South Dakota Strategy for Suicide Prevention:
http://dss.sd.gov/docs/behavioralhealth/community/sdsspfinal.pdf

Partnership for Success Grant

The Prevention Program received a Notice of Grant Award from the Substance Abuse and Mental Health Services Administration, the Center for Substance Abuse Prevention for the Partnership for Success (PFS) grant. The award is for $1,380,000 per year for five years, beginning September 30, 2014 to September 29, 2019. The focus of the grant is the reduction of underage drinking with the target population being 12 to 20 year olds. Prevention currently funds 14 local coalitions in high need counties to provide community based and school based programming to the target population related to underage drinking and binge drinking.

The goals of the PFS Grant are:

1. Reduce underage drinking by using a data-driven decision-making process (SPF) and implementing evidenced-based prevention programs.

2. To enhance and sustain prevention system capacity to implement EBP to reduce underage drinking.

The objectives of the PFS Grant are:

1. Implement a range of EBPs blending individual and environmental programming;
2. Coordinate with other local authorities (civil and legal) to enact proven prevention policies;
3. Collaborate with state, tribal and community stakeholders to reduce underage drinking;
4. Increase sub-recipient's surveillance capacity to implement a Quality Improvement process in each funded community with the assistance of local evaluators;
5. Maintain and update data infrastructure within the funded communities;
6. Provide training and technical assistance to address gaps in the current substance abuse prevention systems; and
7. Increase communities' knowledge of culturally sensitive EBP's.

A particular emphasis of the PFS will be to address the gap in prevention programming for minority youth, particularly American Indian and immigrant youth, who are at a higher risk of underage drinking and negative consequences. Besides a dearth of funding for projects to address these populations, there also is a lack of adequate training and culturally knowledgeable staff to implement and support culturally relevant prevention programming.

Youth Suicide Prevention Project Grant

The Prevention Program received Notice of Grant Award from the Substance Abuse and Mental Health Services Administration, State/Tribal Youth Suicide Prevention, for South Dakota Youth Suicide Prevention Project (SDYSPP). The award is for $736,000 per year for five years, beginning September 30, 2014 to September 29, 2019. The grant will focus on youth at risk for suicide, with the target population being from 10 to 24 years old.

The project strategies include the following:

1. Partnering with hospitals to provide extended follow-up support services to youths admitted to emergency departments and inpatient psychiatric units for suicide attempts or suicidal ideation.
2. Partnering with three institutions of higher learning to introduce a crisis texting program for students and training staff in identifying, supporting and connecting students at risk.
3. Providing training to clinical service providers on assessing, managing and treating at risk youth.
4. Providing training to youth serving organizations to identify and refer youth at risk.

The objectives of the project include:

1. Improving the continuity of care and follow-up with youth identified at risk for suicide discharged from emergency departments and inpatient units.

2. Increasing the number of staff at juvenile justice programs, colleges, universities, high schools and middle schools that are trained to identify and refer youth at risk for suicide.
3. Increasing the number of clinical service providers (behavioral health providers and health professionals) trained to assess, manage and treat youth at risk for suicide.
4. Increasing the number of behavioral health referrals and the utilization of behavioral health services for youth at risk by improving the system across the state.
5. Increasing the access points for youth at risk to receive assistance through a public awareness campaign, promoting the National Suicide Prevention Lifeline and promoting a crisis texting service.

Currently, the following Psychiatric Residential Treatment Facilities in the State provide follow-up services: Avera Medical Group's Inpatient Psychiatric facilities in Sioux Falls and Aberdeen, the Regional Health Care Center in Rapid City and the State operated Psychiatric Hospital in Yankton.

Crisis Texting programming is currently in place at the following Universities: Augustana University, Sioux Falls University, South Dakota State University, and Black Hills State University.

Grant funds also support a variety of suicide prevention curriculums and 10 Suicide Prevention Coalitions in the State.

Now is the Time: Youth Mental Health Training Grant

The Division of Behavioral Health also applied for and received a "Now is the Time" Project AWARE-Community Grant through the Substance Abuse Mental Health Services Administration. The South Dakota "Now is the Time" Project Aware Training Initiative will focus on increasing the mental health literacy of adults who interact with 12 to 18 year old adolescents. The grant is for 3 years at $125,000 per year, beginning September 30, 2015 to September 29, 2018. The plan is to train 12 Behavioral Health professionals who are currently Mental Health First Aid (MHFA) Instructors, to also become Youth Mental Health First Aid (YMHFA) instructors.

The goal of the South Dakota "Now is the Time" Project Aware is to raise mental health literacy though enhancing and supporting training of key youth-serving adults who include in the priority Behavioral Health Planning Regions 1, 2 and 5;

- teachers and educators,
- parents,
- law enforcement and emergency responders,
- pastors and other faith leaders, and
- any adults with regular contact with youth.

The project objectives include:

1. Increase the mental health literacy of youth-serving adults.

2. Increase the capability of youth-serving adults to respond to the behavioral health needs of youth in their community.
3. Foster and support referral of youth with behavioral health needs by linking youth to behavioral health support services.
4. Increase the number of collaborative partnerships with youth-serving agencies.

During the first year of the grant, the DBH trained 12 individuals in YMHFA who had previously been trained in MHFA curriculums. Over the years of the grant, the DBH will hold 123 trainings with 2,946 First Aiders trained in the state.

Screening, Brief Intervention and Referral to Treatment Grant (SBIRT)

The Prevention Program received Notice of Grant Award from the Substance Abuse and Mental Health Services Administration for the South Dakota Screening, Brief Intervention and Referral to Treatment (SBIRT) Grant. The award is for $1,658,375 per year for the next five years, beginning September 30, 2016 to September 29, 2021.

The goals of the grant are:

1. To develop the organizational relationships and infrastructure for integration of SBIRT services into primary care clinics and community behavioral health systems in South Dakota.
2. To develop and implement SBIRT training for primary care, community health, substance use prevention and treatment providers.
3. Implement SBIRT services in primary care and community behavioral health settings in South Dakota.
4. Monitor quality and evaluate SBIRT implementation and programming.

The objectives of the grant are:

Objective 1

1. Enhance organizational readiness and commitment for implementation of SBIRT into community behavioral health systems.
2. Develop SBIRT patient flow processes for primary care and community behavioral health settings.
3. Develop patient flow and referral protocols for referral of patients from primary care settings to behavioral prevention services, treatment services, and/or Medication-Assisted Treatment.
4. Facilitate the establishment of formal referral agreements between SBIRT and partner organizations.

Objective 2

1. Assemble a SBIRT training curriculum for primary care clinics and community behavioral health including substance abuse prevention and treatment providers.
2. Train all staff involved in SBIRT services in primary care clinics and community behavioral health including substance abuse prevention and treatment providers in each partnering community.
3. Provide annual refresher training in SBIRT to behavioral health prevention and treatment provider agencies participating in each community.

Objective 3

1. Integrate screening tools into clinical processes and EHRs.
2. Integrate brief intervention and prevention services into the clinical process
3. Integrate referral to treatment and or MAT.
4. Implement the SBIRT in primary care and community health settings.

Objective 4

1. Develop data collection protocols.
2. Monitor program implementation.
3. Conduct ongoing formative evaluation of SBIRT screening, brief intervention, and referral to treatment and/or MAT.
4. Conduct an impact evaluation of patient outcomes.
5. Participate in national evaluation through collection and reporting of required data elements

Methamphetamine Awareness Campaign

In August 2016, Governor Daaugard rolled out a Methamphetamine (Meth) Awareness Campaign to combat the increase in the use of meth and the subsequent arrest and incarceration of meth users. The campaign was developed by the Division of Behavioral Health and consisted of a website that detailed the devastating effects of meth and testimonials from individuals within the state that have struggled with their meth addiction. The website for the meth campaign is located at http://methchangeseverything.com/.

In addition to the website, the project also funded local prevention providers to conduct both school presentations and community town hall meetings on meth. As of January 2017, there have been 106 school presentations with some schools having presentations in multiple classes, and 11 community town hall meetings with 4,919 students and adults attending the school presentations and the town hall meetings.

From August 2016 to August 2017, there have been 11,820 visits to the website.

Provider System

Community Mental Health Centers (CMHCs)

Integral to South Dakota's community-based mental health delivery system are eleven private, non-profit Community Mental Health Centers (CMHCs). Each CMHC is governed by a local board of directors and has a specific catchment area for which it has responsibility.

Funding that supports mental health services for indigent and/or Medicaid eligible individuals are supported through Mental Health Block Grant funding as authorized under US Title 42 Part B. As a requirement of the funding, a full array of services must be provided and include services to priority populations; children with serious emotional disturbance and adults with serious mental illness. To ensure fulfillment of the

requirements of US Title 42 Part B, South Dakota's Mental Health Block Grant dollars are allocated to agencies defined in South Dakota Codified Law 27A-1-1(16) and accredited according to Administrative Rules of South Dakota 67:62.

All CMHCs provide Children, Youth and Family (CYF) and Comprehensive Assistance with Recovery and Empowerment (CARE) services. However, there are six CMHCs that also provide Individualized Mobile Program of Assertive Community Treatment (IMPACT) services. In addition, ten out of the eleven CMHCs provide Functional Family Therapy (FFT) services as part of the Juvenile Justice Reinvestment Initiative (JJRI) Program.

Ten out of eleven CMHCs are co-occurring capable and provide a wide array of substance use services. Six CMHCs provide Moral Reconation Therapy (MRT) and four CMHCs provide Aggression Replacement Training (ART) as part of the JJIRI Program. In additional, five CMHCs provide Cognitive Behavioral Interventions for Substance Abuse (CBISA) as part of the Criminal Justice Initiative Program.

1. Behavior Management Systems (BMS), Rapid City- Catchment area: Bennett, Butte, Custer, Fall River, Harding, Jackson, Lawrence, Meade, Pennington, and Oglala Lakota counties. The Pine Ridge Indian Reservation falls within the catchment area as well. Additional mental health services include MRT, ART, FFT and IMPACT. BMS established a First Episode Psychosis Program in 2016. Substance use services include early intervention, outpatient services and clinically managed low intensity residential treatment and medically monitored intensive inpatient treatment for pregnant women and women with dependent children. Additionally, BMS provides residential housing supports for individuals with serious mental illness.

2. Capital Area Counseling Services, Inc. (CACS), Pierre- Catchment area: Buffalo, Haakon, Hughes, Hyde, Jones, Lyman, Stanley and Sully. The Lower Brule and Crow Creek Indian Reservations fall within the catchment area as well. Additional mental health services include MRT, ART, FFT and IMPACT. Substance use services include early intervention, outpatient, intensive outpatient, gambling and CBISA. CACS operates a therapeutic foster care program for children placed in the State foster care system. Additionally, CACS provides residential housing supports for individuals who may have co-occurring mental health and substance use issues.

3. Community Counseling Services, Inc., (CCS), Huron- Catchment area: Beadle, Hand, Jerauld, Kingsbury, Lake, Miner, and Moody. Additional mental health services include FFT and IMPACT. Substance use services include prevention, early intervention, outpatient, intensive outpatient, gambling and CBISA.

4. Dakota Counseling Institute (DCI), Mitchell- Catchment area: Aurora, Brule, Davison, Hanson, and Sanborn. Additional mental health services include FFT. Substance use services include early intervention, outpatient, intensive outpatient,

clinically managed low intensity residential, clinically managed residential detoxification, medically monitored intensive inpatient and CBISA.

5. East Central Behavioral Health Center. (ECBH), Brookings- Catchment area: Brookings. Additional mental health services include FFT. Substance use services: prevention, early intervention, outpatient, intensive outpatient and gambling.

6. Human Service Agency (HSA), Watertown- Catchment area: Clark, Codington, Deuel, Grant, Hamlin, and Roberts. The catchment area also includes the Sisseton-Wahpeton Indian Reservation. Additional mental health services include MRT and FFT. Substance use services include prevention early intervention, outpatient services, intensive outpatient, clinically managed low intensity residential, clinically managed residential detoxification, gambling and CBISA. HSA provides services to people with developmental disabilities. Additionally, HSA provides residential housing supports for individuals who may have co-occurring mental health and substance use issues.

7. Lewis and Clark Behavioral Health Services (LCBHS), Yankton- Catchment area: Bon Homme, Charles Mix, Clay, Douglas, Hutchinson, Union, and Yankton. The catchment area also includes the Yankton Sioux Indian Reservation. Additional mental health services include MRT, FFT and IMPACT. Substance use services include prevention early intervention, outpatient, intensive outpatient, medically monitored intensive inpatient and CBISA. Additionally, LCBHS oversees an assisted living facility targeted to homeless adults with serious mental illness and complex medical needs.

8. Northeastern Mental Health Center (NEMHC), Aberdeen- Catchment area: Brown, Campbell, Day, Edmunds, Faulk, Marshall, and McPherson, Potter, Spink, and Walworth. Additional mental health services include MRT, ART, FFT and IMPACT. Substance use services include outpatient. NEMHC also operates a therapeutic foster care program for children placed in the State foster care system.

9. Southeastern Behavioral HealthCare (SEBHC), Sioux Falls- Catchment area: Lincoln, McCook, Minnehaha, and Turner. Additional mental health services include MRT, ART, FFT and IMPACT. SEBHC established a First Episode Psychosis Program in 2015. Substance use services include early intervention and outpatient. SEBHC oversees an assisted living facility targeted to homeless adults with serious mental illness. Additionally, the SEBHC Education and Integration Center also services children with developmental disabilities.

10. Southern Plains Behavioral Health Services (SPBHS), Winner- Catchment area: Gregory, Mellette, Todd, and Tripp. The Rosebud Indian Reservation also falls within the catchment area. Additional mental health services include FFT.

11. Three Rivers Mental Health and Chemical Dependency Center (TRMHCDC), Lemmon- Catchment area: Corson, Dewey, Perkins and Ziebach. The Cheyenne River and Standing Rock Indian Reservations also fall within the catchment area. Substance use services include prevention, early intervention, outpatient and intensive outpatient.

Interactive County Map for Behavioral Health Services:
http://dss.sd.gov/behavioralhealth/agencycounty.aspx

Adult Mental Health Services

The Division of Behavioral Health (DBH), the Behavioral Health Advisory Council, and the Community Mental Health Centers (CMHC) collaborate with one another to ensure that the community-based mental health system provides services that are comprehensive, culturally responsive, consumer driven, and provide a recovery focus to all individuals with mental health issues, including individuals with co-occurring disorders. Although CMHCs provide mental health services to all adults identified with mental health issues, the highest priority target group is adults with a serious mental illness (SMI).

In order to receive targeted services through CMHCs, a person with SMI is defined within Administrative Rule of South Dakota 67:62:12:01 as a person 18 or older that meets at least one of the following criteria:

- Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime, such as, emergency services, alternative residential living, or inpatient psychiatric hospitalization;
- Has experienced a single episode of psychiatric hospitalization with a diagnosis of a major mental disorder;
- Has been treated with psychotropic medication for at least one year; or
- Has frequent crisis contact with a Community Mental Health Center, or another mental health provider, for more than six months as a result of a mental illness.

In addition to meeting at least one of the criteria above, the individual must have impaired functioning as indicated by at least three (3) of the following:

- Is unemployed or has markedly limited job skills and/or poor work history;
- Is unable to perform basic living skills without assistance.
- Exhibits inappropriate social behavior that results in concern by the community or requests for mental health or legal intervention;
- Is unable to obtain public services without assistance;
- Requires public financial assistance for out-of-hospital maintenance or has difficulty budgeting public financial assistance or requires ongoing training in budgeting skills or needs a payee; or
- Lacks social support systems in a natural environment, such as close friends and family, or the client lives alone or is isolated.

Comprehensive Assistance with Recovery and Empowerment (CARE) services are intended to be comprehensive, person-centered, relationship and recovery focused, and co-occurring capable. They are provided within an integrated system of care focusing on individually planned treatment, rehabilitation, and support services to clients with a serious mental illness, including those with co-occurring or complex needs (substance use, developmental disabilities, other medical conditions, etc.). CARE teams, available at each Community Mental Health Center, are organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery team. The team is integral to the CARE philosophy and the expectation that services are welcoming, recovery oriented, co-occurring, trauma-informed and culturally sensitive. Services are designed to incorporate identified needs from all life domains, respond to cultural differences and special needs, and promote community integration.

The team's highest priority is to provide services according to the unique needs and potential of each client. CARE teams provide outreach services and are available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours per day. CARE teams may provide multiple contacts per week to individuals experiencing severe symptoms and/or significant problems in daily living.

The CARE team is responsible for the following services:

- Case Management
- Crisis assessment and intervention, including telephone and face to face contact available to consumers 24 hours per day, seven days per week.
- Liaison services to coordinate treatment planning with inpatient psychiatric hospitals, local hospitals, residential programs, correctional facilities, and in-patient alcohol/drug treatment programs.
- Symptom assessment and management
- Supportive counseling and psychotherapy
- Medication prescription, administration, monitoring, and education.
- Facilitate access to the basic necessities of daily life, and ensure that consumers can perform basic daily living activities.
- Maintain current assessments and evaluations;
- Participate in the treatment planning process;
- Monitor consumer progress towards identified goals;
- Support in helping consumers find and maintain employment in community-based job sites;
- Provide budgeting and financial management/support, including payee services if applicable;
- Support in locating, financing and maintaining safe, clean affordable housing
- Development of psychosocial skills and/or psychosocial rehabilitation;
- Assist with locating legal advocacy and representation, if applicable;
- Collaborate with substance use services, as needed.

- Encourage active participation of family and or supportive social networks by providing education, supportive counseling and conflict intervention and resolution

IMPACT

Administrative Rule of South Dakota, Chapter 67:62:13

The Individualized Mobile Programs of Assertive Community Treatment (IMPACT) follows the Assertive Community Treatment (ACT) model and is an evidence-based, comprehensive, person-centered, recovery focused, individualized integrated system of care offering treatment, rehabilitation, and support services to identified consumers with serious mental illness (SMI), including those with co-occurring conditions (substance use, developmental disabilities, etc.) and those who require the most intensive services. All six IMPACT programs within the state are provided within Community Mental Health Centers that also provide Comprehensive Assistance with Recovery and Empowerment (CARE) services for SMI individuals.

In order to receive IMPACT services, a person must be 18 years of age or order and meet the SMI criteria as defined within Administrative Rule of South Dakota (ARSD) 67:62:12:01, and also ARSD 67:62:13:01 as follows:

1. The client has a medical necessity to receive IMPACT services, as determined by a clinical supervisor;
2. The client is approved by the division to receive IMPACT services;
3. The client understands the IMPACT model and voluntarily consents to receive IMPACT services or is under transfer of commitment from HSC;
4. No other appropriate community-based mental health service is available for the client; and
5. The client meets at least four of the following criteria;
    a. Has a persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family relatives, or community mental health providers;
    b. Has frequent psychiatric inpatient hospitalizations within the past year;
    c. Has constant cyclical turmoil with family, social, or legal systems or inability to integrate successfully into the community;
    d. Is residing in an inpatient, jail, prison or residential facility and clinically assessed to be able to live in a more independent living situation if intensive services are provided;
    e. Has an imminent threat of losing housing or becoming homeless; or
    f. Is likely to need residential or institutional placement if more intensive community-based services are not provided.

An IMPACT team is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery system. These services are provided in a location preferred by the consumer. The services are provided at a frequency level to assist consumers with SMI in coping with the symptoms of their illness, minimizing the effects of their illness; or maximizing their capacity for independent living and minimizing periods of psychiatric hospitalizations.

IMPACT services are required to provide the same services as CARE; however, in order to provide a more intense level of care, each program may not exceed a ratio of twelve consumers per one primary therapist. An average of sixteen contacts per month or more, if clinically appropriate, must be provided to consumers. These services are provided with one primary provider, but because of a team approach, all clinicians on the treatment team provide backup when necessary.

Per the Behavioral Health Services Workgroup recommendations, the Division of Behavioral Health (DBH) contracts with a consultant to conduct fidelity reviews of existing IMPACT programs to ensure fidelity to the ACT model. Three IMPACT programs were reviewed in Fiscal Year 2016 and the remaining three were reviewed in Fiscal Year 2017. Results reflected a high level of fidelity to the ACT model; however, each program was provided feedback on specific areas upon which they can continue to improve. The DBH will continue to review fidelity regularly and work with the consultant to develop trainings to ensure staff have the skills necessary to operate these programs with integrity.

Collaboration of CARE and IMPACT with other agencies

Comprehensive Assistance with Recovery and Empowerment (CARE) and Individualized Mobile Programs of Assertive Community Treatment (IMPACT) services encompass physical health, mental health, rehabilitation, and case management services including services for individuals with co-occurring disorders. Staff work with individuals through regular referral/contact with agencies such as Vocational Rehabilitation, substance use providers, primary care physicians, and dentists. The CARE/IMPACT teams address needs of consumers on an individual basis, and treatment plans for that individual include referrals and linkage with other systems. In addition, nine Community Mental Health Centers act as Health Home providers and provide comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social supports.

Medical and Dental Service Coordination

Comprehensive Assistance with Recovery and Empowerment and Individualized Mobile Program of Assertive Community Treatment teams work with individuals and physicians/dentists in order to connect them to necessary primary care and dental services. Providers collaborate with other service systems to ensure individuals are receiving quality healthcare for their mental and physical health needs. In addition, nine Community Mental Health Centers act as Health Home providers and do additional work to ensure medical needs are addressed and all care is coordinated.

Transitional Housing

Residential housing provides room and board for individuals ages 18 and older who have a serious mental illness, including those with co-occurring substance use disorders and due to their illness, need additional support. Three of the eleven Community Mental Health Centers (Behavior Management Systems, Capital Area Counseling Services, and the Human Service Agency) offer residential housing supports. Individuals living in

residential housing are provided a broad range of services available through Comprehensive Assistance with Recovery and Empowerment or Individualized Mobile Programs of Assertive Community Treatment services. Community Mental Health Centers focus on supporting individuals to develop the skills necessary to live independently and transition into their own apartment, if clinically appropriate. In addition to funding provided by the DBH, providers work with local partners to identify additional resources for their clients.

Assisted Living Centers

South Dakota has two assisted living centers in the state that are designated specifically for individuals with serious mental illnesses. Service needs may be more intense for those who have significant medical issues and/or are homeless. Licensed through the Department of Human Services, Division of Long Term Services and Supports, Cedar Village and Cayman Court are located in the Southeastern part of the State (Yankton and Sioux Falls, respectively). They have an approximately 48 bed capacity between the two centers and are operated by the Community Mental Health Centers (CMHCs) in those areas. Individuals living in these assisted living centers receive Comprehensive Assistance with Recovery and Empowerment services through the CMHCs.

The Behavioral Health Workgroup Geriatric Subcommittee developed recommendations in regards to the growing trends of dementia-related healthcare needs among the state's senior population, which is leading to an increased need for behavioral health training among healthcare staff and additional capacity for patients with dementia and short-term behavioral health needs.

Behavioral Health Services Workgroup Final Report:
http://dss.sd.gov/docs/behavioralhealth/docs/behavioralhealthworkgroupreport-final.pdf

As a result of the Behavioral Health Workgroups final recommendations, the Human Service Center (HSC) and the Division of Long Term Services and Supports worked with a nursing home in Irene to create a specific unit that will serves 11 individuals who have behavioral health challenges. This allows individuals who are currently residing in the nursing facility units at the HSC to transition to a less restrictive community setting.

In addition, nursing facilities or assisted living centers that are struggling with individuals with dementia and/or challenging behaviors are able to request a psychiatric clinical review from the HSC. The purpose of the review is to:

- Maintain nursing facility or assisted living residents in the least restrictive environment.
- Provide facilities with resources and interventions which will allow the residents to remain in their current setting.
- Support appropriate admissions to the HSC.

The nursing facility or assisted living requests a clinical review by completing a Clinical Review form. The Clinical Review form summarizes the patient's medical and psychiatric history along with presenting problems, current medications and supports.

Upon receipt of the Clinical Review form, the Clinical Review Team will contact the facility with recommendations within 48 hours. The Clinical Review Team includes: staff psychiatrists, family practice medical providers, nursing staff, social work staff and therapeutic recreation specialists.

If the Clinical Review is not successful and less restrictive options have failed, residents are transferred directly to the HSC Geriatric Program for a short stay treatment.

The goals of the short stay program in the Geriatric Program are to assess the resident, provide treatment in both medication and non-medication forms, and return the resident to their home community.

Discharge Planning between the Human Services Center and Community

The implementation of a comprehensive, organized, community-based system of care is a key strategy in reducing psychiatric hospitalizations within South Dakota. The Division of Behavioral Health (DBH) and the Human Services Center (HSC) have collaborated by building a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the DBH, the HSC, and the Community Mental Health Center system meet as needed to address streamlining the discharge planning process to ensure that all individuals, once discharged from the HSC, are aware of and have immediate access to mental health services in the community.

The Behavioral Health Workgroup Geriatric Subcommittee collaborated with the discharge planning workgroup in order to reduce the number of inappropriate admissions by developing a capacity for the HSC to provide psychiatric reviews/consultations to nursing facilities to assist with consumers who have challenging behaviors or behavioral health needs. This is also explained in more detail under "Assisted Living Centers (Adult Services)".

Preadmission Screening and Resident Review (PASRR)

Administrative Rule of South Dakota, Chapter 67:62:15

Preadmission Screening and Resident Review (PASRR), is a federal mandate which ensures individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that each resident, regardless of payment source, applying for admission to, or residing in, a Medicaid-certified nursing facility be screened for mental illness and /or intellectual disability.

The PASRR process is made up of a Level I screening completed by the Department of Social Services Medical Review Team. The team refers all who screen positive for mental illness for a Level II evaluation and determination completed by the Division of Behavioral Health. A Level II review determines if the mental health needs of the individual can be met in the nursing facility or if the individual requires specialized services at the State Psychiatric Hospital. This process is consistent with South Dakota's intent to ensure individuals are served in the least restrictive setting.

Projects for Assistance in Transition from Homelessness (PATH)

Through the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program (P.L. 101-645, Title V, Subtitle B), the Division of Behavioral Health (DBH) contracts PATH funds to five accredited Community Mental Health Centers (CMHCs) to provide PATH services to adults with serious mental illnesses and/or substance use disorders, who are homeless or at imminent risk of homelessness.

The allocation amounts of PATH funds are based on the need for services. The urban areas of Sioux Falls and Rapid City have the largest homeless populations and, therefore, need and receive the highest allocation amounts.

In order to make the best use of PATH funds, the DBH has divided funds into two separate categories, Category 1 and Category 2.

Category 1 is for the provision of direct mental health services, including the following:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Case management
- Substance use disorder treatment services
- Referrals for primary health services
- Job training
- Educational services

Category 2 funds are used for one-time rental assistance and security deposits.

The PATH Homeless Outreach Coordinator works to engage homeless individuals into PATH services. Once there is an opening within a CMHC's Comprehensive Assistance with Recovery and Empowerment (CARE) or Individualized Mobile Programs of Assertive Community Treatment program, the individual is transferred to one of those programs. Prior to this transfer, individuals in the PATH program are linked to mainstream resources just as they would be in the CARE Program. Referrals are made to mental health, substance use services, community health centers, community housing, vocational rehabilitation, the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and energy and weatherization assistance.

Housing Coordination and Supports

Five of the 11 Community Mental Health Centers (CMHC) receive Projects for Assistance in Transition from Homelessness (PATH) funds to provide services to individuals with serious mental illness and/or co-occurring substance use disorders, who are homeless or at imminent risk of homelessness. Services include outreach, screening and diagnostic treatment, habilitation and rehabilitation, substance use assessments, case management, primary health care referrals, job training, education, housing supports and community mental health services such as medication management, supportive

counseling and psychotherapy. Other services also provided include technical assistance in applying for housing assistance and financial support including security deposits and one-time rental assistance to prevent eviction.

CMHCs work closely with the South Dakota Housing Development Authority, local housing authorities, and property owners to assist individuals in obtaining and maintaining appropriate housing. Due to the shortage of affordable housing across the state, housing support services through CMHCs are essential components of the community based mental health system. Housing supports actively assist clients in obtaining, moving to, or retaining housing of the client's choice. Supports include providing referrals, assistance in applying for housing subsidies, assisting the client in appealing a denial, suspension, reduction, or termination of a housing subsidy and if appropriate, and with the consent of the individual receiving services, providing periodic visits to the client's home to monitor health and safety.

Mental Health Services to Veterans

The Federal Veteran's Administration (VA) facilities include hospitals in Sioux Falls, Hot Springs, and Sturgis. Individuals accessing services at these facilities are welcomed and encouraged to access state funded community mental health services. Community mental health centers collaborate with the VA to provide needed services to homeless veterans and collaborate with local housing authorities to facilitate access to Section 8 rental assistance vouchers for these individuals. In addition, the Department of Labor and Regulation and the VA also partner with Community Mental Health Centers to provide services that are intended to increase the employability of homeless veterans. Some Community Mental Health Centers work with the VA to identify, count and provide services for homeless individuals and at risk families.

Vocational Coordination

To assist clients with their employment goals, Community Mental Health Centers (CMHCs) will coordinate services with the Division of Rehabilitation Services (DRS). Several CMHCs have vocational counselors located within their agencies, which allows for increased coordination of services. The DRS funds a program titled "Employment Skills Program." The Employment Skills Program provides individuals the opportunity to try various employment occupations, and develop work skills. This is a paid work experience program for adults diagnosed with mental illness to obtain employment skills in the community. It is a temporary placement of up to 250 hours at a job site. The DRS pays the wages, Federal Insurance Contributions Act, and worker's compensation. The DRS also purchases services from CMHCs to provide job development and job supports at the employment placement. The placement and services are coordinated with the CMHCs to assure the success of the work experience. The DRS will also fund tuition fees for eligible individuals with disabilities to further their education through college/trade school attendance.

Children's Mental Health Services

As with adult services, the Division of Behavioral Health, the Behavioral Health Advisory Council, and Community Mental Health Centers (CMHCs) collaborate to ensure the community based mental health system provides services that are comprehensive, culturally responsive, consumer driven, and recovery focused to all children and families with mental health issues, including those with co-occurring disorders. Although CMHCs provide mental health services to all children identified with mental health issues and their families, the highest priority target group is children with serious emotional disturbances (SED), provided through Children, Youth and Family (CYF) services.

To be eligible for CYF services, Administrative Rules of South Dakota 67:62:11:01 states the clinical record shall contain documentation that includes:

1. At least one child in the family under the age of 18 meets the criteria of SED as defined in South Dakota Codified Law (SDCL) 27A-15-1.1; or
2. At least one youth 18 through 21 years of age who needs a continuation of services started before the age of 18, in order to realize specific goals or assist in the transition to adult services and meets criteria of SED defined in SDCL 27A-15-1.1 (2)(3)(4) and (5).

SDCL 27A-15-1.1 defines an individual with a serious emotional disturbance as an individual who:

1. Is under eighteen years of age;
2. Exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family, or peer group;
3. Has a mental disorder specified within the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, 2013, or coding found in the International Classification of Diseases, 10th revision, Clinical Modification, 2015;
4. Has demonstrated a need for one or more special care services, in addition to mental health services; and
5. Has problems with a demonstrated or expected longevity of at least one year or has an impairment of short duration and high severity.

For purposes of this section, intellectual disability, epilepsy, other developmental disability, alcohol or substance abuse, brief period of intoxication, or criminal or delinquent behavior alone do not constitute a serious emotional disturbance.

Children, Youth, and Family Services (CYF)

Administrative Rule of South Dakota, Chapter 67:62:11

CYF provides mental health services to children with a serious emotional disturbance and their families via a system of care that is intensive and comprehensive, child-centered, family-focused, community-based, co-occurring capable, individualized, and integrated. CYF offers a comprehensive array of services and supports that address needs identified in each life domain and provide children/youth with individualized services in accordance with the unique needs and potential of each child. Services are provided in the least restrictive, most normative environment that is clinically appropriate, and in a manner that is sensitive and responsive to cultural differences and special needs. The

parents, families and surrogate families of children with serious emotional disturbances (SED) are full participants in the assessment process, treatment planning, and delivery of services. The goal of these services is to ensure that children with SED are able to live with their families and in their home community, whenever possible.

Vocational Coordination

Community Mental Health Centers support youth with serious emotional disturbances and their families when the youth is seeking employment. Services include assisting the individual in locating, securing and maintaining employment or accessing services through other services, such as Project Skills. Project Skills is funded through the Department of Human Services: Division of Rehabilitation Services (DRS) and Division of Service to the Blind and Visually Impaired (SBVI) and local school districts across South Dakota. DRS and SBVI are referred to as Vocational Rehabilitation (VR) which is a program that provides individualized vocational rehabilitation and supportive services to assist individuals with disabilities to reach their employment goals. Project Skills offers students with disabilities an opportunity to gain paid employment experience of up to 250 hours while in high school. VR funds the wages, workers compensation, and the Federal Insurance Contributions Act while schools provide job development, job coaching and follow-along for the student at the job site.

Educational Coordination

The Division of Behavioral Health encourages Community Mental Health Centers (CMHCs) to work closely with school personnel in the identification and early intervention of children with a serious emotional disturbance as defined under the Disabilities Education Act. Many CMHCs already have a referral process in place with their perspective school districts.

CMHC staff work with school counselors and teachers to provide early interventions and to develop a system of support for children and youths in their communities. They also work with children, youth, families and Individual Education Plan teams to ensure that needed mental health services are provided and that the child or youth is receiving appropriate education, despite mental health issues or other learning disabilities.

Medical/Dental Service Coordination

Children, Youth and Family (CYF) case management services include a holistic approach to maintaining physical and mental health. CYF staff work with individuals through regular referral/contact with agencies such as a child/family's primary health care physician and/or a dentist. CYF case managers and family teams address the needs of children/families on an individual basis, and treatment planning for that child/family includes referrals and linkage with other systems.

Residential Services

The Division of Behavioral Health does not currently fund residential services for children. The South Dakota Medical Assistance Program provides funding of services in licensed group and residential treatment facilities for children who have behavioral or

emotional problems requiring intensive professional assistance and therapy in a highly structured, self-contained environment.

Out of State Placement

The Division of Behavioral Health (DBH) does not make out-of-state placements for children. However, division staff members are included in the process for approving youth in out-of-state facilities through participation in the State Review Team (SRT). The SRT consists of representation from the following departments/divisions: DBH, Developmental Disabilities, Special Education, Social Services, Department of Corrections, Human Services Center, and the Developmental Center. All activities are followed by the Department of Social Services, Auxiliary Placement Program. Out-of-state and in-state out-of-home placements are last resort options. The Team reviews each child/youth's information and discusses what level of care is most appropriate, including home-based community services. Out of state placement requests must also include denials from in-state residential treatment facilities.

Child Welfare, Juvenile Services, and Criminal Justice Coordination

The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections (DOC), and Community Mental Health Centers (CMHCs) collaborate with one another to improve the referral and service delivery system for children who are referred by UJS or CPS to a CMHC. The Division of Behavioral Health (DBH) supports these collaborative efforts by coordinating both system-wide conversations and local conversations, if needed.

In June of 2014, Governor Daugaard established the Juvenile Justice Reinvestment Initiative (JJRI) Workgroup. The workgroup established a comprehensive package of reforms. A final report was issued in November 2014.

JJRI Workgroup Final Report: http://jjri.sd.gov/docs/JJRI%20WG%20Report_Final.pdf

In March 2015, Governor Daugaard signed a bill to reform South Dakota's juvenile justice system. Since that time, the DBH has worked closely with the UJS and the DOC to implement what has been determined in statute through the JJRI.

Adult and Children Mental Health Services

Services for Transition Age Youth Program – New Alternatives

In February 2013, The Division of Behavioral Health (DBH) received technical assistance from the Substance Abuse and Mental Health Services Administration in regard to the Assertive Community Treatment model and housing supports for youth aging out of placements with no family supports.

During the 2014 Legislative Session, funding was approved for the DBH to develop supervised supported housing services for transition-age youth. The Behavioral Health Services Workgroup Final Report identified this as an area of need.

This intensive independent living program serves young adults diagnosed with a serious emotional disturbance or serious mental illness as they transition into adulthood. The program coordinates housing, mental health services, and support services targeted at assisting the young adult at developing independent living skills. An emphasis on employment, independent living skills and developing a community support system are also a part of this program. These youth have a history of foster home or residential placement and are guided on how to access services and complete or continue their education.

The New Alternatives program, located in Rapid City, can serve up to 12 young adults at one time. The housing component of the program provides six (6) two-bedroom apartments to develop and foster the skills needed for independent living. Each apartment is fully furnished and includes two bedrooms, a full kitchen, bathroom and living room. In order to support the young adults' needs, 24-hour onsite staff supervision and support is provided.

Additionally, Lutheran Social Services is coordinating with Rapid City area community mental health and substance use providers to provide services to the program participants.

The goal of the program is to provide transition age youth between the ages of 18-25 with community resources and the ability to live independently in any community they choose.

First Episode Psychosis Program

Two First Episode Psychosis (FEP) Programs, utilizing the OnTrackNY model, have been established within the State of South Dakota. OnTrackNY provided training to Southeastern Behavioral Health Care (SEBHC), in the eastern part of the state and Behavior Management Systems (BMS), in the western part of the state. SEBHC began serving clients in 2015 and BMS began serving clients in 2017. Providers were selected based on the most populous areas of the state, which allows a greater number of individuals the ability to access FEP services.

Health Homes

The Health Home services are a systematic and comprehensive approach to the delivery of primary care or behavioral health care that promises better results than traditional care. The Health Home approach is beneficial as it examines a Health Home recipient as a whole and reduces utilization of high cost services.

In order to be served in a Health Home, recipients must have a chronic condition, which includes a serious mental illness or serious emotional disturbance. Other examples of eligible chronic conditions include substance use disorder, diabetes, heart disease, and hypertension. Designated Health Home providers include providers licensed by the State of South Dakota who practice as a primary care physician, physician assistant, or an advanced practice nurse practitioner working in a Federally Qualified Health Center (FQHC), a Rural Health Clinic, or a mental health professional working in a Community Mental Health Center. The designated provider leads a team to provide identified services needed by the recipient. The team may consist of a primary care physician, physician assistant, advance practice nurse, behavioral health provider, a health coach/care

coordinator, chiropractor, pharmacist, support staff, and other services as appropriate and available.

As of March 2017, nine Community Mental Health Centers, 25 FQHCs, 11 Indian Health Service Units and 74 other clinics act as Health Homes providers. The core services expected to be provided through the Health Homes providers include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social supports.

Respite Care

Administrative Rule of South Dakota, Chapter 46:11:12

The Department of Human Services, Division of Developmental Disabilities, operates the Respite Care Program. Any family having a child or adult family member who has a developmental disability, a developmental delay (children only), a serious emotional disturbance, a serious mental illness, a chronic medical condition (children only), a traumatic brain injury, or a child that has been adopted may be considered for respite care services. The family chooses the respite provider and utilizes the required form to purchase respite care services.

Respite care is designed to help families and caregivers of children and adults with special needs. Caregivers and families often face serious problems and stress as a result of balancing the needs of their child or adult with special needs with the needs of other family members. Respite care is temporary relief care designed for families of children or adults with special needs. Respite care can range from a few hours of care provided on a one-time basis to overnight or extended care sessions. Respite care can be utilized on a regular or irregular basis and can be provided by family members, friends, skilled care providers or professionals.

Indigent Medication Program

The Division of Behavioral Health (DBH) understands the importance of access to psychotropic medications and medications for substance use disorders for individuals who are discharged from the Human Services Center, a correctional facility, and/or who are receiving (or waiting to receive) community mental health services.

The Indigent Medication Program provides temporary funding to assist individuals with a serious mental illness and/or substance use disorder, who do not exceed 185% of the Federal Poverty Level, in purchasing psychotropic medications, related lab costs and medications for substance use disorders, until longer term funding can be obtained.

In addition, the DBH works with Community Mental Health Centers to identify pharmaceutical programs that could provide assistance to individuals in obtaining medications. Most individuals served through the Indigent Medication Program are adults. However, on a case by case basis, some children whose families are not eligible for Medicaid and could otherwise not afford necessary psychotropic medications are served by this program.

Substance Use Disorder and Prevention Providers

As of March 2017, there are 40 accredited substance use disorder treatment programs in the state. The broad spectrum of services includes:

- Crisis intervention
- Assessment
- Counseling
- Outpatient treatment
- Detoxification
- Transitional care and inpatient treatment
- Services for pregnant women and women with dependent children
- Methamphetamine treatment

Nine accredited/contracted providers receive state funding from lottery and gaming revenue to specifically target gambling disorder treatment. Individuals seeking treatment for a gambling disorder at an agency that does not receive these specific gambling dollars are able to utilize block grant dollars when they meet indigent funding requirements.

In addition, the substance use disorder and prevention service delivery systems in South Dakota have built solid foundations and infrastructures including:

- Two specialized community based methamphetamine treatment programs located at City/County Alcohol and Drug Program in Rapid City and Keystone Treatment Center in Canton.
- Two specialized community based treatment programs for pregnant women located at Behavior Management Systems in Rapid City and Volunteers of America (VOA) in Sioux Falls. VOA also serves pregnant adolescents.
- Individuals with co-occurring disorders.
- A comprehensive behavioral health treatment system in all the adult prisons in the state.
- Five clinically managed residential detoxification treatment programs located at the Minnehaha Detoxification Center in Sioux Falls, City/County Alcohol and Drug Program in Rapid City, Keystone Treatment Center in Canton, Dakota Counseling Institute in Mitchell and the Human Service Agency in Watertown.
- A full continuum of care is in place for youth and adolescents, including psychiatric residential facilities providing programming for substance use disorders.

Twenty-five community providers are accredited to provide services to youth and communities across the state. The services provided include:

- Prevention
- Early intervention
- Education on the harmful effects of alcohol and other drugs
- Awareness campaigns
- Environmental strategies

- Training on evidence-based programs
- Implementation on evidence-based programs

These programs provide community and/or school-based prevention services to youth and young adults in South Dakota. Sixteen of these programs provide school-based prevention programs to over twenty public schools. Twenty-two are community coalitions and two programs operate on university campuses. In addition, South Dakota has three Prevention Resource Centers that provide local trainings and are a resource for supporting implementation of evidence-based prevention programming for local communities or schools across the state.

Interactive County Map for Behavioral Health Services:
http://dss.sd.gov/behavioralhealth/agencycounty.aspx

Adult and Children Substance Use Disorder Services

Specialized Services for Pregnant Women and Women with Dependent Children
Pregnant women are at highest priority for admission to services. Clients meeting this status must be admitted to the program no later than 14 days from the initial clinical assessment. If the program does not have the capacity to admit the client on the date of such request, interim services must be provided no later than 48 hours from the initial clinical assessment. The referring provider will ensure the client is provided interim services until an alternative placement can be located.

The Division of Behavioral Health (DBH) complies with Section 1922(c) of the Public Health Service Act and 45 CFR 96.124(e), which requires states to ensure that programs receiving funding for services also provide for or arrange for the provision of primary medical care, prenatal care, child care, primary pediatric care including immunizations for children, gender specific treatment, therapeutic interventions which addresses relationship issues, sexual and physical abuse, and parenting and child care, sufficient case management and transportation to ensure that women and their children have access to all services listed in this paragraph.

The DBH provides funding to two community based treatment programs for pregnant women and women with dependent children. Behavior Management Systems in Rapid City and Volunteers of America (VOA) in Sioux Falls both serve adult women. VOA also provides services to pregnant adolescents. Both programs accept clients statewide and provide medically monitored inpatient, low intensity residential, outpatient services, case management, aftercare and interim services.

The DBH modified the State Treatment Activity Reporting System (STARS) to allow the tracking of specific services provided to pregnant women. Language was written into each provider's contract to assure state compliance with the federal rules governing the notification of 90% program capacity. The capacity of each program is monitored by DHB staff through STARS, including interim services. Monitoring specific services

provided and agency capacity level allows DBH to track utilization rates and to identify those service areas that are greatest in need.

The mission of these programs is to provide a supportive living environment in which women and adolescent girls who have completed primary substance use disorder treatment can, along with their dependent children (0-12 years of age), obtain the assistance they need to make a successful transition back into their home community.

Services to Intravenous Drug Users (IVDU)

Contracted substance use disorder providers prioritize and provide outreach and intervention services to individuals identified as needing treatment for intravenous drug use. As per section 1923(a) (2) of the Public Health Services Act and 45 CFR 96.126 (b), clients are placed into services within 2-14 days after a request for treatment has been made by the referring agency. If an individual cannot be placed into services within 48 hours, the referring agency will provide interim services until a placement can be made.

Each provider receiving Block Grant funds complies with the established referral process for this high risk population to facilitate access to services, testing, and the appropriate level of treatment. Language was written into each provider's contract to assure state compliance with the federal rules governing the notification of 90% program capacity. The capacity of each program is tracked through State Treatment Activity Reporting System.

Each contracted provider is required to develop, adopt and implement policies and procedures to ensure that each individual who requests and is in need of treatment for intravenous drug use is admitted to the program no later than 14 days from the initial clinical assessment. If the program does not have the capacity to admit the individual on the date of such request, interim services must be provided until an individual is admitted to a substance use disorder treatment program. The purpose of interim services is to reduce the adverse health effects of such use, promote the health of the individual, and to reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur. Interim services may also include referral for HIV or TB treatment services if necessary. Interim services must be made available to the individual no later than 48 hours from the initial clinical assessment.

In compliance with 42 U.S.C. 300x-23(a) (2) (A) (B), the DBH provides funding for treatment services for individuals who are unable to pay. All accredited treatment programs are notified on a yearly basis of the existence of this priority population and the process needed to secure the funds from the DBH when needed. To ensure compliance with 4.42 U.S.C. 300x-23(b), DBH specifies in contract the requirement to conduct outreach activities for this specific population. The DBH monitors compliance by reviewing the data submitted to STARS by providers and regular on-site accreditation reviews.

Referral & Assessment Process

Clinicians complete a client assessment to determine the clinical need and the appropriate level of care for each client. Clinicians utilize an integrated assessment that address co-occurring treatment needs for mental health, substance use disorders, or both. Recommendations for substance use disorder treatment are based on the admission criteria from American Society of Addiction Medicine (ASAM) Placement criteria. The ASAM Placement criteria are the basis for eligibility criteria for levels of care in the Administrative Rules of South Dakota. The Division of Behavioral Health (DBH) is partnering with the Central Rockies Addiction Technology Transfer Center in 2017 to provide four ASAM trainings in order to support workforce development and to ensure that the application of the ASAM placement criteria is consistent across the state.

Additionally, in 2016, the DBH aligned with high intensity providers to require prior authorization for the utilization of indigent funding. Prior authorization from the DBH is required for the following levels of care: level 3.7 intensive inpatient services for adults and children, level 3.1 clinically-managed low intensity residential treatment for pregnant women and/or women with dependent children and treatment at the two specialized methamphetamine programs.

A workgroup of provider representatives was formed in the fall of 2016 to streamline the referral process into high intensity services. Quarterly phone calls hosted by the DBH were facilitated to open communication and reduce barriers for clients in accessing needed treatment. All high intensity referral forms are located at http://dss.sd.gov/formsandpubs/.

Hypodermic Needle Program

The Division of Behavioral Health will continue to prohibit local providers from utilizing block grant funding to provide individuals with hypodermic needles or syringes. This requirement is a component of the provider's yearly contract and adherence to this is monitored during fiscal audits and through onsite accreditation reviews.

Cultural Diversity and Gender Minorities

Cultural, ethnic, or linguistic minorities

The Division of Behavioral Health (DBH) supports training of the Native American culture to behavioral health care providers. The DBH collaborates with the National American Indian and Alaska Native Addiction Technology Transfer Center through the University of Iowa to provide a 24 module Native American Curriculum training developed by the late Duane Mackey, Dakota, Isanti, Ed.D. Native American instructors provide a cultural competency educational program for non-native professionals working with Native Americans with substance use disorder and mental health issues. These trainings are offered four times per year to all accredited mental health and substance use disorder treatment providers.

Additionally, families have their own particular culture and live in the context of a wider community, state, and national culture. Community Mental Health Centers (CMHCs)

work to ensure staff are identifying cultural issues and providing appropriate services according to the individual and/or family desires and needs. CMHCs are required to administer an outcome tool that includes questions regarding whether the family feels their culture is respected and if the services they received are appropriate for their culture.

The DBH encourages agencies to examine cultural trends in their communities and provide ongoing training as an integral component of workforce development. During DBH onsite accreditation reviews, staff surveys and client chart reviews place specific emphasis on cultural sensitivity and training to ensure the needs of all clients and families are met.

Resources, Training and Technical Assistance

Educational Coordination

The Division of Behavioral Health (DBH) supports professional training opportunities for prevention and treatment professionals across the state and collaborates with providers to determine training needs. In addition, providers are responsible for ensuring their staff receives appropriate training to adequately fulfill their job duties.

Prevention and treatment providers sponsor two annual conferences within the state. With Addiction Technology Transfer Center support, the DBH collaborates with providers to identify relevant training topics such as:

- Motivational Interviewing
- Corrective Thinking
- ASAM Criteria
- Updates on statewide initiatives

Central Rockies Addiction Technology Transfer Center

The Division of Behavioral Health continues to partner with the Central Rockies Addiction Technology Transfer Center (ATTC) to provide a variety of trainings and services to the substance use disorder workforce within South Dakota. These trainings are designed to raise awareness of evidence-based and promising treatment and recovery practices, build skills to prepare the workforce to deliver state of the art services, and to change practice by enhancing services to improve addictions treatment and recovery outcomes.

The Central Rockies ATTC provides training support to South Dakota's substance use disorder workforce through a variety of evidence-based practice initiatives. Training topics included Women and Substance Abuse, The ABC's of Cognitive Behavioral Therapy for Addiction Recovery, Cultural Competency, Saving Lives: How Substance Abuse Counselors Can Prevent Suicide, Introduction to Motivational Interviewing – Level One, Promoting Awareness of Motivational Incentives, Post-Traumatic Stress Disorder and Traumatic Brain Injury in the Returning Veteran Population, and What Using the American Society of Addiction Medicine Criteria Really Means: Skill Building and Systems Change.

South Dakota Advocacy Services

South Dakota Advocacy Services (SDAS) provides protection and advocacy services for individuals with mental illness statewide. The SDAS mission is "to protect and advocate the rights of South Dakotans with disabilities through legal, administrative, and other remedies." The Division of Behavioral Health partners with SDAS on case consultations and advocacy efforts for individuals and children/families receiving services in the state's behavioral health system. SDAS has four offices across the state, allowing regional ease of access to advocacy support services.

Council of Mental Health Centers & Council of Substance Abuse Directors

Executive Directors of Community Mental Health Centers and accredited substance use disorder providers are members of the Council of Mental Health Centers, the Council of Substance Abuse Directors, and/or both. These organizations meet regularly and employ one individual who serves as Executive Director for both Councils. The Councils, through their committee structures, and in close collaboration with the Division of Behavioral Health, provide review and system improvement feedback on transformational activities associated with the development of recovery-oriented, integrated systems of care for adults, children and families. Although this is an important stakeholder group in South Dakota, these Councils do not fully represent substance use providers across the state.

National Alliance on Mental Illness-South Dakota (NAMI-South Dakota)

http://namisouthdakota.org/

The National Alliance on Mental Illness (NAMI) South Dakota is a public nonprofit organization, founded in 1987 and managed by a Board of Directors and an Executive Director. The Board of Directors must be comprised of at least 50% of people who are living with a mental illness, or family members. The other members are those who embrace the mission of NAMI. The mission is to provide education and support for individuals and families impacted by brain-based (mental illnesses), advocate for the development of a comprehensive system of services, and lessen the stigma in the general public.

NAMI-South Dakota has nine affiliates across the state, an active Statewide Consumer Council and works diligently to reach consumers across the state to bring their ideas and concerns to the NAMI Board of Directors for consideration and action. NAMI-South Dakota also offers local and state support in the following areas:

- *Connection* is a recovery-focused support group led by trained mental health consumers for adults living with a mental illness.
- *Family to Family*, recognized as an evidence-based practice, is NAMI's psycho-education program led by trained family members for family members of adults with mental illness.
- *In Our Own Voice* is NAMI's unique public education program in which two trained adult speakers share compelling personal stories about living with mental illness and achieving recovery. An *In Our Own Voice* presentation is given during

quarterly trainings at the Statewide Law Enforcement Training Center for new officers entering the field across the state.

- Customized trainings for law enforcement agencies utilizing a core curriculum on Crisis Intervention Training.
- Annual educational conference in which NAMI partners with the Division of Behavioral Health (DBH) to provide scholarships to individuals who have limited financial resources for attendance. DBH also provides speakers to keep attendees updated on transformation activities at the state level.

NAMI South Dakota:

- Partnered in the development of Crisis Intervention Teams and Crisis Response Teams in Sioux Falls and Rapid City.
- Provides technical assistance to other communities in developing programs such as this and received a grant from the Attorney General's Office to increase the number of officers trained in Crisis Intervention Team programming.
- Collaborates with the eleven Community Mental Health Centers to provide support and education to their clients and family members.

South Dakota Association of Addiction and Prevention Professionals

The South Dakota Association of Addiction and Prevention Professional's (SDAAPP's) mission is to promote professional leadership and excellence in prevention and treatment of addictions. Those who are members of the SDAAP are also included in the membership of The Association for Addiction Professionals.

The SDAAPP holds bi-annual conferences with continuing educational opportunities, advocacy for counselors and prevention professionals and peer assistance. The SDAAPP also provides information for legislators, law enforcement, schools, other professionals, and the public about addictions treatment and prevention needs and issues.

Development of Community Crisis Services

Behavior Management Systems in Rapid City coordinates the operations of a Crisis Care Center, which was created in 2011. The facility provides access to immediate care for adults (18 years of age and older) with critical mental health episodes or need of substance use stabilization in the Black Hills area. The Center is open 24 hours per day, 7 days per week and is staffed with one Qualified Mental Health Professional and two Emergency Medical Technicians at all times. Services focus on personalized recovery through a stabilization plan that is established collaboratively with the client and their assigned Qualified Mental Health Professional. The plan provides a framework for the client to move forward and prevent future crisis. Individuals are admitted to the Crisis Care Center for up to 24 hours, and then referred to community agencies or service providers for continued care.

The Crisis Center contracts with Pennington County for on-site and community case management, and with the Rapid City Regional Hospital's Emergency Department for telephone support back up. The Crisis Center is currently focused on receiving referrals

from local law enforcement and the emergency department, although walk-ins occur and are not turned away.

Behavior Management Systems Crisis Care Center:
http://www.bmscares.org/services/crisis-care-center

Southeastern Behavioral Health Care coordinated efforts with Minnehaha and Lincoln Counties to create a Mobile Crisis Team consisting of a licensed mental health counselor and a licensed psychological nurse who are on call 24 hours a day to meet with people in their moments of crisis. The mission of the Mobile Crisis Team is to expedite mental health professionals to people in crisis so they can coordinate resources, assess problems and eliminate unnecessary psychiatric placements.

When law enforcement responds to an emergency call, they assess the situation, make contact with the individual in crisis and ensure their environment is safe. Law enforcement will then determine if the Mobile Crisis Team is appropriate to contact. Once the Mobile Crisis Team arrives, they determine whether to have law enforcement present or if they can leave. The Mobile Crisis Team works to assist the individual through their crisis; encourage services and develop a safety plan if necessary.

Additionally, law enforcement and the judicial system receive mental health training to enhance their skills in addressing the needs of individuals with behavioral health crises, reducing the need for transport to emergency facilities.

SOAR (SSI/SSDI Outreach, Access, and Recovery) Training

The Division of Behavioral Health supports SOAR training efforts in South Dakota and encourages substance use disorder and mental health providers to train staff to better assist those who are homeless or at risk of homelessness in applying for SSI/SSDI benefits. Provider staff can access the 20 hour SOAR Online Training at any time and complete it at their own pace.

SOAR in Your State:
https://soarworks.prainc.com/states/south-dakota

Qualified Mental Health Professional Training

Administrative Rule of South Dakota, Chapter 67:62:14

To ensure the involuntary commitment process is implemented appropriately, the Division of Behavioral Health provides training to individuals who perform mental health status examinations in accordance with involuntary commitment laws. Licensed Social Workers, Marriage and Family Therapists, Licensed Professional Counselors, Psychologists, Advanced Practice Nurses/Certified Nurse Practitioners, and Physician Assistants qualify for certification as Qualified Mental Health Professionals (QMHPs). The QMHP training, which became available online May 2015, includes:

- Involuntary Commitment Process
- Mental Health Status Examination
- South Dakota Laws relative to inpatient hospitalization

- Hearing Procedures for QMHP's in the commitment process of an individual
- Overview of medical capabilities of psychiatric hospital

Mental Health First Aid Training

South Dakota continues to support the training of behavioral health professionals in Adult and Youth Mental Health First Aid. Currently, adult Mental Health First Aid trainings are funded through the Garrett Lee Smith Suicide Prevention Grant and Youth Mental Health First Aid Trainings are funded through the "Now is the Time" Youth Mental Health Training Grant.

Mental Health First Aid training assists individuals who do not have clinical training to support people experiencing a mental health crisis. Specifically, participants learn:

- The potential risk factors and warning signs for a range of mental health issues, including depression, anxiety/trauma, psychosis and psychotic disorders, substance use disorders, and self-injury;
- An understanding of the prevalence of various mental health disorders in the United States and the need for reduced stigma in their communities;
- A 5-step action plan encompassing the skills, resources, and knowledge to assess the situation, to select and implement appropriate interventions, and to help an individual in crisis connect with appropriate professional care; and
- The evidence-based professional, peer, social, and self-help resources available to help someone with a mental health issue.

Targeted audiences for Mental Health First Aid include key professions, such as law enforcement, nursing home staff, ministerial associations, school administration, and the general public. The continued expansion of this training assists efforts towards reducing stigma in the community by providing education about the needs of individuals with mental health issues and the role of community mental health services in support them.

Housing for the Homeless Consortium

The goal of the South Dakota Homeless Consortium is to empower homeless individuals and families to regain self-sufficiency to the maximum extent possible. Activities include:

- Facilitation of coordination among concerned organizations and individuals
- Facilitation of statewide discussion and awareness of homelessness in South Dakota
- Coordination of projects and grant writing activities, including the Statewide Continuum of Care Application
- Assessment of the assets and gaps in services/programs to ensure that statewide needs are met (This includes an annual count of homelessness in the state to identify gaps and establish priorities to address those gaps).

The Consortium was formed in January 2001. Involved in the Consortium are private businesses, disability service organizations, local cities/towns, public housing authorities, landlords, formerly homeless individuals, housing developers, regional community action

agencies and state agencies, which include the Division of Behavioral Health. The Consortium meets quarterly to provide opportunities for networking with other providers across the state, problem solve difficult situations, share ideas about "what works," share resource information, and to gain knowledge of new funding opportunities. In addition, the Consortium gives South Dakota a mechanism to apply for federal homeless assistance funds from the U.S. Department of Housing and Urban Development. Several projects have been funded over the years including vocational programs, transitional housing programs, Shelter Plus Care Programs, Emergency Shelter Programs, two assisted living programs (specifically for individuals with mental illness and chronic medical issues), and many others.

Housing for the Homeless Consortium: http://www.housingforthehomeless.org/

Independent Peer Reviews

The Division of Behavioral Health (DBH) supports peer reviews of accredited substance use disorder treatment programs which are conducted under contractual agreement with Mountain Plains Evaluation, LLC. The DBH randomly selects a 5% sample of providers who receive Block Grant funds. The on-site reviews are conducted with the Clinical Director. The provider's substance use disorder policies and procedures manual along with a random sample of client files are reviewed following Administrative Rules of South Dakota and the criteria below.

Criteria 1**:** A treatment program for substance use disorders which provides an organized American Society of Addiction Medicine admission criteria specific to the program and an intake process that provides for an appropriate referral based on the client's needs.

Criteria 2: A treatment program for substance use disorders which has a written procedure for obtaining a client assessment and history and establishing a diagnostic impression.

Criteria 3: A treatment program for substance use disorders which provides a written procedure to ensure that a treatment plan is developed on each client receiving services.

Criteria 4: A treatment program for substance use disorders which provides a written procedure to ensure that documentation of treatment services is completed in a timely manner.

Criteria 5: A treatment program for substance use disorders which provides discharge and continued care criteria specific to each client, which includes the client's reason for admission, the client's problems, treatment and response to treatment, the reason for discharge and the continued care plan and referrals made.

Planning Steps

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

Narrative Question:

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

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

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

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

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

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

Footnotes:

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

The Division of Behavioral Health (DBH) continues to work towards a data driven decision-making process when assessing prevention and treatment needs for behavioral health services in South Dakota. The following details South Dakota's data sources used to identify unmet service needs and critical gaps, and how South Dakota plans to meet those needs and gaps.

Identification of Data Sources used to Identify Needs and Gaps

State Treatment Activity Reporting System (STARS)
South Dakota utilizes treatment data collected from an internal source to identify needs and gaps. In 2005, the DBH developed the State Treatment Activity Reporting System (STARS) which collects, stores, and reports behavioral health data and billing information for publically funded individuals receiving behavioral health services. The STARS collects and reports client level, program level, provider level, and state level data. The STARS data is used to help determine emerging trends and needs for programs and services throughout the state. The data is collected at admission and discharge, allowing data to be updated regularly for individuals receiving publically funded services. The STARS assists the DBH in monitoring waitlist information for priority populations such as pregnant women, intravenous drug users, and others in need of high intensity substance use services. In conjunction with providers, the DBH has enhanced STARS to report treatment data and outcome data at a state level. Having this ability will support the DBH's desire to compare national and state data.

To support this effort, in 2016, the DBH expanded the STARS system to collect perception of treatment outcomes through a web-based survey for adults. In an effort to continue to increase our data reporting capabilities, the STARS will be expanded once more to collect web-based treatment outcome surveys for adolescents receiving publically funded behavioral health services during State Fiscal Year (SFY) 2017. The addition of web-based outcome tools will allow the DBH to ensure publically funded services are held to a higher standard of quality and efficacy.

State Epidemiological and Outcomes Work Group (SEOW)
In addition to the STARS, South Dakota utilizes the State Epidemiological Outcomes Work Group (SEOW) to identify, analyze, and communicate key substance use and related behavioral health data to stakeholders and the DBH. Administered by the DBH, Prevention Program, the SEOW has built a broad representation of diverse community members including:

- South Dakota Department of Social Services (State Prevention Coordinator)
- South Dakota Department of Social Services (Division of Behavioral Health)
- Western Prevention Resource Center Coordinator
- South Dakota Council of Mental Health Center Directors and Council of Substance Abuse Directors
- Partnership For Success State Evaluation Team
- South Dakota Department of Education
- South Dakota Department of Public Safety

- South Dakota Department of Health
- South Dakota Department of Corrections
- South Dakota Unified Justice System
- University of South Dakota, Department of Addiction Studies
- Community Coalitions

The SEOW's role is to maintain and enhance data collection and analysis procedures that provide accurate and comprehensive assessments of the substance use and mental health issues in South Dakota. To achieve this, the SEOW generates epidemiological state and regional profiles annually by utilizing data from many national and state-level sources. These profiles examine the magnitude of substance use and its consequences in South Dakota. The latest epidemiological profiles: *The South Dakota Substance Abuse Epidemiological Profile 2016,* and the *South Dakota Regional Profile of Substance Abuse Consequences and Consumption 2016 (draft)* were produced in the fall of 2016.

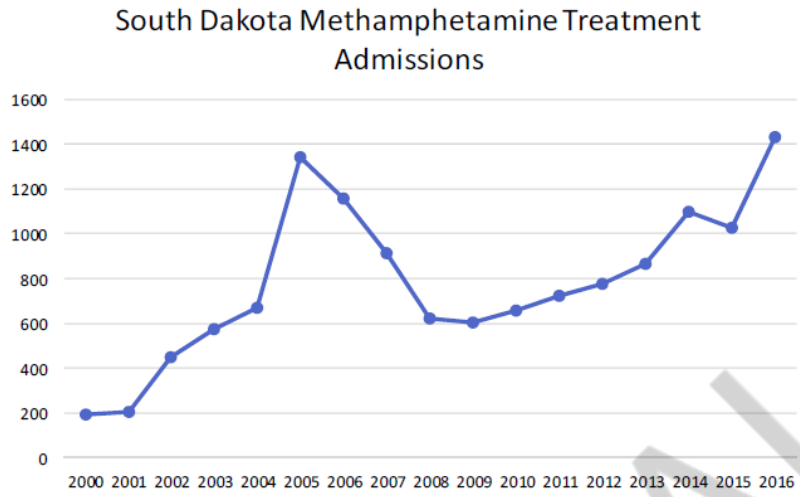
In April 2017, the DBH shifted the SEOW to focus beyond prevention related topics to include all behavioral health services. The goal is to expand the role of the SEOW to make data informed decisions for behavioral health needs in South Dakota.

Other Sources
In addition, the DBH utilizes external resources including the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the Uniform Reporting System (URS), and the Behavioral Health Barometer for South Dakota. South Dakota has used these data sources to monitor and inform decision making for budget purposes and treatment services. National data sources are often used as benchmarks for behavioral health services. South Dakota monitors completion of services, employment, and perception of services.

Next Steps in Addressing Unmet Service Needs and Critical Gaps

Through a comprehensive review of data sources and reports, followed by discussions with advisory groups and other key stakeholders, the DBH has identified four priority areas based on unmet service needs and critical gaps within the current delivery system. Each identified priority has been determined as an area to improve treatment and recovery needs of South Dakotans.

Methamphetamine (Meth) Epidemic
Over the past several years, South Dakota has seen a rise in the use of meth. In South Dakota, 4.2 percent of high school students have tried meth according to the 2015 Youth Risk Behavior Surveillance System (YRBSS). That is slightly higher than the national average of 3.2 percent. Furthermore, approximately 15,000 (2.2%) South Dakotans, age 12 and up, were dependent on or abused illicit drugs in 2015, including meth, according to the National Surveys of Drug Use and Health (NSDUH). Treatment data also show a similar trend of increased admissions for meth use. The number of individuals entering treatment for meth use has been on the rise each year since 2010.



Sources: SAMSHA Treatment Episode Data Set; 2015 and 2016 methamphetamine treatment admissions provided by DSS.

In May 2016, the DBH requested technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop or recommend a current training regarding evidence-based practices (EBPs) for meth treatment and either provide or recommend a trainer to lead the training to the DBH and specialized meth treatment providers.

In June 2016, technical assistance was approved and in September 2016, DBH staff, SAMHSA, and JBS International participated in a teleconference laying out the objectives of the project. In December 2016, two consultants were chosen and a teleconference took place. The consultants traveled to South Dakota in March 2017 to tour each program and meet with agency staff. The consultants will prepare information to present back to the DBH on specific EBPs for the target population in May 2017.

During the 2017 legislative session, Senate Bill 43 was passed to expand intensive methamphetamine treatment services within South Dakota and to declare an emergency. The DBH will be using recommendations from the technical assistance report to develop treatment requirements for the treatment program.

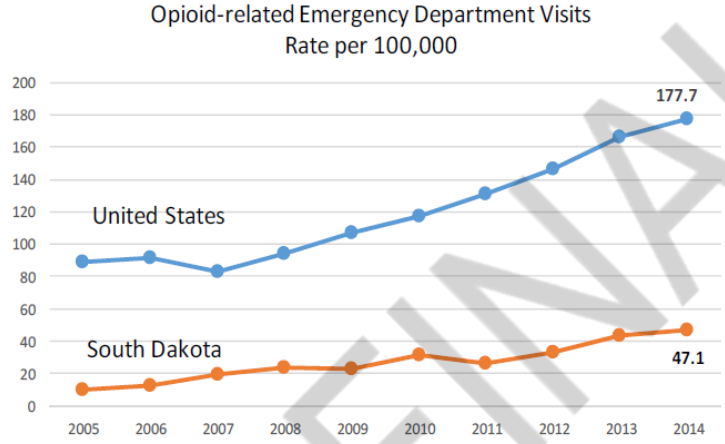
Finally, in August 2016, the DBH launched an awareness campaign, “Meth Changes Everything,” in an effort to educate and talk about the dangers of meth use in South Dakota. The DBH contracted with a local advertising firm, Epicosity, to create “Meth Changes Everything.” The campaign focuses on high school students and community members. Prevention providers across the state have been working to educate students and community members about the effects and dangers of meth through school assemblies and town hall meetings. Additionally, a website was created as a way to provide information about meth use including resources for individuals seeking help and treatment and candid stories from individuals in recovery from meth addiction.

As of March 2017, 198 school presentations and 24 community town hall meetings were held with 6,781 individuals attending. The DBH is reviewing prevention needs to support the on-going efforts of community meetings and website support.

For more information visit: [http://methchangeseverything.com/.](http://methchangeseverything.com/)

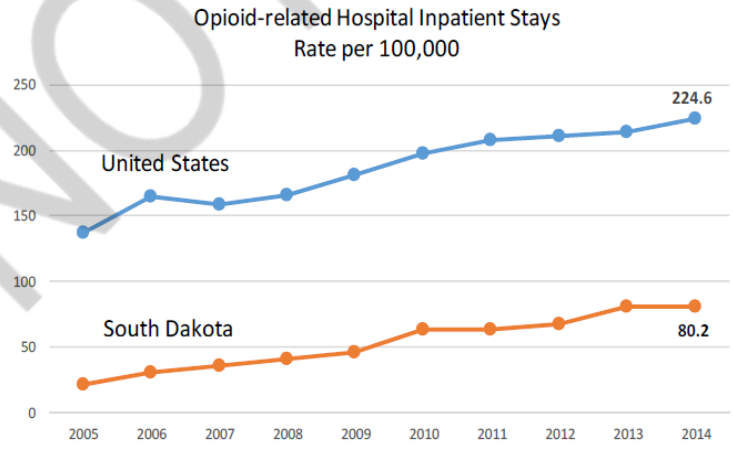
Opioid Epidemic

Although SD is not experiencing a rise in opioid use compared to other states, South Dakota has seen a slight increase in the number of individuals utilizing emergency room departments for an opioid related event.



Source: Source: Weiss AJ (Truven Health Analytic), Elixhauser A (AHRQ), Barrett ML (M.L. Barrett, Inc.), Steiner CA (AHRQ), Bailey MK (Truven Health Analytics), O'Malley L (Truven Health Analytics). Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-2014. HCUP Statistical Brief #219. December 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf.

Furthermore, South Dakota has also seen a slight increase in the number of opioid-related hospital stays.



Source: Source: Weiss AJ (Truven Health Analytic), Elixhauser A (AHRQ), Barrett ML (M.L. Barrett, Inc.), Steiner CA (AHRQ), Bailey MK (Truven Health Analytics), O'Malley L (Truven Health Analytics). Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-2014. HCUP Statistical Brief #219. December 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf.

Understanding that South Dakota trends 3 to 5 years behind national treatment trends, the DBH applied and was awarded the State Targeted Response (STR) to the Opioid Crisis Grant. The

focus of the grant will be a statewide effort to address prevention, intervention and treatment needs across South Dakota, targeting individuals with opioid misuse and opioid use disorder (OUD). Grant funding will be used to conduct a comprehensive statewide needs assessment with a focus on opioid use, and leverage the findings that drive prevention, treatment and recovery supports in the state. Also, through the STR grant, the DBH will continue to explore the use of technology based services to support individuals living in rural and frontier areas of South Dakota in order to gain the access they need to OUD treatment, regardless of where they live.

Data and Outcome Reporting

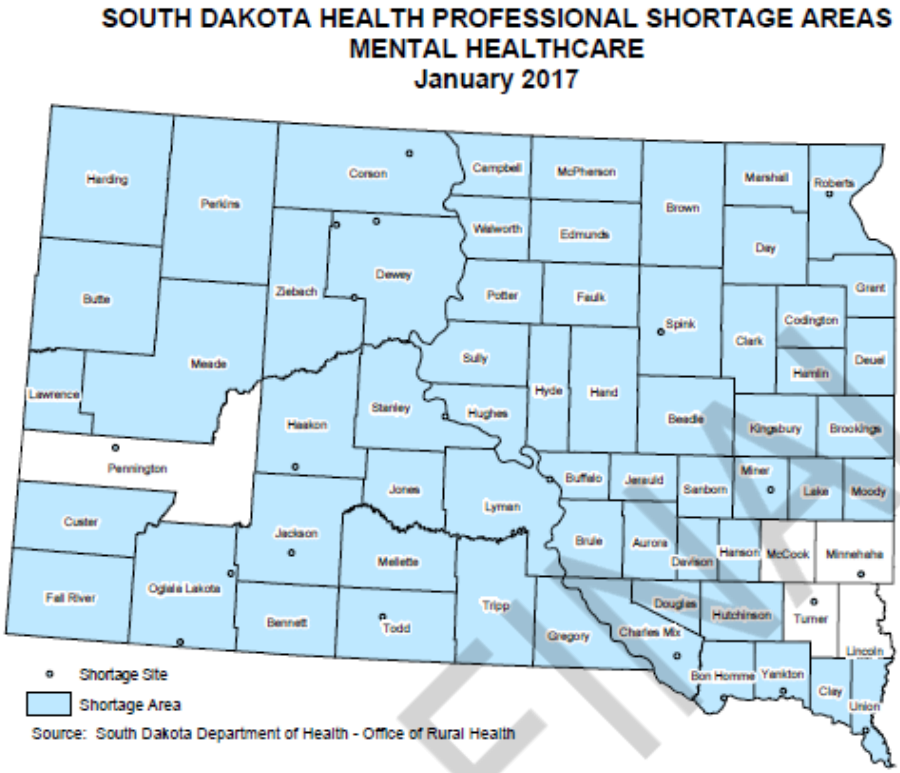
South Dakota has identified data and outcome reporting as a gap in our service system. Collecting and reporting outcome data has presented challenges with maintaining consistency among providers, as well as minimizing the redundancy of current outcome tools. In 2015, the DBH took steps to solidify and streamline treatment data collected through a work group comprised of DBH staff, mental health and substance use disorder treatment providers.

The Data Outcomes Work Group (DOWG) developed a framework for identifying and determining meaningful data and outcome measures for mental health and substance use disorder services. The DOWG agreed upon a comprehensive data collection and analysis process to measure the impacts of behavioral health services. This methodology allows for monitoring and reporting of outcome measures on a variety of levels including, but not limited to, the individual client, the provider, and funding sources at both state and federal levels.

During Fiscal Year (FY) 2017, the DBH began collecting and monitoring outcome measures and performance indicators for all adults receiving services within the public behavioral health system. Also, during FY 2017, the DBH and DOWG members reconvened to develop tools to measure outcomes and performance indicators for all youth and family members of youth receiving services within the public mental health system.

South Dakota's goal is to use this information to drive decision making for behavioral health services in South Dakota.

Work force development



Workforce recruitment and retention is an issue in SD. There are shortages in clinical staff, providers, counselors, case managers and technicians across the state with rural and frontier areas being most effected. Additional issues include staff turnover and retention and clinical staff not having the competencies needed for the delivery of evidence-based practices (EBPs).

The DBH has worked to create a long-term training and quality assurance plan that provides training on specific EBPs. Refresher trainings and learning collaboratives are offered to build upon and develop the skills and competencies needed for the delivery of EBPs. The quality assurance and/or fidelity monitoring processes assist providers in delivering EBPs with fidelity and integrity to the identified model. The DBH has partnered with the Central Rockies Addiction Technology Transfer Center (ATTC), the National Frontier and Rural ATTC and the National American Indian and Alaska Native ATTC in order to provide trainings that support competency development. Beginning Federal Fiscal Year 2018, the DBH will be partnering with Mountain Plains ATTC to continue workforce development efforts. DBH staff members also participate in Region VIII meetings related to workforce development.

Additionally, the DBH will be collaborating with the South Dakota Health Education Center (AHEC) to conduct phone calls and email exchanges with a variety of organizations to identify and development recruitment opportunities to engage individuals interested in behavioral health careers. The AHEC works to recruit, train and retain health care professional in underserved populations with the objective of reducing shortages by partnering with communities to promote statewide solutions regarding workforce development.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Quality and Data Collection Readiness

As described in Planning Step Two, the Division of Behavioral Health (DBH) collects client level data through a management information system called the STARS (State Treatment Activity Reporting System). The STARS collects and reports mental health and substance use disorder client level, program level, provider level, and state level data; and is used to help determine emerging trends and needs for programs and services throughout the state. At this time, the STARS is specific to mental health and substance use disorder services and is not part of any larger data system.

Currently, the DBH is able to generate reports through STARS that includes aggregate client level data that does not contain client identifying information.

In turn, providers are able to generate reports in order to review data specific to their agency and to identify the effectiveness of their programs or any outstanding trends.

Overall, through STARS and other data sources, the DBH is able to track state behavioral health trends, needs and gaps in services, which is used to drive the state's planning efforts.

A detailed description of data sources and collection can be found in Planning Step Two.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Evidence-Based Practices

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, TB, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice)

Goal of the priority area:

Support and expand evidence-based practices (EBPs) in the State of South Dakota and ensure fidelity monitoring is in place. In addition, maintain a registry of the EBPs supported through the Division of Behavioral Health (DBH).

Objective:

Develop a registry and expand EBPs by supporting training, consultation, and technical assistance needs.

Strategies to attain the objective:

The DBH will create an inventory of current EBPs and identify fidelity practices. The DBH will identify gaps in the EBPs and work to increase in areas identified as having gaps.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase in agencies providing EBPs with fidelity monitoring in place. The inventory list has been completed.

Baseline Measurement: None at this time.

First-year target/outcome measurement: In SFY 2018, increase agencies providing an EBP model by 3 agencies.

Second-year target/outcome measurement: In SFY 2019, increase agencies providing an EBP model by 3 agencies.

Data Source:

The DBH

Description of Data:

The DBH will track the number of trainings completed; number of EBPs and number of agencies providing EBP.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 2

Priority Area: First Episode Psychosis

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

The Division of Behavioral Health (DBH) will coordinate with OnTrackNY to provide training and consultation to assist the First Episode Psychosis (FEP) Programs in developing outreach strategies and a means to collect meaningful outcome data.

Objective:

Collect one year of meaningful outcome data and provide outreach to at least five potential referral sources.

Strategies to attain the objective:

The DBH will customize the standardized Adult Outcome Tool to capture the necessary performance measures identified for the FEP program. Also, the DBH will coordinate with OnTrackNY to provide training and consultation to assist the FEP Programs in developing outreach strategies and a means to track those efforts.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Complete enhancements to the collection of outcome data, including the standardized Behavioral Health Adult Outcome Tool, specific to FEP clients.
Baseline Measurement:	Not applicable at this time.
First-year target/outcome measurement:	By the end of SFY 2018, the state will have begun collecting and tracking outcomes utilizing the Adult Outcome Tool and outcomes specific to FEP clients.
Second-year target/outcome measurement:	By the end of SFY 2019, the state will have collected and tracked one complete year of outcomes utilizing the Adult Outcome Tool and outcomes specific to FEP clients.

Data Source:

Adult Outcomes Tool specific to FEP.

Description of Data:

Adult Outcome Tool specific to FEP collects outcome data to determine the effectiveness of the programs.

Data issues/caveats that affect outcome measures::

None at this time

Indicator #:	2
Indicator:	The FEP Programs will identify various groups within their catchment areas that they can provide outreach to in order to expand potential referral sources, expand awareness and reduce stigma associated with behavioral health diagnoses and treatment.
Baseline Measurement:	Not applicable at this time.
First-year target/outcome measurement:	By the end of SFY 2018, the FEP teams will have developed a reliable outreach tracking system in which they can monitor and follow-up with potential referral sources through-out the year.
Second-year target/outcome measurement:	By the end of SFY 2019, the FEP teams will have each provided outreach services to at least five potential referral sources within their catchment area.

Data Source:

Outreach tracking document.

Description of Data:

The outreach tracking document will identify the number of outreach activities conducted each month and the follow-up that occurred.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 3

Priority Area: Opioid

Priority Type: SAP, SAT

Population(s): PWWDC, PP, PWID, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice)

Goal of the priority area:

Equip first responders and emergency departments with Naloxone to increase statewide access and to support distribution in high need communities.

Objective:

Create an awareness campaign and conduct at least 40 trainings for key stakeholders, (i.e. law enforcement, emergency room staff, emergency medical technicians, substance use treatment providers, etc.) on the use and distribution of Naloxone by the end of SFY 2019.

Strategies to attain the objective:

The Division of Behavioral Health (DBH) was awarded a two year Opioid Crisis Grant. A portion of the funding was used to conduct a comprehensive statewide needs assessment which will be used to guide the state's opioid related efforts.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Creation of a training and distribution strategy.
Baseline Measurement:	None at this time.
First-year target/outcome measurement:	By the end of SFY 2018, the DBH will have convened a kick-off meeting; defined expectations and set an interim meeting schedule for the training and distribution of Naloxone.
Second-year target/outcome measurement:	By the end of SFY 2019, the DBH will have equipped and trained first responders and emergency departments with Naloxone.

Data Source:

The DBH

Description of Data:

The DBH will track training events and distribution of Naloxone.

Data issues/caveats that affect outcome measures::

None

Priority #: 4

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): PP

Goal of the priority area:

Provide support and training to health and behavioral health agencies in addressing suicide.

Objective:

Implement the Zero Suicide approach through trainings and/or learning community calls with at least 20 health and behavioral health providers.

Strategies to attain the objective:

The Division of Behavioral Health (DBH) will coordinate with a chosen entity to provide trainings and/or facilitate learning community calls with health and behavioral health providers to support providers in implementing the Zero Suicide model.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The DBH will choose an entity to conduct Zero Suicide trainings and/or community calls with at least 20 health and behavioral health providers.
Baseline Measurement:	None at this time.
First-year target/outcome measurement:	By the end of SFY 2018, the DBH will have identified an entity that will conduct Zero Suicide

trainings/community learning calls with at least 10 health and behavioral health providers.

Second-year target/outcome measurement: By the end of SFY 2019, the identified entity will have conducted Zero Suicide training/learning community calls with at least 10 health and behavioral health providers.

Data Source:

The DBH.

Description of Data:

The DBH will monitor the number of trainings and community learning calls conducted.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 5

Priority Area: Tuberculosis Services

Priority Type: SAT

Population(s): PWWDC, PWID, TB, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice)

Goal of the priority area:

To screen, identify and refer clients with tuberculosis to a healthcare professional.

Objective:

Maintain or improve 70% compliance with Administrative Rules of South Dakota 67:61:07:12.

Strategies to attain the objective:

Substance use disorder (SUD) providers will undergo reviews conducted by the Division of Behavioral Health, Accreditation Team to ensure clients are screened within 24 hours of admission for tuberculosis and are immediately referred to a healthcare professional if identified.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The Accreditation Team will conduct 17 reviews of accredited/contracted SUD providers in SFY2018.

Baseline Measurement: FY16: 9 providers reviewed and 4 compliant at 44%. FY17: 11 providers reviewed and 10 compliant at 91%.

First-year target/outcome measurement: In SFY 2018, maintain the baseline of 70% compliance with tuberculosis screening, identification and referral of clients.

Second-year target/outcome measurement: In SFY 2019, maintain the percentage of compliance with tuberculosis screening, identification and referral of clients in SFY 2018.

Data Source:

The Accreditation Team

Description of Data:

The Accreditation Team tracks accreditation review data.

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Workforce Development

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase workforce development in the State of South Dakota.

Objective:

Identify and outreach to at least eight organizations to expand on how to develop recruitment opportunities to engage individuals interested in behavioral health careers.

Strategies to attain the objective:

The Division of Behavioral Health (DBH) will collaborate with the South Dakota Area Health Education Center (AHEC).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: DBH will coordinate with AHEC to conduct phone calls and email exchanges with identified organizations to expand conversations and collaborations on the development of recruitment opportunities to engage individuals interested in behavioral health careers.

Baseline Measurement: None

First-year target/outcome measurement: In SFY 2018, at least four organizational contacts will have been made.

Second-year target/outcome measurement: In SFY 2019, at least four organizational contacts will have been made.

Data Source:

The DBH

Description of Data:

The DBH will track the number of outreach activities.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 7

Priority Area: Methamphetamine

Priority Type: SAP, SAT

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

Goal of the priority area:

Increase awareness and perception of harm regarding methamphetamine use and dependence and increase access to treatment for individuals with severe methamphetamine use disorder.

Objective:

Develop an evidence-based methamphetamine treatment capacity, and build upon the 2016 “Meth Changes Everything” campaign by increasing the number of school assemblies and town hall meetings 5%.

Strategies to attain the objective:

Utilizing the technical assistance received regarding evidence based methamphetamine treatment services, the Division of Behavioral Health (DBH) will increase the evidence-based practices provided in the existing specialized methamphetamine treatment programs and expand methamphetamine treatment access.

In August 2016, the DBH launched the “Meth Changes Everything” Campaign. The DBH Prevention Program will continue to work towards educating students and community members about the effects and dangers of methamphetamines through school assemblies and town hall meetings.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The DBH will expand the EBPs provided by current specialized meth treatment providers by 3 and expand capacity.
Baseline Measurement:	Number of individuals served in specialized meth treatment services; FY16 - 121 and FY17 - 152. Number of publically funded clients with a primary amphetamine use disorder: FY16 - 934 and FY17 - 1,693. Percent of SD's publically funded clients with a primary substance use disorder: FY16 - 14% and FY17 - 19%.
First-year target/outcome measurement:	By the end of SFY 2018, the DBH will have identified an evidence-based practice or practices for specialized methamphetamine treatment and selected a provider through the Request for Proposal process.
Second-year target/outcome measurement:	By the end of SFY 2019, the DBH will have completed training all treatment program staff in the identified evidence-based practice.

Data Source:

State Treatment Activity Reporting System (STARS)

Description of Data:

STARS creates a report which details the number of individuals receiving services who have a methamphetamine diagnosis.

Data issues/caveats that affect outcome measures::

None at this time.

Indicator #:	2
Indicator:	The DBH Prevention Program will educate students and community members about the effects and dangers of methamphetamines through school assemblies and town hall meetings.
Baseline Measurement:	In SFY 2017, 203 school presentations and 38 community town hall meetings were held.
First-year target/outcome measurement:	By the end of SFY 2018, the number of school presentations and community town hall meetings will have increased by 5% above the baseline measurement.
Second-year target/outcome measurement:	By the end of SFY 2019, the number of school presentations and community town hall meetings will have increased by 5% above SFY 2018 measurement.

Data Source:

Prevention Program

Description of Data:

The Prevention Program tracks the number of town hall meeting and school assemblies held as well as all the related pre/post-test surveys.

Data issues/caveats that affect outcome measures::

None at this time.

Footnotes:

Priority Area: Access to Services for Priority Populations

Priority Type: Substance Abuse Treatment (SAT)

Priority Population: PWWDC & PWID

Goal: South Dakota will ensure contracted substance use treatment providers maintain access to residential services for pregnant women/women with dependent children (PWWDC) and persons who inject drugs (PWID).

Objective: Maintain admitting PWWDC and PWID within 14 days or less.

Strategy: The Division of Behavioral Health (DBH) will monitor admission data and wait list information to ensure identified priority population's admission to residential treatment services occurs no later than 14 days from the clinical assessment.

Annual Performance Indicator: The DBH will track admission data from the Statewide Treatment Activity Reporting System (STARS) in order to monitor access to services.

Baseline Measurement:

Priority Population	Average Length of Wait SFY17
PWWDC	14 Days
PWID	12 Days

First-year target/outcome measurement: In SFY 2018, maintain an average of 14 days or less waiting to enter treatment for PWWDC & PWID.

Second-year target/outcome measurement: In SFY 2019, maintain an average of 14 days or less waiting to enter treatment for PWWDC & PWID.

Data Source: STARS

Description of Data: STARS reports related to necessary federal reporting requirements.

Data Issues: None at this time.

Priority Area: Evidence-Based Practices

Priority Type: Substance Abuse Treatment (SAT), Mental Health Services (MHS)

Priority Population: SMI, SED, PWWDC, ESMI, PWID, TB, Other

Goal: Support and expand evidence-based practices (EBPs) in the State of South Dakota and ensure fidelity monitoring is in place**.** In addition, maintain a registry of the EBPs supported through the Division of Behavioral Health (DBH).

Objective: Develop a registry and expand EBPs by supporting training, consultation, and technical assistance needs.

Strategy: The DBH will create an inventory of current EBPs and identify fidelity practices. The DBH will identify gaps in the EBPs and work to increase in areas identified as having gaps.

Annual Performance Indicator: Increase in agencies providing EBPs with fidelity monitoring in place. The inventory list has been completed.

Baseline Measurement: None at this time.

First-year target/outcome measurement: In SFY 2018, increase agencies providing an EBP model by 3 agencies.

Second-year target/outcome measurement: In SFY 2019, increase agencies providing an EBP model by 3 agencies.

Data Source: The DBH

Description of Data: The DBH will track the number of trainings completed; number of EBPs and number of agencies providing EBP.

Data Issues: None at this time.

Priority Area: First Episode Psychosis

Priority Type: Mental Health Services (MHS)

Priority Population: ESMI

Goal: The Division of Behavioral Health (DBH) will coordinate with OnTrackNY to provide training and consultation to assist the First Episode Psychosis (FEP) Programs in developing outreach strategies and a means to collect meaningful outcome data.

Objective: Collect one year of meaningful outcome data and provide outreach to at least five potential referral sources.

Strategy: The DBH will customize the standardized Adult Outcome Tool to capture the necessary performance measures identified for the FEP program. Also, the DBH will coordinate with OnTrackNY to provide training and consultation to assist the FEP Programs in developing outreach strategies and a means to track those efforts.

#1 Annual Performance Indicator: Complete enhancements to the collection of outcome data, including the standardized Behavioral Health Adult Outcome Tool, specific to FEP clients.

Baseline Measurement: Not applicable at this time.

First-year target/outcome measurement: By the end of SFY 2018, the state will have begun collecting and tracking outcomes utilizing the Adult Outcome Tool and outcomes specific to FEP clients.

Second-year target/outcome measurement: By the end of SFY 2019, the state will have collected and tracked one complete year of outcomes utilizing the Adult Outcome Tool and outcomes specific to FEP clients.

Data Source: Adult Outcomes Tool specific to FEP.

Description of Data: Adult Outcome Tool specific to FEP collects outcome data to determine the effectiveness of the programs.

Data Issues: None at this time.

#2 Annual Performance Indicator: The FEP Programs will identify various groups within their catchment areas that they can provide outreach to in order to expand potential referral sources, expand awareness and reduce stigma associated with behavioral health diagnoses and treatment.

Baseline Measurement: Not applicable at this time.

First-year target/outcome measurement: By the end of SFY 2018, the FEP teams will have developed a reliable outreach tracking system in which they can monitor and follow-up with potential referral sources through-out the year.

Second-year target/outcome measurement: By the end of SFY 2019, the FEP teams will have each provided outreach services to at least five potential referral sources within their catchment area.

Data Source: Outreach tracking document.

Description of Data: The outreach tracking document will identify the number of outreach activities conducted each month and the follow-up that occurred.

Data Issues: None at this time.

Priority Area: Opioid

Priority Type: Substance Abuse Prevention (SAP), Substance Abuse Treatment (SAT)

Priority Population: PWWDC, PWID, PP, Other

Goal: Equip first responders and emergency departments with Naloxone to increase statewide access and to support distribution in high need communities.

Objective: Create an awareness campaign and conduct at least 40 trainings for key stakeholders, (i.e. law enforcement, emergency room staff, emergency medical technicians, substance use treatment providers, etc.) on the use and distribution of Naloxone by the end of SFY 2019.

Strategy: The Division of Behavioral Health (DBH) was awarded a two year Opioid Crisis Grant. A portion of the funding was used to conduct a comprehensive statewide needs assessment which will be used to guide the state's opioid related efforts.

#1 Annual Performance Indicator: Creation of a training and distribution strategy.

Baseline Measurement: None at this time.

First-year target/outcome measurement: By the end of SFY 2018, the DBH will have convened a kick-off meeting; defined expectations and set an interim meeting schedule for the training and distribution of Naloxone.

Second-year target/outcome measurement: By the end of SFY 2019, the DBH will have equipped and trained first responders and emergency departments with Naloxone.

Data Source: The DBH

Description of Data: The DBH will track training events and distribution of Naloxone.

Data Issues: None

Priority Area: Suicide Prevention

Priority Type: Mental Health Services (MHS)

Priority Population: PP

Goal: Provide support and training to health and behavioral health agencies in addressing suicide.

Objective: Implement the Zero Suicide approach through trainings and/or learning community calls with at least 20 health and behavioral health providers.

Strategy: The Division of Behavioral Health (DBH) will coordinate with a chosen entity to provide trainings and/or facilitate learning community calls with health and behavioral health providers to support providers in implementing the Zero Suicide model.

Annual Performance Indicator: The DBH will choose an entity to conduct Zero Suicide trainings and/or community calls with at least 20 health and behavioral health providers.

Baseline Measurement: None at this time.

First-year target/outcome measurement: By the end of SFY 2018, the DBH will have identified an entity that will conduct Zero Suicide trainings/community learning calls with at least 10 health and behavioral health providers.

Second-year target/outcome measurement: By the end of SFY 2019, the identified entity will have conducted Zero Suicide training/learning community calls with at least 10 health and behavioral health providers.

Data Source: The DBH.

Description of Data: The DBH will monitor the number of trainings and community learning calls conducted.

Data Issues: None at this time.

Priority Area: Tuberculosis Services

Priority Type: Substance Abuse Treatment (SAT)

Priority Population: PWWDC, PWID, TB, Other

Goal: To screen, identify and refer clients with tuberculosis to a healthcare professional.

Objective: Maintain or improve 70% compliance with Administrative Rules of South Dakota 67:61:07:12.

Strategy: Substance use disorder (SUD) providers will undergo reviews conducted by the Division of Behavioral Health, Accreditation Team to ensure clients are screened within 24 hours of admission for tuberculosis and are immediately referred to a healthcare professional if identified.

Annual Performance Indicator: The Accreditation Team will conduct 17 reviews of accredited/contracted SUD providers in SFY2018.

Baseline Measurement:

SFY	Number of Agencies Reviewed	Number of Agencies Compliant	% Compliant
FY16	9	4	44%
FY17	11	10	91%
FY18	17		
FY19			

First-year target/outcome measurement: In SFY 2018, maintain the baseline of 70% compliance with tuberculosis screening, identification and referral of clients.

Second-year target/outcome measurement: In SFY 2019, maintain the percentage of compliance with tuberculosis screening, identification and referral of clients in SFY 2018.

Data Source: The Accreditation Team

Description of Data: The Accreditation Team tracks accreditation review data.

Data Issues: None

Priority Area: Workforce Development

Priority Type: Substance Abuse Treatment (SAT), Mental Health Services (MHS)

Priority Population: SMI, SED, PWWDC, ESMI, PWID, TB, Other

Goal: Increase workforce development in the State of South Dakota.

Objective: Identify and outreach to at least eight organizations to expand on how to develop recruitment opportunities to engage individuals interested in behavioral health careers.

Strategy: The Division of Behavioral Health (DBH) will collaborate with the South Dakota Area Health Education Center (AHEC).

Annual Performance Indicator: DBH will coordinate with AHEC to conduct phone calls and email exchanges with identified organizations to expand conversations and collaborations on the development of recruitment opportunities to engage individuals interested in behavioral health careers.

Baseline Measurement: None

First-year target/outcome measurement: In SFY 2018, at least four organizational contacts will have been made.

Second-year target/outcome measurement: In SFY 2019, at least four organizational contacts will have been made.

Data Source: The DBH

Description of Data: The DBH will track the number of outreach activities.

Data Issues: None at this time.

Priority Area: Methamphetamine

Priority Type: Substance Abuse Prevention (SAP), Substance Abuse Treatment (SAT)

Priority Population: PP, PWWDC, PWID, Other

Goal: Increase awareness and perception of harm regarding methamphetamine use and dependence and increase access to treatment for individuals with severe methamphetamine use disorder.

Objective: Develop an evidence-based methamphetamine treatment capacity, and build upon the 2016 "Meth Changes Everything" campaign by increasing the number of school assemblies and town hall meetings 5%.

Strategy: Utilizing the technical assistance received regarding evidence based methamphetamine treatment services, the Division of Behavioral Health (DBH) will increase the evidence-based practices provided in the existing specialized methamphetamine treatment programs and expand methamphetamine treatment access.

In August 2016, the DBH launched the "Meth Changes Everything" Campaign. The DBH Prevention Program will continue to work towards educating students and community members about the effects and dangers of methamphetamines through school assemblies and town hall meetings.

#1 Annual Performance Indicator: The DBH will expand the EBPs provided by current specialized meth treatment providers by 3 and expand capacity.

Baseline Measurement:

	FY16	FY17
Number of Individuals Served in Specialized Methamphetamine Treatment Services	121	152

	FY16	FY17
Number of Publically Funded Clients with a Primary Amphetamine Use Disorder	934	1,693
Percent of SD's Publically Funded Clients with a Primary Substance Use Disorder	14%	19%

First-year target/outcome measurement: By the end of SFY 2018, the DBH will have identified an evidence-based practice or practices for specialized methamphetamine treatment and selected a provider through the Request for Proposal process.

Second-year target/outcome measurement: By the end of SFY 2019, the DBH will have completed training all treatment program staff in the identified evidence-based practice.

Data Source: State Treatment Activity Reporting System (STARS)

Description of Data: STARS creates a report which details the number of individuals receiving services who have a methamphetamine diagnosis.

Data Issues: None at this time.

#2 Annual Performance Indicator: The DBH Prevention Program will educate students and community members about the effects and dangers of methamphetamines through school assemblies and town hall meetings.

Baseline Measurement: In SFY 2017, 203 school presentations and 38 community town hall meetings were held.

First-year target/outcome measurement: By the end of SFY 2018, the number of school presentations and community town hall meetings will have increased by 5% above the baseline measurement.

Second-year target/outcome measurement: By the end of SFY 2019, the number of school presentations and community town hall meetings will have increased by 5% above SFY 2018 measurement.

Data Source: Prevention Program

Description of Data: The Prevention Program tracks the number of town hall meeting and school assemblies held as well as all the related pre/post-test surveys.

Data Issues: None at this time.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

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

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$4,522,642		$5,032,241	$158,615	$13,305,752	$0	$275,281
a. Pregnant Women and Women with Dependent Children**	$277,407		$454,481	$0	$13,305,752	$0	$0
b. All Other	$4,245,235		$4,577,760	$158,615	$0	$0	$275,281
2. Primary Prevention	$1,206,038		$0	$4,398,615	$0	$0	$111,635
a. Substance Abuse Primary Prevention	$1,206,038		$0	$4,398,615	$0	$0	$111,635
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$301,509		$0	$451,282	$477,131	$0	$163,616
10. SubTotal (1,2,3,4,9)	$4,824,151	$0	$5,032,241	$609,897	$13,782,883	$0	$438,897
11. SubTotal (5,6,7,8)	$0	$0	$0	$0	$0	$0	$0
12. Total	$6,030,189	$0	$5,032,241	$5,008,512	$13,782,883	$0	$550,532

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

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

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$84,485	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$718,124	$18,594,284	$741,307	$15,971,123	$0	$0
9. Administration (Excluding Program and Provider Level)		$42,243	$0	$184,034	$654,556	$0	$0
10. SubTotal (1,2,3,4,9)	$0	$42,243	$0	$184,034	$654,556	$0	$0
11. SubTotal (5,6,7,8)	$0	$802,609	$18,594,284	$741,307	$15,971,123	$0	$0
12. Total	$0	$844,852	$18,594,284	$925,341	$16,625,679	$0	$0

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

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

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

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

Please provide an explanation for any data cells for which the stats does not have a data source.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

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

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$4,522,642
2 . Primary Substance Abuse Prevention	$1,206,038
3 . Early Intervention Services for HIV*	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	$301,509
6. Total	$6,030,189

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

do so.

Footnotes:
Planned Resource Development - Table 6a: $35,235.00

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

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

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$229,600
	Selective	$50,400
	Indicated	$0
	Unspecified	$0
	Total	$280,000
Education	Universal	$292,432
	Selective	$47,606
	Indicated	$0
	Unspecified	$0
	Total	$340,038
Alternatives	Universal	$39,360
	Selective	$8,640
	Indicated	$0
	Unspecified	$0
	Total	$48,000
Problem Identification and Referral	Universal	$10,800
	Selective	$0
	Indicated	$97,200
	Unspecified	$0
	Total	$108,000

Community-Based Process	Universal	$260,400
	Selective	$49,600
	Indicated	$0
	Unspecified	$0
	Total	$310,000
Environmental	Universal	$100,800
	Selective	$19,200
	Indicated	$0
	Unspecified	$0
	Total	$120,000
Section 1926 Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$0
Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$0
Total Prevention Expenditures		$1,206,038
Total SABG Award*		$6,030,189
Planned Primary Prevention Percentage		20.00 %

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

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

Activity	FY 2018 SA Block Grant Award
Universal Direct	$738,074
Universal Indirect	$184,518
Selective	$186,246
Indicated	$97,200
Column Total	$1,206,038
Total SABG Award*	$6,030,189
Planned Primary Prevention Percentage	20.00 %

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

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

Footnotes:

Planning Tables

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

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

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems				
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment				
4. Planning Council Activities (MHBG required, SABG optional)				
5. Quality Assurance and Improvement				
6. Research and Evaluation		$15,852		
7. Training and Education		$19,384		
8. Total	$0	$35,236	$0	$0

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

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

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

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

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

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

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

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

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

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

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

[25] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102?123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52?77

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

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

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

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

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

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

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

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

[34] Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[35] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

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

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

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

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

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

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

[42] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation?s Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

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

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

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

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   The state integrates mental health, substance use disorder and primary health care services through the following efforts:

   Screening, Brief Intervention and Referral to Treatment Grant (SBIRT)
   The Division of Behavioral Health's (DBH's) Prevention Program received a Notice of Grant Award in 2016 from the Substance Abuse and Mental Health Services Administration for the SBIRT Grant. The main focus of the grant includes the integration of SBIRT services into primary care clinics and community behavioral health systems in South Dakota. A more detailed description of the grant's activities can be found in Planning Step One.

   Health Homes
   Nine Community Mental Health Centers (CMHCs) act as Health Home providers which include: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social supports. A more detailed description of Health Homes can be found in Planning Step One.

   Electronic Health Records
   Mental health and substance use providers adopted the use of Electronic Health Records to collect, store and access patient information within an electronic format. This simplifies the storing of patient information while also easing the ability to share information with other providers to improve accuracy and quality of patient care.

   Telemedicine Services
   Reimbursable mental health services provided via telemedicine include individual and family therapy, evaluations/assessments, and medication management as identified on the Division's fee schedule located here:

http://dss.sd.gov/medicaid/providers/feeschedules/dss/.

Integrated Assessments

Integrated assessments are used to address co-occurring treatment needs for mental health, substance use disorders, or both. For substance use disorders, recommendations are made for treatment based on the American Society of Addiction Medicine (ASAM) Criteria, which forms the basis for eligibility criteria for levels of care in ARSD. The DBH partnered with Central Rockies Addiction Technology Transfer Center in 2017 to bring four, two day ASAM trainings to South Dakota to support workforce development and the application of the ASAM Criteria in a consistent manner across the state.

Provider Contracts

All eleven CMHCs are required through contract language to provide co-occurring capable mental health and substance use services. Substance use provider's contractual agreement requires a collaborative effort between mental health service providers, either within their own agency or with other agencies, to provide mental health services to their clients.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Mental health and substance use providers are required to provide an integrated system of care as described in contract language and ARSD. Services must be individualized according the client's needs and strengths, while also being responsive to cultural differences and special needs. The process can involve parents/guardians, family members, friends and any professionals or advocates the individual wishes to be involved.

Mental health services are provided on a fee-for-service basis through Medicaid, Block Grant, and state general funds. Funding utilized for mental health services include direct services to individuals with serious mental illnesses and children with serious emotional disturbances as well as outpatient services, emergency services, and services through the Indigent Medication Program.

Funding utilized for substance use services include prevention, outpatient, intensive outpatient, day treatment, medically monitored intensive inpatient treatment, clinically managed low intensity residential treatment, clinically managed residential detoxification, and specialty programs including, gambling, relapse programs, methamphetamine treatment.

For both mental health and substance use services, all clients undergo a financial eligibility process. Clients are found financially eligible based on 185 percent of the Federal Poverty Level (FPL). If a client's yearly gross income, minus allowable deductions, does not exceed 185 percent of the FPL for a family of comparable size, they are considered indigent and are automatically eligible for state funding for mental health and/or substance use services, when there is no other payer available. If a client's yearly gross income, minus allowable deductions, exceeds 185 percent of the FPL for a family of comparable size, they have the option of completing forms requesting a Hardship Consideration. This process takes into account any hardship that the client or family may have that would make paying for services an undue financial burden. The Division of Behavioral Health is responsible for determining eligibility based on hardship considerations defined in provider contract requirements.

In addition, through the Children's Health Insurance Program (CHIP), South Dakota's Medicaid program expanded coverage to all families and children whose incomes are at or below 204% of federal poverty level. Each Community Mental Health Center informs clients and families on the eligibility criteria and application process for CHIP, as well as the overall advantages to being in the program.

Finally, the DBH Accreditation Program monitors the system of care approach for the delivery of mental health and substance use services through on-site accreditation reviews. The accreditation monitoring consists of review of policies and procedures, individual charts, and interviews with families and individuals. Questions in the interview process include processes to determine methods the agency employs to create a system of care that is hopeful and empowering, respectful and welcoming, individual/family driven, culturally sensitive and integrated for individuals and families with co-occurring complex needs.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ( ) Yes ( ) No

   and Medicaid? ( ) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ( ) Yes ( ) No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ( ) Yes ( ) No

   b) Health risks such as

      i) heart disease ( ) Yes ( ) No

      ii) hypertension ( ) Yes ( ) No

viii) high cholesterol — Yes No

ix) diabetes — Yes No

c) Recovery supports — Yes No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? — Yes No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? — Yes No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

The Health Care System, Parity and Integration

1. **Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental health and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorder settings.**

The state integrates mental health, substance use disorder and primary health care services through the following efforts:

Screening, Brief Intervention and Referral to Treatment Grant (SBIRT)

The Division of Behavioral Health's (DBH's) Prevention Program received a Notice of Grant Award in 2016 from the Substance Abuse and Mental Health Services Administration for the SBIRT Grant. The main focus of the grant includes the integration of SBIRT services into primary care clinics and community behavioral health systems in South Dakota. A more detailed description of the grant's activities can be found in Planning Step One.

Health Homes

Nine Community Mental Health Centers (CMHCs) act as Health Home providers which include: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social supports. A more detailed description of Health Homes can be found in Planning Step One.

Electronic Health Records

Mental health and substance use providers adopted the use of Electronic Health Records to collect, store and access patient information within an electronic format. This simplifies the storing of patient information while also easing the ability to share information with other providers to improve accuracy and quality of patient care.

Telemedicine Services

Reimbursable mental health services provided via telemedicine include individual and family therapy, evaluations/assessments, and medication management as identified on the Division's fee schedule located here: http://dss.sd.gov/medicaid/providers/feeschedules/dss/.

Integrated Assessments

Integrated assessments are used to address co-occurring treatment needs for mental health, substance use disorders, or both. For substance use disorders, recommendations are made for treatment based on the American Society of

Addiction Medicine (ASAM) Criteria, which forms the basis for eligibility criteria for levels of care in ARSD. The DBH partnered with Central Rockies Addiction Technology Transfer Center in 2017 to bring four, two day ASAM trainings to South Dakota to support workforce development and the application of the ASAM Criteria in a consistent manner across the state.

Provider Contracts

All eleven CMHCs are required through contract language to provide co-occurring capable mental health and substance use services. Substance use provider's contractual agreement requires a collaborative effort between mental health service providers, either within their own agency or with other agencies, to provide mental health services to their clients.

2. **Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.**

Mental health and substance use providers are required to provide an integrated system of care as described in contract language and ARSD. Services must be individualized according the client's needs and strengths, while also being responsive to cultural differences and special needs. The process can involve parents/guardians, family members, friends and any professionals or advocates the individual wishes to be involved.

Mental health services are provided on a fee-for-service basis through Medicaid, Block Grant, and state general funds. Funding utilized for mental health services include direct services to individuals with serious mental illnesses and children with serious emotional disturbances as well as outpatient services, emergency services, and services through the Indigent Medication Program.

Funding utilized for substance use services include prevention, outpatient, intensive outpatient, day treatment, medically monitored intensive inpatient treatment, clinically managed low intensity residential treatment, clinically managed residential detoxification, and specialty programs including, gambling, relapse programs, methamphetamine treatment.

For both mental health and substance use services, all clients undergo a financial eligibility process. Clients are found financially eligible based on 185 percent of the Federal Poverty Level (FPL). If a client's yearly gross income, minus allowable deductions, does not exceed 185 percent of the FPL for a family of comparable size, they are considered indigent and are automatically eligible for state funding for mental health and/or substance use services, when there is no other payer available. If a client's yearly gross income, minus allowable deductions, exceeds 185 percent of the FPL for a family of comparable size, they have the option of completing forms requesting a Hardship Consideration. This process takes into account any hardship that the client or family may have that

would make paying for services an undue financial burden. The Division of Behavioral Health is responsible for determining eligibility based on hardship considerations defined in provider contract requirements.

In addition, through the Children's Health Insurance Program (CHIP), South Dakota's Medicaid program expanded coverage to all families and children whose incomes are at or below 204% of federal poverty level. Each Community Mental Health Center informs clients and families on the eligibility criteria and application process for CHIP, as well as the overall advantages to being in the program.

Finally, the DBH Accreditation Program monitors the system of care approach for the delivery of mental health and substance use services through on-site accreditation reviews. The accreditation monitoring consists of review of policies and procedures, individual charts, and interviews with families and individuals. Questions in the interview process include processes to determine methods the agency employs to create a system of care that is hopeful and empowering, respectful and welcoming, individual/family driven, culturally sensitive and integrated for individuals and families with co-occurring complex needs.

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

WebBGAS Logo

Skip Navigation

An error occurred

SAMHSA Logo

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

[56] http://psychiatryonline.org/

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

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

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

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

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

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

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ( ) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ( ) Yes ( ) No

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

   South Dakota implemented the OnTrackNY model, which is an extension of the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program. OnTrackNY builds on the RAISE initiative as an innovative, evidence-based team approach to providing recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms.

   Two First Episode Psychosis (FEP) Programs, utilizing the OnTrackNY model, have been established within the State of South Dakota. OnTrackNY provided training to Southeastern Behavioral Health Care (SEBHC), in the eastern part of the state and Behavior Management Systems (BMS), in the western part of the state. SEBHC began serving clients in 2015 and BMS began serving clients in 2017.

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

   The state is utilizing EBPs for those with FEP in the two programs described above. The OnTrackNY model's focus centers around individualized treatment planning through a shared decision making process that includes all aspects of the client's life, including physical health services.

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

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

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

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

In late 2015, SEBHC began receiving referrals and providing services. In July of 2016, OnTrack NY returned to SEBHC and provided additional technical assistance and training to ensure proficiency in delivery of services and fidelity to the model.

BMS was chosen to pilot a second program in August 2016 and staff received training through OnTrackNY. BMS began receiving referrals in 2017.

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

As described in Planning Table 1: Priority Areas and Annual Performance Indicators, the Division of Behavioral Health will coordinate with OnTrackNY to provide training and consultation to assist the First Episode Psychosis Programs in developing outreach strategies and a means to collect meaningful outcome data.

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

Once the adult outcome tool and data collection process is finalized for FEP, it is the expectation that the programs will complete the tool and outcomes collection process at the time of enrollment, every six months and at the time of discharge. The FEP programs will submit the completed tools to the DBH, who will assist in tracking overall state FEP outcomes.

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

Diagnostic categories identified include:
- Suicidality
- Psychiatric hospitalizations
- Use of emergency rooms
- Prescription adherence and side effects
- Physical health
- Program involvement
- Substance use
- Global functioning
- Employment
- Education/school participation
- Legal involvement
- Living situation
- Social connectedness
- Identification
- Intake
- Enrollment
- Improved Symptoms

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

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

Footnotes:

Environmental Factors and Plan

Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10% set aside

1. **Does the state have policies for addressing early serious mental illness (ESMI)?**
   ☐ Yes ☒ No

2. **Has the state implemented any evidence-based practices (EBPs) for those with ESMI?** ☒ Yes ☐ No
   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   South Dakota implemented the OnTrackNY model, which is an extension of the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program. OnTrackNY builds on the RAISE initiative as an innovative, evidence-based team approach to providing recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms.

   Two First Episode Psychosis (FEP) Programs, utilizing the OnTrackNY model, have been established within the State of South Dakota. OnTrackNY provided training to Southeastern Behavioral Health Care (SEBHC), in the eastern part of the state and Behavior Management Systems (BMS), in the western part of the state. SEBHC began serving clients in 2015 and BMS began serving clients in 2017.

3. **How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?**
   The state is utilizing EBPs for those with FEP in the two programs described above. The OnTrackNY model's focus centers around individualized treatment planning through a shared decision making process that includes all aspects of the client's life, including physical health services.

4. **Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?** ☒ Yes ☐ No
   The FEP programs coordinate outreach and recovery efforts across public and private sectors within their identified catchment areas.

5. **Does the state collect data specifically related to ESMI?** ☐ Yes ☒ No
   The Division of Behavioral Health (DBH) is currently in the process of customizing the standardized Adult Outcome Tool that the Data and Outcomes Work Group (DOWG) finalized in July 2016 in order to capture the necessary performance measures identified for the FEP program. This tool is required for other mental health services within the state such as Individualized Mobile Program of Assertive Community Treatment and

Comprehensive Assistance with Recovery and Empowerment services. It is the expectation to still be able to capture the necessary performance measures identified by the DOWG, but also enhance the tool specific to FEP clients.

6. **Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?** ☐ Yes ☒ No
   At this time, the DBH is not implementing statewide trainings regarding ESMI. The focus has been on the two identified Community Mental Health Centers, which fall within the most populous areas of the state allowing a greater number of individuals the ability to access FEP services.

7. **Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.**
   In late 2015, SEBHC began receiving referrals and providing services. In July of 2016, OnTrack NY returned to SEBHC and provided additional technical assistance and training to ensure proficiency in delivery of services and fidelity to the model.

   BMS was chosen to pilot a second program in August 2016 and staff received training through OnTrackNY. BMS began receiving referrals in 2017.

8. **Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs.**
   As described in Planning Table 1: Priority Areas and Annual Performance Indicators, the Division of Behavioral Health will coordinate with OnTrackNY to provide training and consultation to assist the First Episode Psychosis Programs in developing outreach strategies and a means to collect meaningful outcome data.

9. **Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.**
   Once the adult outcome tool and data collection process is finalized for FEP, it is the expectation that the programs will complete the tool and outcomes collection process at the time of enrollment, every six months and at the time of discharge. The FEP programs will submit the completed tools to the DBH, who will assist in tracking overall state FEP outcomes.

10. **Please list the diagnostic categories identified in your state's ESMI programs.**
    Diagnostic categories identified include:
    - Suicidality
    - Psychiatric hospitalizations
    - Use of emergency rooms
    - Prescription adherence and side effects
    - Physical health
    - Program involvement
    - Substance use
    - Global functioning
    - Employment

- Education/school participation
- Legal involvement
- Living situation
- Social connectedness
- Identification
- Intake
- Enrollment
- Improved Symptoms

This proposal is contingent on the premise that DBH reserves the right to make any necessary changes needed in order to ensure fidelity to the model during implementation of the program.

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

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

1. Does your state have policies related to person centered planning? [ ] Yes [ ] No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   The state supports the promotion, implementation and sustainability of a person centered approach to services. Services provided through the state's 11 Community Mental Health Centers (CMHCs) are intended to be a comprehensive, person-centered; relationship and recovery focused, and co-occurring capable within an integrated system of care which provides individually planned treatment, rehabilitation, and support services to identified clients with a serious mental illness or serious emotional disturbance, including those with co-occurring or complex needs conditions (substance use disorders, developmental disabilities, etc.). Article 67:62 Mental Health of the Administrative Rules of South Dakota (ARSD) describes the person centered approach and requires CMHCs to have written policies and procedures for the delivery of those services. Implementation of person centered services is also a part of each provider's contractual agreement.

4. Describe the person-centered planning process in your state.

   The person centered planning process is an ongoing problem solving process used to help people identify goals and objectives that promote recovery. The team focuses on the person's goals and then identifies opportunities necessary to achieve those goals. The process builds upon the person's strength and abilities while also considering their individual preferences, choices and abilities. The process can involve parents/guardians, family members, friends and any professionals or advocates the individual wishes to be involved.

   The ARSD require children and adult mental health services to be provided according to the individualized needs and strengths of the client, while also being responsive to cultural differences and special needs. Services provided based on the individualized needs of the client may include:
   1. Integrated assessment, evaluation, and screening;
   2. Case management;
   3. Individual therapy;
   4. Group therapy;
   5. Parent or guardian group therapy;
   6. Family education, support, and therapy;
   7. Crisis assessment and intervention services available 24 hours per day, seven days per week;
   8. Psychiatric services with the primary purpose of prescribing or reviewing a client's use of pharmaceuticals, including psychiatric assessments, treatment, and prescription of pharmacotherapy;
   9. Psychiatric nursing services including components of physical assessment, medication assessment and monitoring, and medication administration for clients unable to self-administer their medications;
   10. Collateral contacts; and
   11. Liaison services to facilitate treatment planning and coordination of services between mental health and other entities.

   Evidence of the client's or client's parent or guardian's participation and meaningful involvement in treatment planning must be documented in the case file.

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

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

Footnotes:

Environmental Factors and Plan

Person Centered Planning (PCP)
MHBG

1. **Does your state have policies related to person centered planning?**
   ☒ Yes ☐ No

2. **If no, describe any action steps planned by the state in developing PCP initiatives in the future.**

3. **Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.**
   The state supports the promotion, implementation and sustainability of a person centered approach to services. Services provided through the state's 11 Community Mental Health Centers (CMHCs) are intended to be a comprehensive, person-centered; relationship and recovery focused, and co-occurring capable within an integrated system of care which provides individually planned treatment, rehabilitation, and support services to identified clients with a serious mental illness or serious emotional disturbance, including those with co-occurring or complex needs conditions (substance use disorders, developmental disabilities, etc.). Article 67:62 Mental Health of the Administrative Rules of South Dakota (ARSD) describes the person centered approach and requires CMHCs to have written policies and procedures for the delivery of those services. Implementation of person centered services is also a part of each provider's contractual agreement.

4. **Describe the person-centered planning process in your state.**
   The person centered planning process is an ongoing problem solving process used to help people identify goals and objectives that promote recovery. The team focuses on the person's goals and then identifies opportunities necessary to achieve those goals. The process builds upon the person's strength and abilities while also considering their individual preferences, choices and abilities. The process can involve parents/guardians, family members, friends and any professionals or advocates the individual wishes to be involved.

   The ARSD require children and adult mental health services to be provided according to the individualized needs and strengths of the client, while also being responsive to cultural differences and special needs. Services provided based on the individualized needs of the client may include:

   1. Integrated assessment, evaluation, and screening;
   2. Case management;
   3. Individual therapy;

4. Group therapy;
5. Parent or guardian group therapy;
6. Family education, support, and therapy;
7. Crisis assessment and intervention services available 24 hours per day, seven days per week;
8. Psychiatric services with the primary purpose of prescribing or reviewing a client's use of pharmaceuticals, including psychiatric assessments, treatment, and prescription of pharmacotherapy;
9. Psychiatric nursing services including components of physical assessment, medication assessment and monitoring, and medication administration for clients unable to self-administer their medications;
10. Collateral contacts; and
11. Liaison services to facilitate treatment planning and coordination of services between mental health and other entities.

Evidence of the client's or client's parent or guardian's participation and meaningful involvement in treatment planning must be documented in the case file.

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

6. Self-Direction - Requested

Narrative Question

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

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

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

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

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

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

   Please indicate areas of technical assistance needed to this section.

Footnotes:

7. Program Integrity ? Required

Narrative Question

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

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

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

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

Administrative Rules of South Dakota
The Administrative Rules of South Dakota are used to implement, interpret or prescribe actions that may be taken by the Division of Behavioral Health (DBH) in relation to accredited and contracted mental health and substance use providers.

Provider Contracts
Mental health and substance use providers who receive funding by the DBH enter into a contractual agreement with the DBH for the procurement of those services. Contract language includes state and federal requirements which are required for the delivery of those services.

Accreditation Reviews
The DBH's Accreditation team conducts onsite reviews of accredited/contracted mental health, substance use disorder treatment and prevention programs across the state. The review encompasses areas of governance, fiscal management, personnel training/qualifications, statistical reporting, client rights, quality assurance, case record content, medication administration and consumer outcome/satisfaction reports.

State Treatment Activity Reporting System
The State Treatment Activity Reporting System (STARS) is a web-based management information system containing data for clients

receiving mental health, substance use services or both, funded through the DBH. Through STARS, the DBH has the capability to capture demographic information, service eligibility, services provided, and cost data for clients. The data is used for both clinical and fiscal monitoring.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

Program Integrity

1. **Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?** ☒ Yes ☐ No
2. **Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?** ☒ Yes ☐ No
3. **Does the state have any activities related to this section that you would like to highlight?**

   Administrative Rules of South Dakota
   The Administrative Rules of South Dakota are used to implement, interpret or prescribe actions that may be taken by the Division of Behavioral Health (DBH) in relation to accredited and contracted mental health and substance use providers.

   Provider Contracts
   Mental health and substance use providers who receive funding by the DBH enter into a contractual agreement with the DBH for the procurement of those services. Contract language includes state and federal requirements which are required for the delivery of those services.

   Accreditation Reviews
   The DBH's Accreditation team conducts onsite reviews of accredited/contracted mental health, substance use disorder treatment and prevention programs across the state. The review encompasses areas of governance, fiscal management, personnel training/qualifications, statistical reporting, client rights, quality assurance, case record content, medication administration and consumer outcome/satisfaction reports.

   State Treatment Activity Reporting System
   The State Treatment Activity Reporting System (STARS) is a web-based management information system containing data for clients receiving mental health, substance use services or both, funded through the DBH. Through STARS, the DBH has the capability to capture demographic information, service eligibility, services provided, and cost data for clients. The data is used for both clinical and fiscal monitoring.

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

8. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   In 2016 and 2017, the Division of Behavioral Health (DBH) worked collaboratively with tribal agencies, Indian Health Services (IHS), Urban Indian Health, and the Great Plains Tribal Chairmen's Health Board to inform and educate about opportunities for Community Mental Health Center (CMHC) accreditation by the DBH. Several meetings were held which discussed federal block grant and Administrative Rules of South Dakota requirements needed to become accredited. Service provisions for adults and children suffering from a mental health disorder were described, including services for individuals with co-occurring substance use disorders. Information regarding clinical processes, fiscal management and personnel requirements was also discussed and shared.

   Additionally, DBH staff presented information regarding expectations for becoming a CMHC as well as an accredited substance use disorder treatment provider at a Tribal Action Plan Workshop held in July 2016 in conjunction with the Substance Abuse and Mental Health Services Administration's Tribal Training and Technical Assistance Center. The DBH also regularly participates in South Dakota Medicaid's quarterly Tribal Consultation meetings with tribes, IHS, and South Dakota Urban Indian Health. The agenda, minutes, and handouts from those meetings are posted on the Department's website: http://dss.sd.gov/medicaid/generalinfo/tribalconsultation.aspx.

   In 2016 and 2017, the DBH provided information regarding the DBH's involvement with the criminal justice initiative and the juvenile justice reinvestment initiative, the technical assistance available to tribes to become tribal CMHCs, and the Department's Meth Awareness Campaign.

   The DBH and South Dakota Medicaid work closely together to respond to the needs of tribes on an informal basis as questions arise. The Department of Social Services is committed to working with tribes who wish to administer their own programs and supporting access to care on South Dakota's nine Indian reservations. In the past year, South Dakota Medicaid provided outreach

to each tribal health director in South Dakota to discuss opportunities for enrolling in Medicaid. South Dakota Medicaid also visited tribes to share information and learn more about services provided by tribal health programs. South Dakota Medicaid connected tribes to the DBH to follow-up on questions for billing substance use disorder services.

The state of South Dakota has worked closely with tribes and other stakeholders as part of the Health Care Solutions Coalition convened by Governor Daugaard to address access to care and health disparities for American Indians in South Dakota. As a result of the work of the coalition, IHS is implementing telehealth services to increase access to specialty care including behavioral health care. South Dakota Medicaid also expanded the use of telehealth for behavioral health and substance use disorder providers. The coalition continues to work towards other goals for increasing access including expanding capacity for IHS and tribes to provide additional behavioral heal services or partner together to form CMHCs or Medicaid behavioral health Health Homes. Agendas, minutes, handouts, and reports from the coalition are available online: http://boardsandcommissions.sd.gov/Information.aspx?BoardID=145

2. What specific concerns were raised during the consultation session(s) noted above?

The sessions were educational so that the interested entities would be knowledgeable regarding the accreditation requirements to become a CMHC. Specific concerns were not identified however similar challenges were shared with other entities across the state related to workforce shortages

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

The Great Plains Tribal Chairmen's Health Board representative attended an accreditation review at a CMHC in June 2016 and CMHC staff provided a very comprehensive overview of CMHC accreditation and requirements. These consultation activities have opened the door for continued conversation and collaboration with tribal entities and the DBH will continue to explore opportunities for partnerships.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

Tribes

1. **How many consultation sessions have the state conducted with federally recognized tribes?**
   In 2016 and 2017, the Division of Behavioral Health (DBH) worked collaboratively with tribal agencies, Indian Health Services (IHS), Urban Indian Health, and the Great Plains Tribal Chairmen's Health Board to inform and educate about opportunities for Community Mental Health Center (CMHC) accreditation by the DBH. Several meetings were held which discussed federal block grant and Administrative Rules of South Dakota requirements needed to become accredited. Service provisions for adults and children suffering from a mental health disorder were described, including services for individuals with co-occurring substance use disorders. Information regarding clinical processes, fiscal management and personnel requirements was also discussed and shared.

   Additionally, DBH staff presented information regarding expectations for becoming a CMHC as well as an accredited substance use disorder treatment provider at a Tribal Action Plan Workshop held in July 2016 in conjunction with the Substance Abuse and Mental Health Services Administration's Tribal Training and Technical Assistance Center. The DBH also regularly participates in South Dakota Medicaid's quarterly Tribal Consultation meetings with tribes, IHS, and South Dakota Urban Indian Health. The agenda, minutes, and handouts from those meetings are posted on the Department's website: http://dss.sd.gov/medicaid/generalinfo/tribalconsultation.aspx.

   In 2016 and 2017, the DBH provided information regarding the DBH's involvement with the criminal justice initiative and the juvenile justice reinvestment initiative, the technical assistance available to tribes to become tribal CMHCs, and the Department's Meth Awareness Campaign.

   The DBH and South Dakota Medicaid work closely together to respond to the needs of tribes on an informal basis as questions arise. The Department of Social Services is committed to working with tribes who wish to administer their own programs and supporting access to care on South Dakota's nine Indian reservations. In the past year, South Dakota Medicaid provided outreach to each tribal health director in South Dakota to discuss opportunities for enrolling in Medicaid. South Dakota Medicaid also visited tribes to share information and learn more about services provided by tribal health programs. South Dakota Medicaid connected tribes to the DBH to follow-up on questions for billing substance use disorder services.

   The state of South Dakota has worked closely with tribes and other stakeholders as part of the Health Care Solutions Coalition convened by Governor Daugaard to address access to care and health disparities for American Indians in South Dakota. As a result of the work of the coalition, IHS is implementing telehealth services to increase access to

specialty care including behavioral health care. South Dakota Medicaid also expanded the use of telehealth for behavioral health and substance use disorder providers. The coalition continues to work towards other goals for increasing access including expanding capacity for IHS and tribes to provide additional behavioral heal services or partner together to form CMHCs or Medicaid behavioral health Health Homes. Agendas, minutes, handouts, and reports from the coalition are available online: http://boardsandcommissions.sd.gov/Information.aspx?BoardID=145

2. **What specific concerns were raised during the consultation session(s) noted above?**
   The sessions were educational so that the interested entities would be knowledgeable regarding the accreditation requirements to become a CMHC. Specific concerns were not identified however similar challenges were shared with other entities across the state related to workforce shortages.

Does the state have any activities related to his section that you would like to highlight?
The Great Plains Tribal Chairmen's Health Board representative attended an accreditation review at a CMHC in June 2016 and CMHC staff provided a very comprehensive overview of CMHC accreditation and requirements. These consultation activities have opened the door for continued conversation and collaboration with tribal entities and the DBH will continue to explore opportunities for partnerships.

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

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

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

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

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

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

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

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

- ☐ Archival indicators (Please list)
- ☐ National survey on Drug Use and Health (NSDUH)
- ☐ Behavioral Risk Factor Surveillance System (BRFSS)
- ☐ Youth Risk Behavioral Surveillance System (YRBS)
- ☐ Monitoring the Future
- ☐ Communities that Care
- ☐ State - developed survey instrument
- ☐ Others (please list)

Local community and school survey data.

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ☐ Yes ☐ No

If yes, (please explain)

The state requires that each local prevention coalition complete a needs assessment. This information, along with regional and statewide data, are factors in determining which of the state's five behavioral health planning regions have the highest need for funding.

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

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

Please indicate areas of technical assistance needed related to this section

Narratve Question

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

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

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

Capacity Building

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

   If yes, please describe

   The South Dakota Board of Addiction and Prevention Professionals has a certification process for Prevention Specialists.

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

   If yes, please describe mechanism used

   The state contracts with three prevention resource centers to provide training and technical assistance to communities, schools, local coalitions and the prevention workforce.

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

   If yes, please describe mechanism used

   Each funded coalition needs to complete a local needs assessment, which allows the state to determine a community's readiness to change.

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

   Please indicate areas of technical assistance needed related to this section

Narratve Question

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

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

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

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ( ) Yes ( ) No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   See attachement A - SD DSS Prevention Program Five Year Strategic Plan (2015-2020).

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ( ) Yes ( ) No ( ) N/A

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

   a) [b] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds

   b) [b] Timelines

   c) [b] Roles and responsibilities

   d) [b] Process indicators

   e) [b] Outcome indicators

   f) [b] Cultural competence component

   g) [b] Sustainability component

   h) [b] Other (please list):

   Mechanism to identify priority populations.

   i) [c] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ( ) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ( ) Yes ( ) No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

   See attachment B - Request for Approval of Evidence-Based Program or Promising Practices. This form is used to determine which programs, policies and strategies are evidence-based.

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

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

Narratve Question

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

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

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

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) ☐ SSA staff directly implements primary prevention programs and strategies.

   b) ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) ☒ The SSA funds regional entities that provide training and technical assistance.

   e) ☐ The SSA funds regional entities to provide prevention services.

   f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.

   g) ☒ The SSA funds community coalitions to provide prevention services.

   h) ☐ The SSA funds individual programs that are not part of a larger community effort.

   i) ☐ The SSA directly funds other state agency prevention programs.

   j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

   See Attachment D - Prevention Strategies & Programs

   b) Education:

   See Attachment D - Prevention Strategies & Programs

   c) Alternatives:

   See Attachment D - Prevention Strategies & Programs

   d) Problem Identification and Referral:

   See Attachment D - Prevention Strategies & Programs

   e) Community-Based Processes:

   See Attachment D - Prevention Strategies & Programs

   f) Environmental:

See Attachment D - Prevention Strategies & Programs

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

If yes, please describe

The state reimburses community coalitions and the prevention resource centers on a fee for service basis. Each month prevention providers submit an invoice into the prevention programs data collection system. Prevention Program staff review each invoice against those contract items that were designated to be paid with SABG funds before an invoice is processed. In addition, fiscal audits are conducted to ensure that the provider has billed the appropriate services to the appropriate funding stream and has documentation of the services provided.

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

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

Narratve Question

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

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

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

Evaluation

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

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   See attachement C - SD PFS Evaluation Plan. Since the SABG funds are blended with the Partnership for Success (PFS) grant and the target population is the same, we utilize the PFS evaluation plan for the the SABG funded services as well.

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

   a) [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) [x] Includes evaluation information from sub-recipients
   c) [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) [x] Establishes a process for providing timely evaluation information to stakeholders
   e) [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) [ ] Other (please list:)
   g) [ ] Not applicable/no prevention evaluation plan

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

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

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

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

b) ☐ Heavy use

☐ Binge use

☐ Perception of harm

c) ☐ Disapproval of use

d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

SOUTH DAKOTA
DEPARTMENT OF SOCIAL SERVICES
PREVENTION PROGRAM

FIVE YEAR STRATEGIC PLAN (2015 -2020)

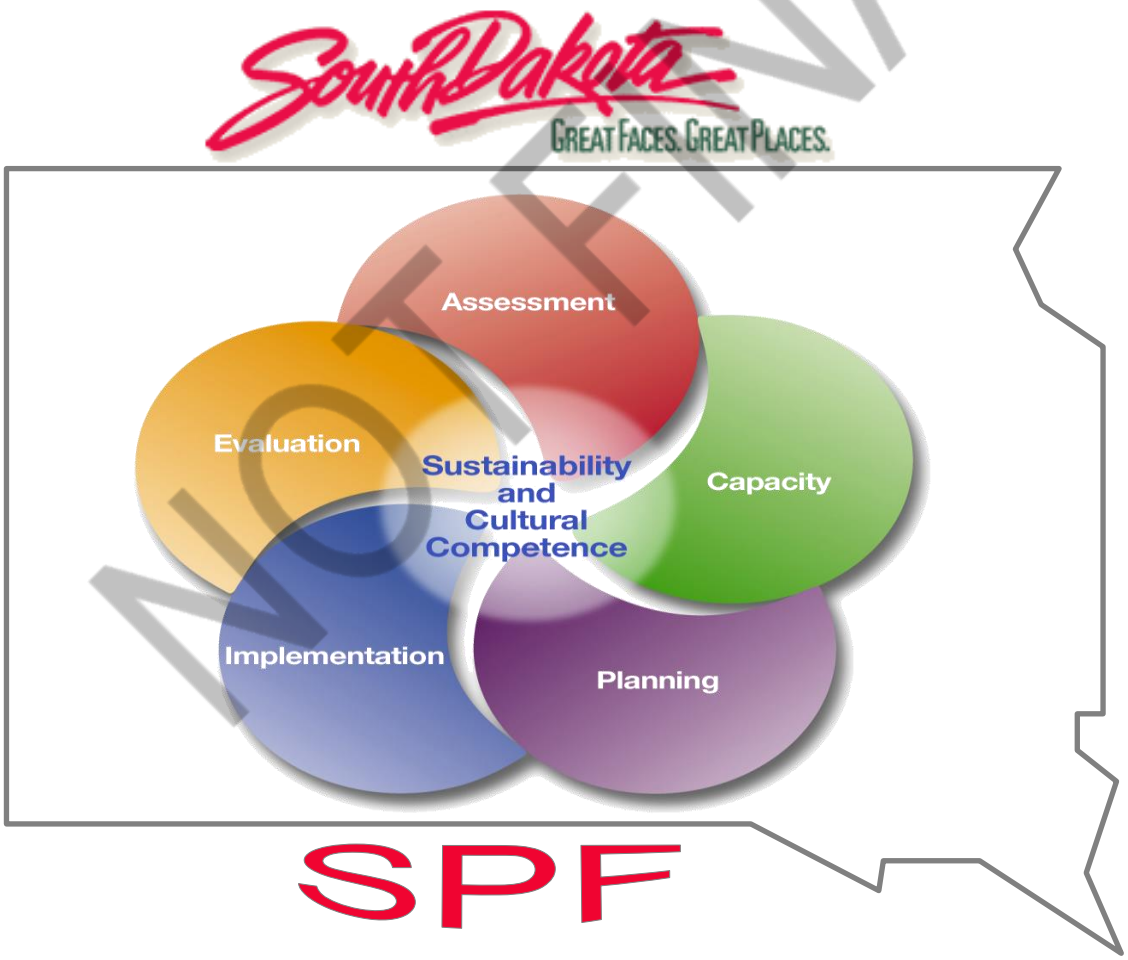


TABLE OF CONTENTS

EXECUTIVE SUMMARY

In October of 2009, the Prevention Program within the South Dakota Department of Social Services, Division of Behavioral Health, applied for and received a Federal Grant called the Strategic Prevention Framework State Incentive Grant (SPF SIG). The grant was for 2.135 million per year for 5 years. Through a competitive Request for Proposals Process, the Prevention Program selected 15 local prevention coalitions to be funded by SPF SIG dollars. In addition, the Prevention Program selected 7 other community-based coalitions to be funded with Substance Abuse Prevention and Treatment Block Grant dollars to expand prevention services across the State. All 22 coalitions focused on the following populations: underage drinking among 12-20 year olds, and young adult binge drinking among 18-25 year olds. After 18 months of planning and 42 months of implementation, the statewide outcome data on the project follows in Table 1, Table 2, and Table 3 below.

Table 1

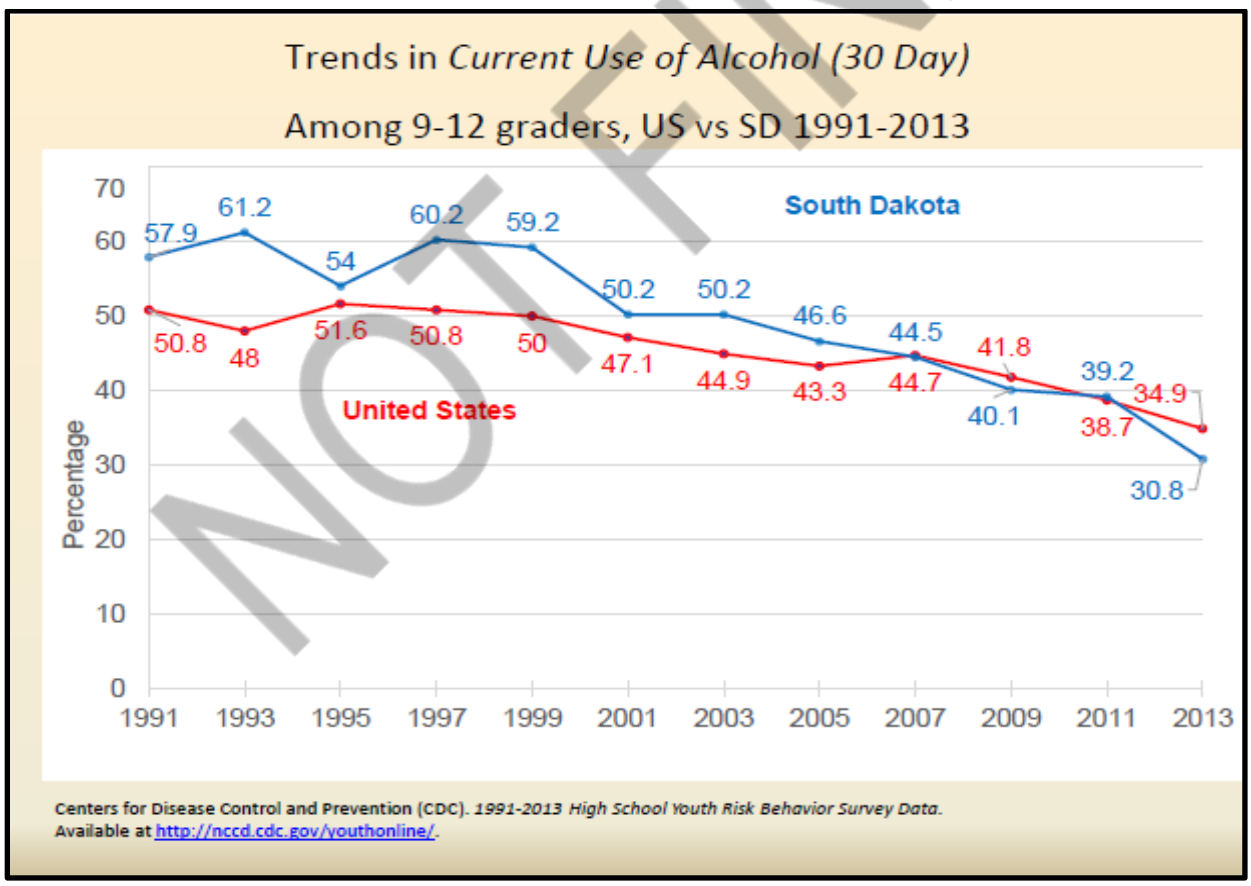


Table 2

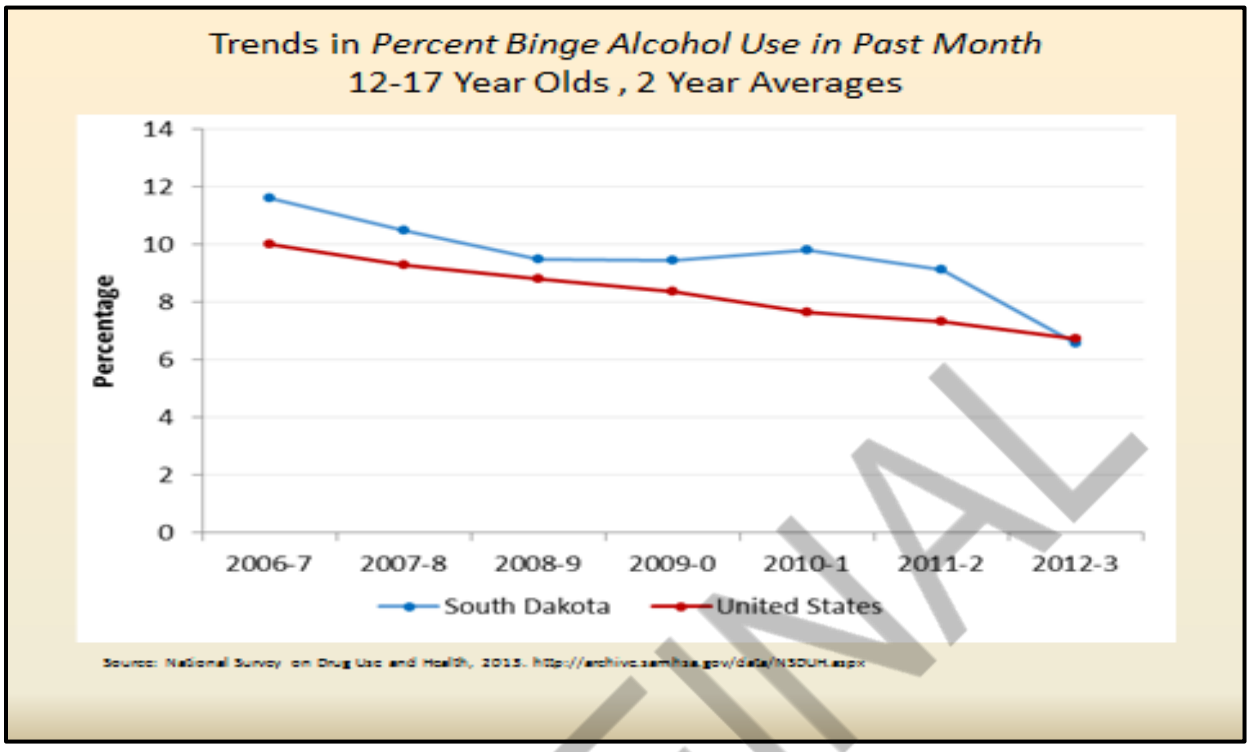
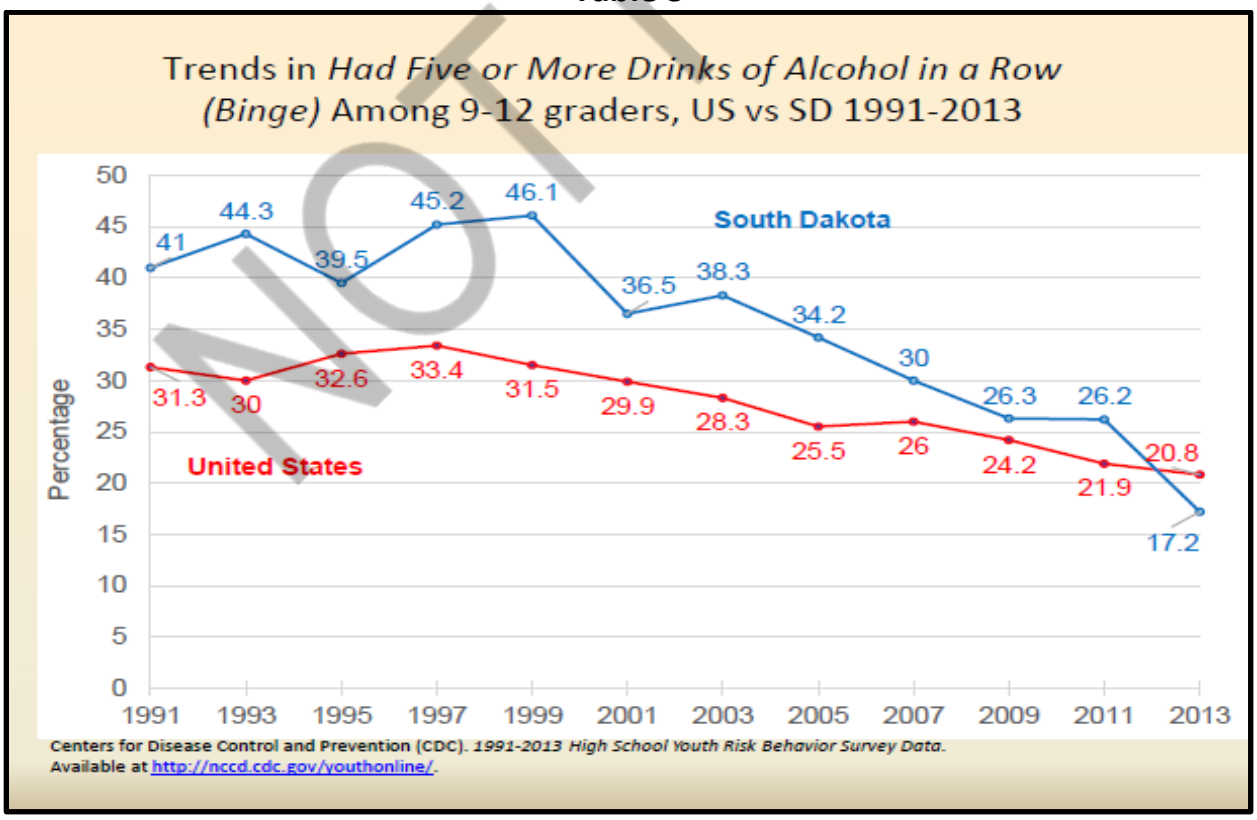


Table 3



The SPF SIG grant was completed in June of 2014. As part of the requirement of the grant, the Prevention Program was required to complete a Five Year Prevention Strategic Plan.

The following information summarizes the accomplishments tied to the previous Prevention Program Strategic Plan (2012-2014):

- Completed a comprehensive review of all prevention curriculums currently offered in the five Behavioral Health Planning Regions in the State;
- Conducted a comprehensive review of the prevention workforce in the State to determine the gaps in their knowledge-base in the prevention area. This document will form the baseline for the development of a workforce training plan to begin in the fall of 2015;
- Established an Evidence-Based Workgroup made up of prevention specialists and evaluators to review those programs currently being utilized in the State, and rank order them based on the population they target and on their applicability to frontier/rural regions of the State;
- Developed a list of Evidence-Based Programs (EBPs) in the prevention areas of primary prevention, early intervention and recovery supports which were reviewed and approved by Prevention Program staff. The selected EBPs are supported by the State for implementation at the local level;
- Mapped the five Behavioral Health Planning Regions identifying where the State approved list of EBPs are located and where the gaps exist regarding the implementation of these EBPs;
- Provided support for 22 coalitions and trainings across the State on approved EBPs to increase the capacity of local prevention specialists to implement the State approved EBPs in their local communities;
- Updated the prevention data collection system with the goal of integrating both process and outcome measures into the system;
- Worked with the Prevention Program's epidemiologist and local prevention providers on the establishment of community outcome measures that will be collected on an ongoing basis;
- Assisted local coalitions in modifying their survey questions to include questions to measure community outcome measures and the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures;
- Created community dashboards which contain data on national, state, and regional outcomes where local coalitions can add their local data to in order to help them assess the impact of their local programming; and
- Enhanced the data collection capabilities at the community level.

On September 30, 2014, the Prevention Program received award notices that the State would receive a Partnership for Success Grant from the (SAMHSA) for $1.3 million per year for five years, and a South Dakota Youth Suicide Prevention Grant for $736,000 per year for five years. The revised Strategic Plan that follows will be an integrated substance use disorder prevention, mental health promotion, and suicide prevention plan for the State for the next five years.

VISION AND MISSION

Vision

Behavioral health and wellness across the lifespan of South Dakotans

Mission

Advancing behavioral health and wellness for individuals, families and communities through prevention leadership, education, and support

THE STRATEGIC PREVENTION FRAMEWORK AND SD PREVENTION GOALS

Each goal of the SD Prevention Strategic Plan corresponds with the 5 steps of SAMHSA's Strategic Prevention Framework (SPF). The five steps of the SPF are:

STEP ONE – ASSESSMENT *The collection of data to understand a population's needs and assess the resources that are currently available and those that are lacking. Assessment also helps define the problem or the issue that a project will need to impact.*

STEP TWO – CAPACITY BUILDING *Mobilizing human, organizational, and financial resources to meet the demands of the prevention initiatives and programming that are being implemented.*

STEP THREE – PLANNING *Development of a strategic plan that includes goals, objectives, strategies, activities and timelines aimed at meeting the prevention needs of South Dakota.*

STEP FOUR – IMPLEMENTATION *During program implementation, organizations detail the evidence-based programs, policies and practices that need to be undertaken, develop specific timelines, decide on ongoing program evaluation needs and identify and overcome any potential barriers.*

STEP FIVE – EVALUATION *The systematic collection and analysis of information about program activities, characteristics, and outcomes. Measuring the impact of the program is not just about collecting and analyzing information, but using that information to improve the effectiveness of the prevention programming being implemented.*

GOALS, OBJECTIVES, STRATEGIES, AND ACTIVITIES

Goal 1: Collect behavioral health indicator data and assess need for community-based prevention programming

Objective A: Collect indicators of substance use disorder, behavioral health, and suicide in South Dakota

Strategy 1: *Collect consumption data for community-based prevention programs for the target population(s) at the state, region, and community levels*

Activities:

a) Annually compile consumption data from national data sources and surveys
b) Collect consumption data from state data systems through collaboration with other state agencies
c) Work with local community coalitions to collect consumption data at the community level

Strategy 2: *Collect risk and protective factors (intervening variables) for the community-based prevention programs for the target population(s) at the state, region, and community level*

Activities:

a) Annually compile risk and protective factor data from national data sources and surveys
b) Collect risk and protective factor data from state data systems through collaboration with other state agencies
c) Work with local community coalitions to collect risk and protective factor data at the community level.

Strategy 3: *Collect consequence data for community-based prevention programs for the target population(s) at the state, region, and community level*

Activities:

a) Annually compile consequence data from national data sources and surveys
b) Collect consequence data from state data systems through collaboration with other state agencies
c) Work with local community coalitions to collect consequence data at the community level

Objective B: Analyze and disseminate information on substance use disorders, behavioral health, and suicide rates at the state, regional, and community level

Strategy 1: *Analyze data and identify needs of target population for community-based prevention programming*

Printed: 7/31/2017 5:20 PM - South Dakota - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

Activities:

a) Calculate substance use disorders, behavioral health, suicide indicator prevalence rates for the target population at the state, region and community level
b) Compare prevalence rates at the state, regional and community level with benchmarks to identify high need areas

Strategy 2: *Disseminate substance use disorder, behavioral health and suicide epidemiological data for community-based prevention programs*

Activities:

a) Update and disseminate published reports and profiles of substance use disorder, behavioral health and suicide epidemiological data
b) Maintain and enhance the current website for the dissemination of substance use disorder, behavioral health and suicide epidemiological data
c) Integrate federal reporting requirements into substance use disorder, behavioral health and suicide epidemiological summary reports

Goal 2: Ensure access to a prevention system to support individuals, families and communities

Objective A: Support a comprehensive prevention behavioral health system

Strategy 1: *Identify the gaps in the substance use disorder area, mental health promotion and suicide prevention services in the State*

Activities

a) Conduct a yearly survey of the substance use disorder and suicide prevention coalitions to determine current services available
b) Develop a document on services available in the five Behavioral Health Planning Regions
c) Assess each planning region to determine gaps in the continuum of services in substance use disorder prevention, mental health promotion and suicide prevention systems
d) Develop a plan to focus resources to eliminate gaps in the system of services
e) Assess sustainability of existing funding, programs, and approaches

Strategy 2: *Identify ongoing priority populations for behavioral health services*

Activities:

a) Review local, regional and state level data to determine the population of greatest need for behavioral health services
b) Prepare a report that details the priority populations by age, race, and gender for all federal grants received by the State Prevention Program.
c) Prepare a report that identifies those populations in need of services and the priority populations required to be served by funding sources
d) Assess what priority populations are not being served in each region

e) Develop a plan to secure culturally-competent services and support to address underserved populations experiencing health disparities
f) Ensure cultural competence in plans to address identified underserved populations

Strategy 3: *Foster linkages of behavioral health prevention services to the behavioral health treatment system to enhance care coordination*

Activities:

a) Work with suicide prevention and substance use disorder coalitions on mapping each region on the availability of mental health and substance use disorder treatment services
b) In collaboration with treatment providers, establish reciprocal referral protocols for behavioral health prevention and treatment services
c) Monitor the effectiveness of the reciprocal referral protocols
d) Provide technical assistance to regions to improve their care coordination process upon request

Objective B: Inform the public and behavioral health provider system on the availability of community-based prevention services in each planning region

Strategy 1: *Promote community-based prevention services*

Activities

a) Develop an internet directory of substance use disorder, mental health promotion and suicide prevention services by region
b) Coordinate with the statewide "211" directory to ensure inclusion of prevention resources
c) Develop toolkits on the prevention services available to the general public
d) Place the directory and toolkits on the Prevention Program's website
e) Develop an awareness campaign to educate the public on available services

Strategy 2: *Increase the knowledge-base of the prevention workforce*

Activities:

a) In September 2015, begin work with the Center for Substance Abuse Prevention on a five-year prevention workforce training plan that includes the State supported evidence-based programs
b) Assess cultural competence of prevention workforce and cultural competence of existing services
c) Complete the comprehensive training plan by September 30, 2016
d) Identify curriculums and prevention workforce training needs, including cultural competence considerations, beginning in October 2016 through September 30, 2020
e) Roll out the training plan to the prevention workforce in January 1, 2017

Goal 3: Foster alignment and planning of community-based prevention services at the state and regional levels, and system integration at the local level

Objective A: Compile information on statewide prevention services

Strategy 1: *Identify prevention activities supported by other State agencies and other public, Tribal or private entities in local communities*

Activities:

a) Prepare a contact list of State agencies, Tribal entities, and the branches of the military that have or are currently providing prevention services in the behavioral health area
b) Develop an online survey and distribute it to the listed agencies and programs to determine what type of programming is being supported, the target population to be served, the number of prevention events funded each year, the number of individuals served, and the sustainability of the program
c) Map the five Behavioral Health Planning Regions with the information gathered from the survey
d) Prepare a report that details what prevention programs and events are being supported in each of the five behavioral health regions, the population each program targets and outcomes obtained for each program
e) Distribute the report to the participating entities
f) Hold a planning meeting to discuss any possible overlap in funding of programs, populations not being served, and gaps in behavioral health services

Objective B: Develop an intergovernmental prevention and wellness plan

Strategy 1: *Establish prevention priorities*

Activities:

a) List current prevention priorities for State agencies, Tribal entities, and the branches of the military for behavioral health services
b) Identify which prevention priorities are the result of federal grant requirements or are independently established by the funding source
c) Prepare a summary report of prevention priorities including required federal priorities and those priorities that are optional for the State
d) Develop a SurveyMonkey to be sent to local agencies listing current prevention priorities and their priority for each of the Behavioral Health Planning Regions
e) Prepare a summary document and distribute to the funding agencies

Strategy 2: *Promote collaboration on prevention efforts*

Activities:

a) Develop a standing Behavioral Health Prevention Workgroup

b) Have webinars or meetings quarterly to begin discussions on the prevention priorities document and the priorities detailed by local behavioral health providers
c) Discuss integration of prevention priorities
d) Identify gaps in prevention priorities by region as detailed by behavioral health providers
e) Collaborate on seeking resources to fill the gaps

Goal 4: Implement data-driven community-based prevention services to improve behavioral health and wellness

Objective A: Ensure current prevention efforts meet the needs of the target populations

Strategy 1: *Identify and support evidence-based programs to meet the needs of the prevention target populations*

Activities:

a) Maintain the Evidence-Based Prevention Workgroup under the State Epidemiological Outcomes Workgroup (SEOW)
b) Continue the process of reviewing proposals from local coalitions for new evidence-based programing with an emphasis on identifying new culturally-competent interventions
c) The Evidence-Based Prevention Workgroup will recommend to the Prevention Program which programs should be approved for implementation, with consideration given to cultural competency
d) The Prevention Program will add the newly approved programs to the State-approved and supported list of programs
e) The list will be distributed to behavioral health providers annually

Objective B: Ensure the implementation of evidence-based, culturally-competent prevention across the five behavioral health planning regions

Strategy 1: *Support the continued use of culturally-competent evidence-based programs*

Activities:

a) Develop a document on outcomes for prevention programming utilized in the areas of primary prevention, early intervention, recovery supports, mental health promotion and suicide prevention.
b) Rank order those programs demonstrating the greatest impact on the target populations
c) Distribute the list of ranked programs to the prevention network in the State
d) Encourage the use of evidence-based programming with the greatest impact on target populations
e) Review the list on an annual basis

Strategy 2: *Support local implementation of evidence-based programs*

Activities:

a) Survey the current prevention workforce on training needs related to State-supported programs
b) Rank the training needs based on the largest number of prevention providers asking for a specific training
c) Select the number of curriculums to be trained on each year based on level of funding
d) Once trained, provide technical assistance to local coalitions on the implementation of the curriculum in their local communities

Strategy 3: *Ensure fidelity and maintain high-quality prevention services*

Activities:

a) Analyze fidelity of implemented EBPs
b) List the EBPs supported by the Prevention Program
c) Contact the developers of the programs and develop a checklist of program components that are essential to implement to ensure program fidelity
d) Pilot each program's fidelity checklist to ensure effectiveness
e) Utilize trained prevention personnel to conduct yearly reviews of a percentage of EBPs
f) Develop a report on each provider surveyed to determine compliance with the fidelity requirements of the program
g) Assess the need for technical assistance to improve the implementation of the program
h) Provide additional training if needed

Goal 5: Analyze, evaluate and report the impact of data-driven prevention efforts in the areas of substance use disorders, suicide prevention and mental health promotion

Objective A: Evaluate the impact of prevention efforts in the State on a yearly basis

Strategy 1: *Determine local prevention coalition's impact on risk and protective factors (intervening variables), consumption, and consequences rates*

Activities:

a) Collect local coalition evaluation data on risk and protective factors (intervening variables), consumption, and consequences rates
b) Analyze the data yearly with the baseline for measurement beginning State Fiscal Year 2016
c) Prepare a report on progress on raising the perception of harm at the local level and other risk and protective factors (intervening variables), in the five Behavioral Health Planning Regions and the State
d) If improvement is not seen in local outcomes, provide technical assistance to local programs
e) Provide additional training if needed

Objective B: Determine the capabilities of local coalitions' data collection systems

Strategy 1: *Collect information from local coalitions on their capacity to collect data in multiple behavioral health areas*

Activities:

a) Develop a questionnaire on substances use disorders and the coalitions ability to collect data in multiple behavioral health areas
b) Include information related to suicide attempts and suicides in the questionnaire
c) Analyze the information to determine local capabilities
d) Provide technical assistance to increase local data collection capacity

Objective C: Disseminate evaluation findings and data to key stakeholders

Strategy 1: *Develop targeted reports to communicate findings and program impacts*

Activities:

a) Define target audiences and key stakeholders
b) Develop an annual statewide evaluation report with program summaries by region and populations, based on existing data collection and reporting
c) Distribute relevant reports and findings to each target audience and stakeholder group

KEY TERMS AND CONCEPTS

From SAMHSA's Centers for the Application of Prevention Technologies:

Strategic Prevention Framework SAMHSA's Strategic Prevention Framework (SPF) is a 5-step planning process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The effectiveness of this process begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process. The SPF includes these five steps: **Step 1** - Assess Needs; **Step 2** - Build Capacity; **Step 3** - Plan; **Step** 4 - Implement; **Step** 5 - Evaluation.

Step One – Assess Need Under the SPF, communities are expected to assess population needs, including levels of substance abuse and related problems, available resources to support prevention efforts, and community readiness to address identified prevention problems or needs.

Step Two – Build Capacity States and communities must have the capacity, that is, the resources and readiness, to support their chosen prevention programs and practices. Why? Because programs and practices that are well-supported are more likely to succeed. Building capacity means taking a close look at the assessment data, finding the gaps that lie therein, and developing an action plan to address those gaps. Keep in mind that resources and readiness often go hand-in-hand, and building resources for capacity also contributes to greater readiness. For example, when key stakeholders are involved in

solving problems, they are more likely to engage others. This leads to more people recognizing the value of prevention.

Step Three – Plan Planning is pivotal to prevention success. Planning will increase the effectiveness of the prevention efforts by focusing energy, ensuring that staff and other stakeholders are working toward the same goals, and providing the means for assessing and adjusting programmatic direction as needed. If done carefully, planning will also make future evaluation tasks much easier. Good planning is also key to sustainability. It ensures the involvement and commitment of community members who will continue program efforts and activities beyond the initial funding period. It establishes the organizational structure necessary to maintain program activities over time. And it greatly increases the likelihood that expected outcomes will be achieved by ensuring that the activities selected are the right ones for the community.

Step Four – Implementation Where the rubber hits the road—where states, tribes, jurisdictions, and communities do what they've said they're going to do. When implementing prevention efforts, it's important to consider the balance between fidelity and adaptation, the range of factors that contribute to successful implementation, and the importance of developing a clear implementation plan.

Step Five – Evaluation The systematic collection and analysis of information about program activities, characteristics, and outcomes to reduce uncertainty, improve effectiveness, and decision making. Evaluation isn't about acquiring knowledge for the sake of knowledge. It's more practical. It's about utility. It helps states and communities become more skillful and exact in describing what they plan to do, monitor what they are doing, and improve the process if needed. Evaluation results can and should be used to determine what efforts should be sustained and to assist in sustainability planning efforts. Ultimately, good evaluation will help improve not only our own programs but those implemented by others.

Cultural-Competence This process is the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, prevention practitioners must understand the cultural context of their target community, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable persons of and from the community to plan, implement, and evaluate prevention activities.

Sustainability When thinking about sustainability, prevention practitioners typically think of sustaining prevention programs. But best practice challenges us to think about sustainability more contextually; to consider the multiple factors that contribute to program success—such as the existence of a stable prevention infrastructure, available training systems, and community support to work toward sustaining these contributors. Best practice also encourages us to think critically about which activities we should, or should not, sustain. Our ultimate goal is to sustain prevention outcomes, not programs. Programs that produce positive outcomes should be continued. Programs that are ineffective should not be sustained. In addition, the SPF emphasizes sustaining the prevention process, recognizing that practitioners will return to each step of the process as the problems communities face continue to evolve.

Risk and Protective Factors (Intervening Variables) Once communities have selected their prevention priorities, they also need to assess the factors driving the prioritized problem(s). Each substance use disorder prevention problem has its own set of risk and protective factors (intervening variables). However, the factors driving a problem in one community may differ from the factors driving it in another community. One of the most important lessons learned from prevention research is that, in order to be effective, prevention strategies must address the underlying factors driving a problem. It doesn't matter how carefully a program or practice is implemented, if it's not a good match for the problem, it's not going to work.

Fidelity and Adaptation Fidelity refers to the degree to which a program is implemented as its original developer intended. Programs or practices that are implemented with complete fidelity are most likely to be effective. Yet practitioners often find the need to change the interventions they've selected. They may be working with a target population that is in some way different from the population that was originally evaluated. Or they may need to change certain program elements due to budget, time, or staffing restraints. In these cases, practitioners may adapt the program or practice to meet local circumstances. Balancing fidelity and adaptation can be tricky because any time you change an intervention, you may be compromising outcomes. Even so, implementing a program that requires some adaptation may be more efficient, effective, and cost-effective than designing a program from scratch. However, if adaptations are to be made, prevention coalitions need to work with the developer of the EBP to be modified to make sure the changes do not negatively impact program fidelity.

Request for Approval of Evidence Based Program or Promising Practice

Note: *This form must be completed (separately) for each of your EBP's that were not pre-approved (e.g., not included on South Dakota's pre-approved EBP list). Provide answers/information below.*

Coalition/Agency/Department Name and Contact Information:

EBP Name:

What target behavior(s) or environmental change is targeted by the EBP?

What type of EBP is this?

_____Individual-Based _____Population-Based _____ Both Individual and Population Based

Explain:

The EBP being submitted for approval: *(✓check one)*

___Included on Federal Lists or Registries of evidence-based interventions;

OR

___Has been reported (with positive effects on the primary targeted outcome) in a **peer-reviewed journal**;

The following documentation for this category of programs must be submitted as attachments to this completed form:

- Narrative description of the program, including how you are planning to implement this strategy. Please attach any supportive materials, such as a curriculum, syllabus, or implementation guide that you plan to follow. (in electronic form, if possible)
- Description of how well outcomes of the original evidence-based intervention match the expected outcomes in your community
- Explanation of why this strategy was chosen, rather than one of the approved evidence-based interventions
- Any evaluation data showing evidence of effectiveness (including information such as study design, number of studies/evaluations, consistency across studies/evaluations, population size of the study, and evidence of long-term effects).

OR

___Has **documented effectiveness** supported by other sources of information and the consensus judgment of informed experts based on the following guidelines (provide documentation for each of the following).

The following documentation for this category of programs must be submitted as attachments to this completed form:

- The intervention is based on a theory of change that is documented in a clear logic or conceptual model **(required)**;
- The intervention appears in a registry(ies) and/or the peer-reviewed literature; **and/or**
- The intervention is supported by documentation that it has been effectively implemented in the past in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; **and/or**
- The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

- Please list all sources for which documented evidence of effectiveness is available. In addition, please include a copy of each source (in electronic format, if possible) along with this form when you submit it.

Rev

- Describe how you are planning to implement this strategy and attach any supportive materials, such as a curriculum, syllabus, or implementation guide that you plan to follow (in electronic format, if possible).

**** Explain evidence and documentation supporting this EBP or Promising Practice**

What training is required to implement the EBP with fidelity: What are the costs of the training and what resources will be used to support the training?

** Explain training requirements here

Ability to Implement with Fidelity: Will this strategy be implemented as intended in your community?

____ Yes, this EBP will be implemented as intended. (Skip to the next question)

____ No, we will be making some changes to how this EBP is implemented…to better address our target population or the readiness/abilities of our community/coalition. (Discuss below**)

** Explain your changes here.

Test Cultural Fit: Is this EBP culturally appropriate and culturally relevant for your target population?

____ Yes, this strategy is culturally appropriate and relevant as intended. (Skip to the next question)

____ Yes, but we have modified it to make it more culturally appropriate and relevant for your community. (Discuss below***)

***Explain your modifications here.

Test Sustainability: What will be needed to sustain this EBP in your community beyond the PFS or other present funding? (place an X next to all that apply)

_____Additional funding
_____Almost nothing, it should be sustainable on its own
_____Strong support from stakeholders
_____Other, please specify

***Explain your plan for sustaining the EBP.

2. Using the chart below, provide the following information on the EBP you are requesting approval for:

EBP Title	Anticipated Outcomes	Ages	Races/Ethnicity	Settings	Cost
	1.				

Attachments included with documentation of programming mailed.

Logic Model – Please complete the logic model below for the EBP.

Problem and Related Behaviors the EBP will Address	Risk/Protective Factors	EBP/Intervention	Short Term Outcome (s)	Long Term Outcome(s)

TABLE OF CONTENTS

I. South Dakota PFS Goals

The South Dakota PFS will prevent the onset and reduce the progression of underage drinking in adolescents and young adults (ages 12-20). The strategies chosen by the sub-recipients (community coalitions) will influence the evaluation as we move forward. However, a majority of sub-recipients (community coalitions) will implement both individual-focused strategies (e.g. school-based programs) and environmental strategies (e.g. social access policies); the evaluation team will collect the appropriate data for each strategy that is implemented by the sub-recipient (community coalition). The second goal is to improve the substance about infrastructure in the state and funded communities. Specifically:

1) Implement the SPF process at the state and community levels;
2) To reduce underage drinking (ages 12-20) and consequences by using a data-driven decision-making process (SPF) and implementing evidenced-based prevention programs;
3) To enhance and sustain prevention system capacity to implement EBP to reduce underage drinking; and
4) Leverage substance abuse prevention resources and align statewide funding streams to improve efficiency.

A. Overview of the Evaluation Plan

The SPF PFS initiative is a complex effort to change the substance abuse system at the national, state and local levels. The goals and objectives at these three project levels are detailed in **Figure 1** below. It includes extensive data collection by the state and sub-recipients (community coalitions), which are reported via the mandated PEP-C reporting system and community outcomes that are appropriate to the state and community.

Figure 1: Project goals and objectives by level of the evaluation

Levels of evaluation	GOALS	PROCESS OBJECTIVES	OUTCOME OBJECTIVES
National SPF-PFS	1. Improve Prevention infrastructure and capacity in the states through the SPF Process. 2. Reduce incidences and consequences of underage drinking.	Cross-Site Evaluation: collection of evaluation data: GLI-R, CLI-R (PEP-C), quarterly reporting, and Community Outcomes.	PFS Outcome Measures related to substance use, intervening variables, and consequences.
South Dakota SPF-PFS	1. Improve Prevention infrastructure and capacity in South Dakota through the SPF Process. 2. Reduce incidences and consequences of underage drinking (age 12-20). 3. To streamline prevention funding and resources across the state of South Dakota.	1. Implement 5-step SPF process for state. 2. Maintain and update data infrastructure. 3. Provide training and technical assistance to address gaps in the current substance abuse prevention systems. 4. Develop a plan to streamline funding resources.	1. Reduce the incidence and consequences of underage drinking among youth ages 12 to 20 years. 2. Collect alcohol-related arrests for entire state.

Sub-Recipients **SPF-PFS Coalitions**	1. Reduce underage drinking (ages 12-20).	1. Increase coalition capacity. 2. Implement 5-step SPF process. 3. Choose and implement EBPs. 4. Change community outcomes.	1. **Consumption:** 30-day use of alcohol and binge drinking. 2. **Intervening variables:** Perception of harm for alcohol use. 3. **Consequences:** alcohol related arrests

II. Evaluation Questions

1. General Evaluation Questions

B Consulting, LLC will conduct the outcome evaluation to answer three primary questions:

1) Was implementation of PFS evidenced programs associated with a reduction in underage drinking?
2) Did South Dakota achieve outcome objectives set forth by South Dakota Prevention Team and National Cross-Site Evaluation Team? and
3) Was prevention capacity and infrastructure at the state and sub-recipients (community coalition) levels improved?

2. Process Evaluation Questions

How well the PFS was implemented at the state and sub-recipient (community coalition) levels? This question will be addressed through collection and analysis of records, participant observations, PEP-C reporting, EBP fidelity tool, community surveys, GLI, coalition capacity checklist, sub-recipient (community coalition) annual work plans, and sub-recipient (community coalition) evaluation plans (**see Figure 2 in Section III for detailed performance measure collections**). This qualitative and quantitative data are relevant to five sub-questions:

1) Did the implementation of the SPF PFS match the plan;
2) What deviations from the plan occurred and what led to the deviations;
3) How was fidelity of EBP ensured;
4) What impact did the deviations have on the intervention and evaluation; and
5) Who provided what services to whom in what context and at what cost?
6) Does dosage of EBPs have an effect on outcome measures?

3. Outcome Evaluation Questions

1) Was underage drinking and its related problems, especially those regarding consumption, intervening variables, and consequences, prevented or reduced;
2) Did SD achieve the outcome objectives (see section 1 goals and objectives) and;
3) Was prevention capacity and infrastructure at the state and sub-recipient (community coalition) levels improved?

The first two questions will be addressed through collection and analysis of quantitative data; the third question through a multi-method approach. All data will be relevant to three outcome sub-questions:

a) What was the effect of the PFS on service capacity and other system outcomes;
b) Did the PFS project achieve the intended project **goals; and**
c) What program/contextual factors were associated with outcomes?

(**See Section IV for detailed Outcome Measures and collection methods)**

III. REQUIRED PERFORMANCE MEASURES

The South Dakota SPF PFS encompasses the grantee, State of South Dakota Department of Social Services: Prevention Program, and 14 sub-recipients (community coalitions) that span across the whole state. Multiple tools will be utilized to collect data needed for the evaluation plan and the mandated performance measures that are located in the PEP-C. Below is a list of tools that will be utilized to collect said measures.

1) Key stakeholder interviews (KSI) semi structured interviews of a representative state and community program staff. The interview protocol will assess general progress in implementing improved programming. The information collected will include:

The implementation of the project at both the state and community levels for adherence to or deviation from work plans, reasons for implementation changes, impact of deviations, prevention activities supported by leveraging resources;

- Updated work plans based on implementation and evaluation efforts;
- Needs and gaps in the service system; and
- Cultural appropriateness and reach.

2) Coalition Capacity Checklist (CCC) the Coalition Capacity Checklist, designed to measure prevention capacity and infrastructure development in South Dakota at the coalition level, and will be the main data source for answering the primary evaluation question, "Was prevention capacity and infrastructure at the coalition levels improved." And secondarily, "What was the effect of the SPF on service capacity and other system outcomes." To answer those questions the B Consulting evaluators will compare the data from the pretest (Fall 2014) with the post-test scheduled for the summer of 2019.

This assessment tool will solicit the views of each community grantee's coalition coordinator and coalition members about the structure and operation of the coalition. It is intended to gauge the current capacity of the coalition to function effectively in implementing the five steps of the SPF-PFS process. Information gained is intended to be helpful to coalitions in assessing their current capabilities, identifying areas that may need enhancement and used to inform statewide evaluation efforts with respect to the goal of building prevention capacity and infrastructure at the community level.

3) Population-level epidemiological data (ED) will be tracked using national surveillance datasets (NSDUH, BRFSS, and YRBS) and NOMS data indicators (specifically alcohol use in the past 30-days by youth 12 to 20). Since the project will include two counties with significant Native American populations and three counties with significant African American populations,

particular attention will be paid to outcomes in populations for which data are not typically available.

4) Participant observations (PO) will be made by evaluation staff on an ongoing basis to provide important qualitative data on State and sub-recipients (community coalitions) - level organizational and structural change. Standardized forms will not be used for data collection. South Dakota Prevention team is also requiring that sub-recipients (community coalitions) who use individual EBPs must have their participants complete a pre and post South Dakota Participant-Level Survey (SD PLI). The SD-PLI is very similar in nature to the PLI that was required by SPF-SIG; however, this survey has been modified to ask the participant questions that are relevant to South Dakota's population.

5) Program records and archives (RA) documenting the work of the SPF-PFS Advisory Committee and state prevention staff will track progress in infrastructure, capacity building, and environmental changes. Standardized forms will not be used for data collection. We will collect process data specific to process evaluation questions through records and observations, document and policy content analyses, and secondary data sets including archival records.

6) Fidelity assessment (FA) sub-recipients (community coalitions) will complete fidelity assessments of their EBPs. This assessment will be based on the National Implementation Research Network at the University of North Carolina at Chapel Hill. Accessed April 8, 2014 from www.implementation.fpg.uncat.edu.

7) Project management data reporting system (MRS) - South Dakota uses a customized version of MOSAIX data reporting system to manage all substance abuse prevention programs funded by the state. This data will provide a rich source of management data to supplement PEP-C reports. Information that is collected from the sub-recipients (community coalitions) includes: number of participants served, EBPs, cost of services, demographics of participants, coalition meetings, trainings, and additional activities performed.

Figure 2 below describes an overview of the indicators related to the required process measures and the instruments that will be utilized to collect this information.

Figure 2: Required Process Measures to be Reported

Indicators	Instruments	Indicators	Instruments
# Of training and technical assistance activities per funded community.	PEP-C, PO & KSI	# Of active collaborators supporting the community's comprehensive prevention approach.	CCC
Reach of the training and technical assistance provided by the state (numbers served).	GLI, CLI-R, PO & KSI	# of people served or reached by IOM category, six strategies and demographic group.	PO, PEP-C & MRS
% of communities that have increased the number and % of EBPs provided.	MRS & PEP-C	# Of EBPs implemented in the community.	PEP-C & MRS
% of communities that report an increase in prevention activities supported by leveraging resources.	SKI & CCC	# Of prevention activities that are supported by collaboration and leveraging funding streams.	KSI & RA
% of communities that submit data to the grantee data system.	PEP-C, MRS	#, type and duration of EBPs by prevention strategy implemented in the community.	PEP-C, KSI & RA
*****See above for definitions.			

IV. REQUIRED OUTCOME MEASURES

1. Grantee-Level Measures for PFS

The State of South Dakota does not have a state survey used to measure substance use and this has provided a challenge to collect substance use and intervening variables (risk and protective factors) across the state. However, the state has an extensive Uniform Crime Reporting system that allows the state to collect alcohol-related arrests at the city level (Police Department) and county level (Sheriff Office). This data was an effective measurement tool to assess sub-recipients (community coalition) and the state in the South Dakota SPF SIG. The State of South Dakota will be collecting the following outcome consequence measure:

1) Alcohol-related crime; and

2. Sub-Recipient (community coalition) -Level Measures for PFS

The sub-recipients (community coalitions) have several methods of how they will collect outcome measures. First, sub-recipients (community coalitions) will be utilizing their community-level surveys, and secondly, the South Dakota PLI (SD-PLI) for participants who participate in individual prevention education EBPs.

1) Community-Level Survey: Each sub-recipient (community coalition) has a community level survey that collects substance use and intervening variables along with demographics and additional information. This data is collected on an annual basis. Eleven (11) of the fifteen (15) sub-recipients (community coalitions) have above a 70% response rate. Technical assistance has been requested for the four (4) sub-recipients (community coalitions) that have below the 70% response rate.

2) South Dakota Participant-Level Instrument (SD-PLI): The State of South Dakota is requiring that their sub-recipients (community coalitions) collect participant level data on individuals who participate in prevention education EBPs. This instrument is similar in nature to the PLI that was required in SPF SIG; however, participants will not be matched and will only take a pre and post survey.

Sub-recipients (community coalitions) will be required to collect the following outcome measures at both the community level and at the participant level to be reported to the national cross-site evaluation team:

Substance Use

1. Past 30-day alcohol use
2. Binge drinking

Intervening Variables (Risk and Protective Factors)

3. Perceived risk or harm of use for alcohol

Consequences (Community and County Level)

4. Alcohol-related crime

V. Measurement

The required outcome measures in **Section IV** will be measured in multiple ways. At the grantee (**figure 3)** and sub-recipient (community coalition) level (**figure 4)** each measures is illustrated

by the indicator, the measure, outcome, source of data, the frequency it is collected, and the method of collection. The sub-recipient (community coalition) community surveys are also important. **Figure 5** defines each community survey, their population, response rate, need for technical assistance, and data collection methods. Finally, the evaluation data collection is time lined and shows details of how it will be collected in **figure 6 and 7.**

1) Grantee-Level measures (**figure 3**)
2) Sub-Recipient (community coalition) community measures (**figure 4**)
3) Sub-Recipient (community coalition) community surveys **(figure 5)**
4) Evaluation data collection timeline **(figure 6)**
5) Evaluation Data collection details (**figure 7)**

Figure 3: Grantee-Level Measures for PFS

Indicator	Measure	Outcome	Sample Size	Source	Frequency Collected	Method of Collection	Level of Data
Alcohol-Related Crime*	Measure calculation: The number of alcohol-related arrests divided by the total number of arrests and multiplied by 100	Measure calculation: # of alcohol-related arrests divided by the total number of arrests and x100	Approx. of 6,000 total juvenile arrests per year with an average of 1,300 alcohol related arrests	Uniform Crime Reporting (UCR) Program	Annual (summer)	Administrative Data	State

*Alcohol-related arrests include the following Uniform Crime Reporting [UCR] categories: DUI and Liquor Law Violations.)

Figure 4: Sub-Recipient (community coalition) Community-Level Measures for PFS

Indicator	Measure	Measure Response	Outcome	Source	Frequency Collected	Method of Collection	Level of Data
Substance use: Past 30 day alcohol use	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	A number between 0 and 30	Percent who reported having used alcohol during the past 30 days (i.e., percent who responded 1 or more days)	School Survey	Annual	In-person collection in sub-recipient (community coalition) schools.	Community

Figure 4: Sub-Recipient (community coalition) Community-Level Measures for PFS							
Indicator	**Measure**	**Measure Response**	**Outcome**	**Source**	**Frequency Collected**	**Method of Collection**	**Level of Data**
Substance use: Binge drinking	During the past 30 days, on how many days did you have 5 or more drinks on the same occasion?	A number between 0 and 30	Percent who reported having binge drank during the past 30 days (i.e., percent who responded 1 or more days)	School Survey	Annual	In-person collection in sub-recipient(community coalition) schools	Community
Perception of Harm: Alcohol	How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?	No risk, Slight risk, Moderate risk, Great risk	Percent reporting moderate or great risk (i.e., percent reporting "moderate risk" and percent reporting "great risk" combined)	School Survey	Annual	In-person collection in sub-recipient (community coalition) schools	Community
Alcohol-Related Crime*	Measure calculation: The number of alcohol-related arrests divided by the total number of arrests and multiplied by 100	N/A	Measure calculation: The number of alcohol-related arrests divided by the total number of arrests and multiplied by 100	Uniform Crime Reporting (UCR) Program	Annual (summer)	Administrative Data	Community and/or County
*Alcohol-related arrests include the following Uniform Crime Reporting [UCR] categories: DUI and Liquor Law Violations.)							

Figure 5: Sub-Recipient (community coalition) Community Level Survey Data						
Sub-Recipient (community coalition) Name	**Survey Name**	**Population**	**Sample Size**	**Response Rate**	**TA Needed**	**Data collection**
1. Aberdeen Roundtable Coalition	Pride	Grades 6th-12th	2195	85% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 6th-12th on the day the survey is administrated.
2. Action for a Betterment of the Community	Meade Survey	Grades 6th, 8th, 10th, and 11th	708	73% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in grades 6th, 8th, 10th, and 12th on the day the survey is administrated.
3. Aliive-Roberts County	Pride	Grades 6th-12th.	850	90.80% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 6th-12th on the day the survey is administrated.
4. Coalition for a Drug Free South Dakota	Safety Survey	Grades 9th-10th	3557	74.10% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 9th-10th on the day the survey is administrated.
5. Coalition for Drug Free Yankton	Yankton School District Survey	Grades 5th-8th	573	93.40% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 5th-8th on the day the survey is administrated.
	Yankton School District Survey	Grades 9th-12th	875	83.40% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 9th-12th on the day the survey is administrated.
6. EMPOWER Coalition of Southern Hills	Pride	Grades 6th-12th	433	79.7% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 6th-12th on the day the survey is administrated.
7. Lemmon SAFE Communities	Lemmon SAFE survey	Grades 6th-12th	213	95% Calculated by total number of surveys divided by the	NO	Census of students in Grades 6th-12th on the day the survey is administrated.

Sub-Recipient (community coalition) Name	Survey Name	Population	Sample Size	Response Rate	TA Needed	Data collection
				enrollment population.		
8. Lifeways Rapid City Coalition	Rapid City Alcohol Survey	Grades 6th-9th and 11th	5126	50.70% Calculated by total number of surveys divided by the enrollment population.	YES	Census of students in Grades 6th-9th and 11th on the day the survey is administrated.
9. NSU Campus Community Coalition	NSU student Survey	NSU students	327	97.50% Calculated by the total number of responses divided by the total number of participants in the stratified group.	NO	Stratified group of random students.
10. Oyate Okolakiciye Coalition	Community Health and Well-being Survey	Ages 11- adulthood in Rapid City Ward 4-2 and 4-3.	500	8.20% Calculated by the total number of responses divided by the total number of randomly selected participants.	YES	Randomly selected individuals located in the population group.
11. Rural Sioux Empire Coalition for Youth	Carroll Institute Survey	Grades 6th-12th	4434	82.20% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 6th-12th on the day the survey is administrated.
12. Spink Coalition	Pride	Grades 7th-12th	550	77% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 7th-12th on the day the survey is administrated.
13. Watertown Healthy Youth Coalition	Pride	Grades 7th-12th	1785	80% Calculated by total number of surveys divided by the enrollment population.	NO	Census of students in Grades 7th-12th on the day the survey is administrated.
14. Wicozani Patintanpi	Wicozani Patintanpi Community Use Survey	Ages 11- Adult	500	20% Calculated by the total number of surveys divided by the number	YES	Census of individuals at the SGU Founders Day and Spring POW WOW.

Sub-Recipient (community coalition) Name	Survey Name	Population	Sample Size	Response Rate	TA Needed	Data collection
				individuals at the 2 events.		

Figure 6: Evaluation data collection timeline			
Instrument	**Contents**	**Who completes?**	**Frequency**
CCC	Coalition Capacity Checklist	Coalition managers and local evaluators	Beginning of SPF-PFS and year 5.
KSI	Key Stakeholder Interview	State evaluation staff conducts with state and coalition stakeholders	Year one and in year five.
NOMs	National Outcome Measures	Existing population data, unless unavailable	Submitted to PEP-C in November annually
ED	Population-level epidemiological data	SEOW for state data and local evaluators for coalition data (community outcomes)	As available
FA	Fidelity assessment	Coalition managers and local evaluators	Beginning of EBP implementation and annually
MRS	South Dakota's project management system	Staff of the funded coalitions	Monthly
PO	Participant observations & observations	State evaluation staff	Ongoing
PR	Program records and archives	State evaluation staff analyzes data from Kits Solution records	Ongoing
SD-PLI	Individual-level surveys	Individual participants (IF AVAILABLE)	Pre and Post of EBP

Figure 7: Evaluation Data collection details					
Ongoing Data Collection	**Purpose**	**Frequency/ Schedule**	**Format**	**Who enters data**	**Access to the data**
Coalition Capacity Check list	Require by South Dakota SPF PFS project as part of the state-level evaluation.	Twice. Pretest is completed (2014) and Post (2019).	Pre and Post-test are web-based.	B Consulting, LLC	Coalitions maintain own records of data supplied to B Consulting, LLC.
South Dakota Participant-Level Instrument (SD PLI)	SD Prevention is requiring coalitions to collect data on all persons participating in an individually-focused program.	Pretest and Post of individual based EBP. Coalition Evaluators must submit an excel document to B Consulting, LLC at least 1x per year with survey data.	Coalitions will decide based on resources if survey will be conducted by paper or via web.	Coalition evaluators will submit excel files to B Consulting.	The State of South Dakota, State Evaluators, and State Epidemiologist will have access to all data.

Figure 7: Evaluation Data collection details					
Ongoing Data Collection	**Purpose**	**Frequency/ Schedule**	**Format**	**Who enters data**	**Access to the data**
Community-Level Instruments, Revised (CLI-R)	CSAP requires data about the Coalition, its progress in implementing the project and its progress going through the Strategic Prevention Framework.	Annually, however most will not change from year to year. The exception is the section on demographics which are reported every quarter.	PEP-C defined format.	Coalitions, State of South Dakota Prevention Staff and B Consulting, LLC.	Coalition Directors have access to this data within 24-hours depending on the functioning of the PEP-C system.
Community Outcome Data	CSAP required information on the impact of EBPs (interventions) on priorities for the entire service area: the data is parallel to the coalition's service area.	At least twice. The baseline data will be from a period prior to implementing the EBP (Spring 2015) and will be updated as it becomes available.	Pre- defined format. Fillable Excel document sent in Summer. Two forms: one for surveillance or event data and one for community surveys.	B Consulting, LLC from data provided by the local evaluators with input from Coalitions.	Coalitions maintain own records of data supplied to B Consulting, LLC.

VI. BEHAVIORAL HEALTH DISPARITIES

1. Subpopulation

South Dakota's geography consists of a mix of urban, sub-urban, small towns, rural, and frontier landscape spread across over 75,000 square miles and home to approximately 833,354 residents. A large number of counties in the state have a population base of five persons or less per square mile. The enormous challenge is providing statewide services to ensure all citizens have access to needed services, including prevention and intervention services for substance abuse and mental health services. Sioux Falls (159,908) and Rapid City (69,854) are the largest cities. Nine towns have 10,000 to 30,000 residents and five communities have 5,000 to 10,000 residents. The remainder of the citizens are spread out across wide stretches of agricultural and prairie lands dotted by farms and small communities.

The population of South Dakota is 86.2% Caucasian. American Indians make up 8.9% of the population within the state that includes nine tribal reservations. Other racial groups comprise 4.9% of the population and are a mix of Black, Hispanic, Asian, and minority immigrants from Africa, Eastern Europe and Southeast Asia.

It should be noted that the dichotomy of our population varies depending on the location. For example, the mid-section of the state, which includes a number of Native American Reservations, is approximately 25% Native American, although the population density is rather low. While other portions of the state is 90-95% White with other races and ethnic groups making up the balance in small percentages. A strong immigrant tradition continues in the state,

which has become home to small sub-groups of Somalian, eastern European, and the Karen from Southeast Asia.

Overall, the South Dakota SPF-PFS grant is projecting to reach directly over 51% of the 12 to 20 year old population of the state. The South Dakota SPF-PFS grant will also reach a majority of racial and ethnically diverse youth age 12 to 20. The only group other than the White 12 to 20 years old for which the South Dakota SPF-PFS grant will reach less than 60% of the population is for American Indians. The South Dakota SPF-PFS grant will reach 40% of the American Indian youth, but there are other SPF funded grantees that are operating within the largest American Indian communities and will also be providing services to Native youth and young adults.

The numbers in the **figure 8** below reflects the proposed numbers of individuals to be served during the grant period through the projects services and all identified subpopulations in the grant service area.

Figure 8

Proposed Numbers to be Served *

	Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4	Grant Year 5
Direct Services: Number to be served	53,097	53,628	54,164	54,706	55,253
By Race/Ethnicity					
African American	1,745	1,762	1,780	1,798	1,816
American Indian/Alaska Native	4,907	4,956	5,006	5,056	5,106
Asian	963	973	982	992	1,002
White (non-Hispanic)	40,307	40,710	41,117	41,528	41,944
Hispanic or Latino (not including Salvadoran)	3,118	3,149	3,181	3,212	3,245
Native Hawaiian/Other Pacific Islander	31	31	32	32	32
Two or more Races	2,026	2,046	2,067	2,087	2,108
By Gender					
Female	25,500	25,755	26,013	26,273	26,535
Male	27,597	27,873	28,152	28,433	28,718

*Based on annual 1% increase estimation.

2. Implementation of Interventions to Decrease Behavioral Health Disparities

The South Dakota's SPF-PFS is proposing a systems wide approach to target youth and reduce underage drinking in South Dakota. The project's interventions will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community in which the services are occurring. The project will contract with local community sub-recipients (community coalitions) who are familiar with the local culture and will collaborate with the community leaders in planning the design and implementation of program activities to ensure the cultural and linguistic needs of participants in community-based programs are effectively addressed, particularly the disparate populations.

The project will use a continuous quality improvement approach to assess and monitor key GPRA performance indicators as a mechanism to ensure high-quality and effective program operations. Data collected will be used to monitor and manage program services and outcomes by race and ethnicity status within a quality improvement process. Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program services.

A primary objective of the data collection and reporting will be to monitor/measure project activities in a manner that optimizes the usefulness of data for project staff, sub-recipients (community coalitions) and youth and families; formative evaluation findings will be integrated into program planning and management on an ongoing basis (a formative evaluation). For example, program participation data will be collected by sub-recipients (community coalitions) staff and reported to state staff on an ongoing basis, including analyses and discussions of who may be more or less likely to enroll and complete the program (and possible interventions). The sub-recipients (community coalitions) will utilize the expertise of local evaluators to meet on a regular basis with the sub-recipients (community coalitions) and project team, providing an opportunity for staff to identify successes and barriers encountered in the process of project implementation. These meetings will be a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success. Outcomes for all services and supports will be monitored across race and ethnicity to determine the grant's impact on behavioral health disparities.

Our quality improvement plan will support and ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

1) Diverse cultural health beliefs and practices training and hiring protocols will be implemented to support the culture and language of the South Dakota population;

2) Preferred languages Interpreters and translated materials will be used for non-English speaking clients as well as those who speak English, but prefer materials in their primary language. Key documents will be translated into the preferred language of choice for the participant; and

3) Health literacy and other communication needs of all sub-populations identified in the proposal. All services programs will be tailored to include limited English proficient individuals. Staff will receive training to ensure capacity to provide services that are culturally and linguistically appropriate.

VII. ANALYSIS PLAN

1. Process Evaluation Questions

1) Did the implementation of the SPF PFS match the plan;

   Analysis will be conducted by reviewing Grantee and sub-recipient (community coalition) strategic plan and evaluation plan. Detailed assessment of activities will be conducted annually to track changes in their plans.

2) What deviations from the plan occurred and what led to the deviations;

   Analysis of deviations from the plan will be reviewed annually.

3) How was fidelity of EBP ensured;

   The fidelity assessment document will be utilized by the sub-recipients (community coalitions) at the beginning of implementation of their EBP and annually. Fidelity tool will also pay special attention to the dosage of the designed EBP and the dosage of implementation.

4) What impact did the deviations have on the intervention and evaluation; and

   Qualitative analysis will be utilized to discuss the impacts of the interventions and activities.

5) Who provided what services to whom in what context and at what cost?

   Quantitative and qualitative analysis will be conducted to evaluate services provided and the cost of services.

6) Dosage of EBP interventions will be reported and monitored in the CLI-R along with detailed report kept by sub-recipients (community coalitions). Dosage will be analyzed with outcome measures to determine if dosage was a significant factor.

A. Analysis of Process Evaluation Questions (See Performance Measures located in Section III for details of measures)

1) Key stakeholder interviews (KSI): Qualitative analysis will be conducted to evaluate implementation.
2) Coalition Capacity Checklist (CCC): Quantitative and Qualitative analysis will be utilized to evaluate the capacity of the sub-recipients (community coalitions) between their pre and post surveys.
3) Participant observations (PO): Qualitative data on State and sub-recipients (community coalitions) - level organizational and structural change will be collected.
4) Program records and archives (RA): Qualitative analysis of the documented work of the SPF-PFS Advisory Committee and state prevention staff will be analyzed to evaluate infrastructure, capacity building, and environmental changes.
5) Fidelity assessment (FA): Pre-FA and annual FA will be analyzed to evaluate EBP implementation and dosage of EBP.
6) Project management data reporting system (MRS): Quantitative analysis will be conducted to report changes in the number of participants served, EBPs, cost of service, demographics of participants, coalition meetings, trainings, and additional activities performed.

2. Outcome Evaluation Questions

1) Was underage drinking and its related problems, especially those regarding consumption, intervening variables, and consequences, prevented or reduced;
2) Did SD achieve the outcome objectives **(See section IV)** and;
3) Was prevention capacity and infrastructure at the state and sub-recipient (community coalition) levels improved?

The first two questions will be addressed through collection and analysis of quantitative data and the third question through a multi-method approach. All data will be relevant to three outcome sub-questions:

a) What was the effect of the PFS on service capacity and other system outcomes;
b) Did the PFS project achieve the intended project **goals; and**
c) What program/contextual factors were associated with outcomes?

A. Grantee-Level Outcome Evaluation

1. Alcohol-related crime: Quantitative analysis will be conducted with this data. Trend data will be analyzed from 2010 to present.

B. Sub-Recipient (community coalition) Level Outcome Evaluation

Substance Use

1. Past 30-day alcohol use
2. Binge drinking

Intervening Variables (Risk and Protective Factors)

3. Perceived risk or harm of use for alcohol

Outcomes 1-3 will be analyzed two different ways. First, 1-3 will be analyzed from sub-recipient (community coalition) community surveys. These community surveys vary in sample sizes depending on the population of the community. Communities also have trend data in regards to 30 day alcohol use, binge drinking, and perceived risk or harm for alcohol that goes back at least 4 years. Quantitative analysis will be conducted to evaluate these measures. Secondly, sub-recipients (community coalitions) will collect all three measures through the SD-PLI. This data will consist of pre and post data and quantitative analysis will also be conducted.

Consequences (Community and County Level)

4. Alcohol-related crime: Quantitative analysis will be conducted with this data. Trend data will be analyzed from 2010 to present.

In general, the evaluation staff will analyze program participant outcome data using analysis of variance (ANOVA) and analysis of covariance (ANCOVA) to determine whether the targeted changes in prevalence of substance use, age of onset, underage drinking outcomes, risk and protective factors have occurred. Local systems-level change data will be analyzed both quantitatively (i.e. with Student's t-test) and qualitatively, as appropriate. Geographic Information Systems or Spatial Dynamic Models may also be used to analyze data collected to evaluate environmental approaches to prevention as appropriate.

Qualitative data specific to answering process and some of the outcome evaluation questions using interview protocols that follow standardized qualitative methods will be collected (Tashakorri and Teddlie 2003; Campbell and Russo 2001; Denzin and Lincoln 2000; Creswell 1998; Patton 1997). Process data analysis will include content analysis, chronology of events, secondary data sets, frequency tables and an overall systems analysis of each county's ATOD prevention system. We will use content analysis to integrate the findings of the sub-recipients' (community coalitions) proposals and annual reports into the state level reports (Miles and

Huberman1994; Patton 1990; Gruenewald 1997). Software for qualitative data analysis (Atlas t.i.) will be another available resource for managing and analyzing text and interview data.

Unfortunately, South Dakota does not have access to a control or comparison communities to provide another level of data analysis.

VIII. PARTICIPATION IN THE PFS NATIONAL CROSS-SITE EVALUATION

Throughout the evaluation plan, the evaluation team has been very cognizant of the data requirements from the National Cross-Site Evaluation Team. The evaluation team will adhere to all PEP-C reporting requirements and timelines. In addition, sub-recipients (community coalitions) will be collecting the following data.

1) Past 30-day nonmedical use of prescription drugs
2) Perceived risk or harm of use for nonmedical use of prescription drugs
3) Prescription drug-related emergency room visits (Collected at Grantee and Sub-Recipient (community coalition) level)

IX. REPORTING PLAN

The grantee and sub-recipients (community coalitions) will report annual updates and findings to their key stakeholders at the Annual Prevention Conference. The evaluation team has weekly contacts with grantee and monthly contacts sub-recipients (community coalitions). The grantee also has at least monthly contacts with sub-recipients (community coalitions) if not more frequently.

The evaluation team will submit a final evaluation report to PEP-C at the end of SPF PFS per PEP-C requirement.

X. B CONSULTING, LLC EVALUATION FUNCTIONS

Three major functions of the South Dakota PFS evaluation:

1. Provide data to the national cross-site instruments and schedule for federal data collection;
2. Conduct an evaluation of the state PFS project in the State of South Dakota;
3. Provide technical assistance and guidance to local evaluators for individual sub-recipients (community coalitions) evaluations; and
4. Additional tasks:
   - Participate in South Dakota's PFS management team;
   - Cooperate with national cross-site evaluation team to further refine evaluation methods and design;
   - Participate in the South Dakota PFS Advisory Council; and

- Attend required CSAP meetings for state staff and evaluators.

1. Training and Technical Assistance

A major focus of the South Dakota SPF PFS will be training and technical assistance for the funded sub-recipients (community coalitions). These activities can be broken into four types:

- Learning about the requirements of the SPF PFS and the State contracting;
- How to implement the five steps of the SPF process;
- How to evaluate sub-recipients (community coalitions) efforts and the implementation of EBPs; and
- Training on implementing specific EBPs.

The state evaluation team, from B Consulting, LLC, will conduct an Evaluation Training and Technical Assistance Needs Assessment Survey in late 2014 to early 2015 to prepare the most appropriate training for the South Dakota SPF PFS sub-recipients (community coalitions).

Throughout the course of SPF PFS, B Consulting, LLC staff will be actively involved with each of the sub-recipients (community coalitions). Sub-recipient (community coalition) directors and evaluators will have monthly and weekly contact with B Consulting, LLC staff via email, phone, and in - person. B Consulting, LLC staff will help directors develop their evaluation plans that included measureable goals and objectives along with helping them establish community outcome measures that could be utilized to measure their programs and efforts.

B Consulting, LLC staff will also provide a substantial amount of technical assistance with the PEP-C data reporting requirements. Assistance ranged from trouble shooting the PEP-C system to how a sub-recipient (community coalition) needs to accurately report data on their EBPs in the PEP-C system.

Environmental Factors and Plan

Primary Prevention - SABG

Assessment

1. **Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?** ☒ Yes ☐ No
2. **Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):**
   a. ☒ Data on consequences of substance-using behaviors
   b. ☒ Substance-using behaviors
   c. ☒ Intervening variables (including risk and protective factors)
   d. ☐ Other (please list)
3. **Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply):**
   a. ☐ Children (under age 12)
   b. ☒ Youth (ages 12-17)
   c. ☒ Young adults/college age (ages 18-26)
   d. ☒ Adults (ages 27-54)
   e. ☒ Older adults (ages 55 and above)
   f. ☒ Cultural/ethnic minorities
   g. ☐ Sexual/gender minorities
   h. ☒ Rural communities
   i. ☐ Other (please list)
4. **Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):**
   a. ☐ Archival indicators (please list)
   b. ☒ National Survey on Drug Use and Health (NSDUH)
   c. ☒ Behavioral Risk Factor Surveillance System (BRFSS)
   d. ☒ Youth Risk Behavior Surveillance System (YRBS)
   e. ☐ Monitoring the Future
   f. ☐ Communities that Care
   g. ☐ State-developed survey instrument
   h. ☒ Other (please list) Local community and school survey data.
5. **Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?** ☒ Yes ☐ No
   a. If yes, please explain. The state requires that each local prevention coalition complete a needs assessment. This information, along with regional and statewide data, are factors in determining which of the state's five behavioral health planning regions have the highest need for funding.
   b. If no, please explain how SABG funds are allocated.

Capacity Building

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

a. If yes, please describe The South Dakota Board of Addiction and Prevention Professionals has a certification process for Prevention Specialists.

2. **Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?** ☒ Yes ☐ No
   a. If yes, please describe mechanism used The state contracts with three prevention resource centers to provide training and technical assistance to communities, schools, local coalitions and the prevention workforce.
3. **Does your state have a formal mechanism to assess community readiness to implement prevention strategies?** ☒ Yes ☐ No
   a. If yes, please describe mechanism used: Each funded coalition needs to complete a local needs assessment, which allows the state to determine a community's readiness to change.

Planning

1. **Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?** ☒ Yes ☐ No
   a. If yes, please attach the plan in BGAS See attachement A - SD DSS Prevention Program Five Year Strategic Plan (2015-2020).
2. **Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?** ☒ Yes ☐ No ☐Not Applicable
3. **Does your state's prevention strategic plan include the following components? (check all that apply):**
   a. ☒ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b. ☒ Timelines
   c. ☒ Roles and responsibilities
   d. ☒ Process indicators
   e. ☒ Outcome indicators
   f. ☒ Cultural competence component
   g. ☒ Sustainability component
   h. ☒ Other (please list) Mechanism to identify priority populations
   i. ☐ Not application/no prevention strategic plan
4. **Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?** ☒ Yes ☐ No
5. **Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?**
   ☒ Yes ☐ No
   a. If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies and strategies are evidence-based. See attachment B - Request for Approval of Evidence-Based Program or Promising Practices. This form is used to determine which programs, policies and strategies are evidence-based.

Implementation

1. **States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:**
    a. ☐ SSA staff directly implements primary prevention programs and strategies.
    b. ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
    c. ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
    d. ☒ The SSA funds regional entities that provide training and technical assistance.
    e. ☐ The SSA funds regional entities to provide prevention services.
    f. ☐ The SSA funds county, city, or tribal governments to provide prevention services.
    g. ☒ The SSA funds community coalitions to provide prevention services.
    h. ☐ The SSA funds individual programs that are not part of a larger community effort.
    i. ☐ The SSA directly funds other state agency prevention programs.
    j. ☐ Other (please describe)
2. **Please list the specific primary prevention programs, practices and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies**. **Please see instructions for definitions of the six strategies.**
    a. ☒ Information Dissemination: See Attachment D - Prevention Strategies & Programs
    b. ☒ Education: See Attachment D - Prevention Strategies & Programs
    c. ☒ Alternatives: See Attachment D - Prevention Strategies & Programs
    d. ☒ Problem Identification and Referral: See Attachment D - Prevention Strategies & Programs
    e. ☒ Community-Based Processes: See Attachment D - Prevention Strategies & Programs
    f. ☒ Environmental: See Attachment D - Prevention Strategies & Programs
3. **Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?** ☒ Yes ☐ No
    a. If yes, please describe: The state reimburses community coalitions and the prevention resource centers on a fee for service basis. Each month prevention providers submit an invoice into the prevention programs data collection system. Prevention Program staff review each invoice against those contract items that were designated to be paid with SABG funds before an invoice is processed. In addition, fiscal audits are conducted to ensure that the provider has billed the appropriate services to the appropriate funding stream and has documentation of the services provided.

Evaluation

1. **Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?** ☒ Yes ☐ No
    a. If yes, please attach the plan in BGAS See attachement C - SD PFS Evaluation Plan. Since the SABG funds are blended with the Partnership for Success (PFS) grant and the target population is the same, we utilize the PFS evaluation plan for the the SABG funded services as well.

2. **Does your state's prevention evaluation plan include the following components? (check all that apply):**
    a. ☒ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks.
    b. ☒ Includes evaluation information from sub-recipients
    c. ☒ Includes SAMHSA National Outcome Measurement (NOMs) requirements
    d. ☒ Establishes a process for providing timely evaluation information to stakeholders
    e. ☒ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
    f. ☐ Other (please describe)
    g. ☐ Not applicable/no prevention evaluation plan
3. **Please check those process measures listed below that your state collects on its SABG funded prevention services:**
    a. ☒ Numbers served
    b. ☒ Implementation fidelity
    c. ☒ Participant satisfaction
    d. ☒ Number of evidence-based program/practices/policies implemented
    e. ☒ Attendance
    f. ☒ Demographic information
    g. ☐ Other (please describe)
4. **Please check those outcome measures listed below that your state collects on its SABG funded prevention services:**
    a. ☒ 30-day use of alcohol, tobacco, prescription drugs, etc.
    b. ☐ Heavy use
       ☒ Binge use
       ☒ Perception of harm
    c. ☐ Disapproval of use
    d. ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
    e. ☐ Other (please describe)

Information Dissemination	Education	Community Based	Environmental	Problem ID and Referral	Alternatives
Canoe Journey Life's Journey: Life Skills for Native Adolescents - Culturally specific prevention activities	Canoe Journey Life's Journey: Life Skills for Native Adolescents - Culturally specific prevention activities	Canoe Journey Life's Journey: Life Skills for Native Adolescents - Culturally specific prevention activities	Canoe Journey Life's Journey: Life Skills for Native Adolescents - Culturally specific prevention activities	BASICS - Motivational interviewing (2 sessions) for college students who have multiple alcohol related offenses (Ages 18-20)	Canoe Journey Life's Journey: Life Skills for Native Adolescents - Culturally specific prevention activities
CCAA (Challenging College Alcohol Abuse) - Promotion of non-alcohol social events that provide healthy options other than traditional drinking occasions	CCAA (Challenging College Alcohol Abuse) - Social norm marketing campaign(s) to address misperceptions about alcohol	CCAA (Challenging College Alcohol Abuse) - Promotion of non-alcohol social events that provide healthy options other than traditional drinking occasions	CCAA (Challenging College Alcohol Abuse) - Promotion of non-alcohol social events that provide healthy options other than traditional drinking occasions	BASICS - Screening and referral for college students (Ages 18-20) to prevention service populations for placement in prevention or other appropriate services	CCAA (Challenging College Alcohol Abuse) - Promotion of non-alcohol social events that provide healthy options other than traditional drinking occasions
CHOICES - Social norms efforts	CMCA (Communities Mobilizing for Change on Alcohol) - Community projects that address youth access to alcohol	CCAA (Challenging College Alcohol Abuse) - Social norm marketing campaign(s) to address misperceptions about alcohol	CCAA (Challenging College Alcohol Abuse) - Social norm marketing campaign(s) to address misperceptions about alcohol	CHOICES - Alcohol education programming	CMCA (Communities Mobilizing for Change on Alcohol) - Community projects that address youth access to alcohol
CMCA (Communities Mobilizing for Change on Alcohol) - Community projects that address youth access to alcohol	LifeSkills Training - Classroom cognitive skills training	CMCA (Communities Mobilizing for Change on Alcohol) - Community projects that address youth access to alcohol	CHOICES - Social norms efforts	CHOICES - Motivational interviewing and screening tool	Project Success - Prevention awareness efforts
CMCA (Communities Mobilizing for Change on Alcohol) - Strategy team approaches that address youth access to alcohol	LifeSkills Training - Staff training, implementation planning and evaluation	CMCA (Communities Mobilizing for Change on Alcohol) - Strategy team approaches that address youth access to alcohol	CMCA (Communities Mobilizing for Change on Alcohol) - Community projects that address youth access to alcohol	e-Check Up To Go (e-CHUG) - Alcohol educational programming	Project Venture - Skill-building experiential and challenge activites delivered after school, weekend or during the summer
e-Check Up To Go (e-CHUG) - Social norms efforts	Positive Action - Classroom prevention education programming	e-Check Up To Go (e-CHUG) - Social norms efforts	CMCA (Communities Mobilizing for Change on Alcohol) - Enforcement efforts that address youth access to alcohol	e-Check Up To Go (e-CHUG) - Motivational interviewing and screening tool	S.A.F.E. (Student Assistance and Family Education) - Prevention awareness efforts
LifeSkills Training - Classroom cognitive skills training	Positive Action - Staff training, implementation planning and evaluation	LifeSkills Training - Staff training, implementation planning and evaluation	CMCA (Communities Mobilizing for Change on Alcohol) - Strategy team approaches that address youth access to alcohol	Interactive Journaling (Alternatives) - Motivational interviewing for youth (12-20) who have alcohol related offenses	
LifeSkills Training - Staff training, implementation planning and evaluation	Project Success - Classroom prevention educational programming	Positive Action - Staff training, implementation planning and evaluation	e-Check Up To Go (e-CHUG) - Social norms efforts	Interactive Journaling (Alternative)-Structured and expressive writing that allows students to write about their alcohol problem and its association with their current negative life situation	

Information Dissemination	Education	Community Based	Environmental	Problem ID and Referral	Alternatives
Positive Action - Classroom prevention education programming	Project Success - Prevention awareness efforts	Project Success - Environmental and outreach efforts	Project Success - Environmental and outreach efforts	Prime for Life - Intensive prevention education programming for repeat offenders (ages 20 and under)	
Positive Action - Staff training, implementation planning and evaluation	Project Success - Provide student assistance services for at risk youth	Project Success - Prevention awareness efforts	Project Success - Prevention awareness efforts	Prime for Life - Primary prevention education programming for youth (18 and under)	
Project Success - Classroom prevention educational programming	Project Venture - Culturally specific classroom prevention activities delivered throughout the school year	Project Venture - Community-oriented service learning and service leadership projects throughout the year	S.A.F.E. (Student Assistance and Family Education) - Environmental and outreach efforts	Prime for Life - Young adult alcohol diversion programming for young adults (19-20 year olds)	
Project Success - Environmental and outreach efforts	S.A.F.E. (Student Assistance and Family Education) - Classroom prevention educational programming	S.A.F.E. (Student Assistance and Family Education) - Environmental and outreach efforts	S.A.F.E. (Student Assistance and Family Education) - Prevention awareness efforts	Project Success - Provide student assistance services for at risk youth	
Project Success - Prevention awareness efforts	S.A.F.E. (Student Assistance and Family Education) - Provide student assistance services for at risk youth	S.A.F.E. (Student Assistance and Family Education) - Prevention awareness efforts		S.A.F.E. (Student Assistance and Family Education) - Provide student assistance services for at risk youth	
Project Venture - Community-oriented service learning and service leadership projects throughout the year	S.A.F.E. (Student Assistance and Family Education) - Prevention awareness efforts				
S.A.F.E. (Student Assistance and Family Education) - Classroom prevention educational programming	Strengthening Family Program for Parents and Youth 10-14 - Providing family skills training				
S.A.F.E. (Student Assistance and Family Education) - Environmental and outreach efforts					
S.A.F.E. (Student Assistance and Family Education) - Provide student assistance services for at risk youth					

Information Dissemination	Education	Community Based	Environmental	Problem ID and Referral	Alternatives
S.A.F.E. (Student Assistance and Family Education) - Prevention awareness efforts					
Strengthening Family Program for Parents and Youth 10-14 - Providing family skills training					

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

   Within South Dakota's community-based mental health delivery system, there are 11 private, non-profit Community Mental Health Centers (CMHCs). All CMHCs provide Children, Youth and Family and Comprehensive Assistance with Recovery and Empowerment services. Six CMHCs provide Individualized Mobile Program of Assertive Community Treatment services. In addition, ten out of the eleven CMHCs provide Functional Family Therapy services as part of the Juvenile Justice Reinvestment Initiative (JJRI) Program.

   Ten out of eleven CMHCs are co-occurring capable and provide a wide array of substance use services. Six CMHCs provide Moral Reconation Therapy and four provide Aggression Replacement Training as part of the JJIRI Program.

   As of March 2017, nine Community Mental Health Centers act as Health Home providers. Health Home services are a systematic and comprehensive approach to the delivery of primary care or behavioral health care that promises better results than traditional care. This approach is beneficial as it examines a Health Home recipient as a whole and reduces utilization of high cost services.

   The State of South Dakota also has 33accredited and contracted substance use providers, which provide a full continuum of services including prevention, outpatient, intensive outpatient, day treatment, medically monitored intensive inpatient treatment, clinically managed low intensity residential treatment, clinically managed residential detoxification, and specialty programs including, gambling, relapse programs and methamphetamine treatment.

   In addition, there are 25 prevention programs accredited to provide services to youth and communities across the state. The services provided include prevention, early intervention, education on the harmful effects of alcohol and drugs; awareness campaigns, environmental strategies and training and implementation of evidence-based programs.

   The prevention programs also provide community and/or school-based prevention services to youth and young adults. Sixteen of the programs provide school-based prevention programs to over twenty schools in the state, 22 are community coalitions and two programs operate on state university campuses. In addition, three Prevention Resource Centers provide local trainings and are a resource for supporting implementation of evidence-based prevention programming for local communities or schools across the state.

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

a)	Physical Health	Yes / No
b)	Mental Health	Yes / No
c)	Rehabilitation services	Yes / No
d)	Employment services	Yes / No
e)	Housing services	Yes / No
f)	Educational Services	Yes / No
g)	Substance misuse prevention and SUD treatment services	Yes / No
h)	Medical and dental services	Yes / No
i)	Support services	Yes / No

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) ( ) Yes ( ) No

k) Services for persons with co-occuring M/SUDs ( ) Yes ( ) No

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

3. Describe your state's case management services

Administrative Rules of South Dakota (ARSD), Article 67:62, Mental Health, requires case management services be provided for the following mental health services; Comprehensive Assistance with Recovery and Employment, Individualized Mobile Programs of Assertive Community Treatment; Children, Youth and Family services and Outpatient services. Case management services is defined in ARSD as a collaborative process which assesses, plans, implements, coordinates, and monitors; and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.

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

Some activities the DBH has accomplished to reduce hospitalizations include working with the Human Services Center (HSC) to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. By streamlining the discharge planning process ensures all individuals, once discharged from HSC, is aware of and has immediate access to mental health services in the community.

Also, in order to reduce the number of inappropriate admissions for geriatric clients to the HSC, a clinical review process was established that provides psychiatric reviews/consultations to nursing facilities and assisted living centers. In order to assist with clients who have challenging behaviors or behavioral health needs, an HSC Clinical Review Team provides the nursing home or assisted living center with resources and interventions that may allow the client to live in the least restrictive environment possible.

In addition, six CMHCs provide IMPACT services. IMPACT teams are organized as a mobile group of mental health professionals who merge clinical, medial and rehabilitation expertise within one service delivery system, which has proven through the DBH's outcome data to significantly reduce hospitalizations.

Furthermore, nine CMHCs act as Health Home providers, which promise the reduction of high cost services, emergency room visits and inpatient hospitalizations. In order to be served in a Health Home, recipients must have a chronic condition, which includes a serious mental illness or serious emotional disturbance.

Lastly, community crisis services also assist with reducing unnecessary hospitalizations. Behavior Management Systems in Rapid City coordinates the operations of a Crisis Care Center. The facility provides access to immediate care for adults (18 years of age and older) with critical mental health episodes or need of substance use stabilization in the Black Hills area. The Center is open 24 hours per day, seven days per week and is staffed with one Qualified Mental Health Professional and two Emergency Medical Technicians at all times.

Southeastern Behavioral Health Care coordinates with Minnehaha and Lincoln Counties to operate a Mobile Crisis Team consisting of a counselor and a licensed psychological nurse who are on call 24 hours a day to meet with people in their moments of crisis.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	3.9%	25,000
2.Children with SED	8%	8,412

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

The DBH does not calculate prevalence and incident rates, but relies on national data sources such as the National Surveys on Drug Use and Health (NSDUH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide prevalence information for mental health and substance use disorders. According to the NSDUH, in 2014 South Dakota's statewide prevalence rate for individuals with SMI was 3.9% or roughly 25,000 individuals. This percentage has not changed significantly since 2011. The DBH does not have a method to determine how many of the estimated 25,000 individuals with SMI may qualify for publically funded behavioral health services in South Dakota. Also, according to the SAMHSA State Prevalence Document, 8% or 8,412 youth were estimated to meet the diagnostic requirements for SED in 2015.

In the future, the DBH will be utilizing the State Epidemiological Outcome Work Group to look further into mental health and substance use disorders prevalence information with the intent of identifying the need to be supported through public funding. The DBH plans to use this prevalence data to help make informed funding decisions for behavioral health treatment service.

Criterion 3: Children's Services

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

Criterion 3

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

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

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

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

Criterion 4

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

To ensure community-based behavioral health services across the state, including rural areas, the Behavioral Health Workgroup final report recommended a regional approach to ensure access to essential services. Essential services, as defined by the Workgroup are prevention services, assessment and referral, community crisis intervention, care coordination, supported living services, inpatient specialty services, outpatient specialty services and family supports.

In order to increase access to essential services, the Workgroup concluded with the selection of five regional areas. These regions mirror the five call center regions developed for the Aging and Disability Resource Connections. These regions were selected because they reflect locations where people access medical care and other necessary services across the state.
Current essential services within each region were assessed and critical caps were identified. The state continues to their progress towards meeting the recommendations given to ensure all essential services are provided within each identified region.

The Behavioral Health Services Regional Map: http://dss.sd.gov/behavioralhealth/workgroup.aspx
To assist with homelessness, five of the 11 CMHCs receive Projects for Assistance in Transition from Homelessness funds to provide services to individuals with serious mental illness and/or co-occurring substance use disorders, who are homeless or at imminent risk of homelessness. Services include outreach, screening and diagnostic treatment, habilitation and rehabilitation, substance use assessments, case management, primary health care referrals, job training, education, housing supports and community mental health services such as medication management, supportive counseling and psychotherapy. Other services also provided include technical assistance in applying for housing assistance and financial support including security deposits and one-time rental assistance to prevent eviction.
To assist with the older adult population, South Dakota also has two assisted living centers that are designated specifically for individuals with serious mental illnesses. Service needs may be more intense for those who have significant medical issues and/or are homeless. Licensed through the Department of Social Services, Division of Adult Services and Aging, Cedar Village and Cayman Court are located in the Southeastern part of the State (Yankton and Sioux Falls, respectively). They have approximately a 48 bed capacity between the two of them, and are operated by the CMHCs in those areas. Individuals living in these assisted living centers receive Comprehensive Assistance with Recovery and Empowerment services through the CMHCs.

The DBH also assists with Preadmission Screening and Resident Reviews which is a federal mandate that ensures individuals are not inappropriately placed in nursing homes for long term care. All individuals who screen positive for a mental illness are referred for a Level II evaluation and the determination is completed by the DBH. A Level II review determines if the mental health needs of the individual can be met in the nursing facility or if the individual requires specialized services at the State Psychiatric Hospital.

Lastly, the HSC developed a clinical review process that provides psychiatric reviews/consultations to nursing facilities and assisted living centers. In order to assist with clients who have challenging behaviors or behavioral health needs, an HSC Clinical Review Team provides the nursing home or assisted living center with resources and interventions that may allow the client to live in the least restrictive environment possible.

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

The Division of Behavioral Health (DBH) consists of five separate programs: Prevention Program, Resource Coordination Program, Accreditation Program, Criminal Justice Initiative Program and Juvenile Justice Initiative Program. The DBH employs 80 staff and is the Single State Agency for South Dakota providing both mental health and substance use disorder treatment services.

Mental health services are provided on a fee-for-service basis through Medicaid, Block Grant, and state general funds. Funding utilized for mental health services include direct services to individuals with serious mental illnesses and children with serious emotional disturbances as well as outpatient services, emergency services, and services through the Indigent Medication Program. It is the state's intent to expend the Mental Health Bock Grant funding for Federal Fiscal Years 2018 and 2019 similar to how it has been expended in the past with the majority be allocated for direct services, 10 percent to address early serious mental illness and 5 percent for administrative costs.
In regard to workforce development, the DBH supports professional training opportunities for mental health and substance use treatment professionals across the state and works with providers to determine training needs. The DBH contracts with the Central Rockies Addiction Technology Transfer Center (ATTC) to provide a variety of trainings, services and topics such as Motivational Interviewing, Corrective Thinking, American Society of Addiction Medicine Criteria and other statewide initiatives. Also, four times per year, the National American Indian and Alaska Native Addiction Technology Transfer Center through the University of Iowa, provides a 24 module Native American Curriculum training.

South Dakota also supports the training of behavioral health professionals in Adult and Youth Mental Health First Aid. Currently, adult Mental Health First Aid trainings are funded through the Garrett Lee Smith Suicide Prevention Grant and Youth Mental Health First Aid Trainings are funded through the "Now is the Time" Youth Mental Health Training Grant.

In May 2015, the Qualified Mental Health Professional (QMHP) training became available online and includes information regarding the involuntary commitment process, mental health status examinations, reviews South Dakota laws relative to inpatient hospitalizations; hearing procedures for QMHPs in the commitment process of an individual and an overview of the medical capabilities of the state psychiatric hospital. This follows Administrative Rule of South Dakota, Chapter 67:62:14.

The DBH supports SOAR (SSI/SSDI Outreach, Access, and Recovery) training efforts in South Dakota and encourages substance use disorder and mental health providers to train staff to better assist those who are homeless or at risk of homelessness in applying for SSI/SSDI benefits. Provider staff can access the 20 hour SOAR Online Training at any time and complete it at their own pace.

Footnotes:

Environmental Factors and Plan

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

   Within South Dakota's community-based mental health delivery system, there are 11 private, non-profit Community Mental Health Centers (CMHCs). All CMHCs provide Children, Youth and Family and Comprehensive Assistance with Recovery and Empowerment services. Six CMHCs provide Individualized Mobile Program of Assertive Community Treatment services. In addition, ten out of the eleven CMHCs provide Functional Family Therapy services as part of the Juvenile Justice Reinvestment Initiative (JJRI) Program.

   Ten out of eleven CMHCs are co-occurring capable and provide a wide array of substance use services. Six CMHCs provide Moral Reconation Therapy and four provide Aggression Replacement Training as part of the JJIRI Program.

   As of March 2017, nine Community Mental Health Centers act as Health Home providers. Health Home services are a systematic and comprehensive approach to the delivery of primary care or behavioral health care that promises better results than traditional care. This approach is beneficial as it examines a Health Home recipient as a whole and reduces utilization of high cost services.

   The State of South Dakota also has 33accredited and contracted substance use providers, which provide a full continuum of services including prevention, outpatient, intensive outpatient, day treatment, medically monitored intensive inpatient treatment, clinically managed low intensity residential treatment, clinically managed residential detoxification, and specialty programs including, gambling, relapse programs and methamphetamine treatment.

   In addition, there are 25 prevention programs accredited to provide services to youth and communities across the state. The services provided include prevention, early intervention, education on the harmful effects of alcohol and drugs; awareness campaigns, environmental strategies and training and implementation of evidence-based programs.

The prevention programs also provide community and/or school-based prevention services to youth and young adults. Sixteen of the programs provide school-based prevention programs to over twenty schools in the state, 22 are community coalitions and two programs operate on state university campuses. In addition, three Prevention Resource Centers provide local trainings and are a resource for supporting implementation of evidence-based prevention programming for local communities or schools across the state.

2. **Does your state provide the following services under comprehensive community-based mental health service systems?**
    a. Physical Health ☒ Yes ☐ No
    b. Mental Health ☒ Yes ☐ No
    c. Rehabilitation services ☒ Yes ☐ No
    d. Employment services ☒ Yes ☐ No
    e. Housing services ☒ Yes ☐ No
    f. Educational services ☒ Yes ☐ No
    g. Substance use prevention and SUD treatment services ☒ Yes ☐ No
    h. Medical and dental services ☒ Yes ☐ No
    i. Support Services ☒ Yes ☐ No
    j. Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA). ☒ Yes ☐ No
    k. Services for persons with co-occurring M/SUDs. ☒ Yes ☐ No

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

3. **Describe your state's case management services**.
Administrative Rules of South Dakota (ARSD), Article 67:62, Mental Health, requires case management services be provided for the following mental health services; Comprehensive Assistance with Recovery and Employment, Individualized Mobile Programs of Assertive Community Treatment; Children, Youth and Family services and Outpatient services. Case management services is defined in ARSD as a collaborative process which assesses, plans, implements, coordinates, and monitors; and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.

4. **Describe activities intended to reduce hospitalization and hospital stays**.
Some activities the DBH has accomplished to reduce hospitalizations include working with the Human Services Center (HSC) to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. By streamlining the discharge planning process ensures all individuals, once discharged from HSC, is aware of and has immediate access to mental health services in the community.

Also, in order to reduce the number of inappropriate admissions for geriatric clients to the HSC, a clinical review process was established that provides psychiatric reviews/consultations to nursing facilities and assisted living centers. In order to assist with clients who have challenging behaviors or behavioral health needs, an HSC Clinical Review Team provides the nursing home or assisted living center with resources and interventions that may allow the client to live in the least restrictive environment possible.

In addition, six CMHCs provide IMPACT services. IMPACT teams are organized as a mobile group of mental health professionals who merge clinical, medial and rehabilitation expertise within one service delivery system, which has proven through the DBH's outcome data to significantly reduce hospitalizations.

Furthermore, nine CMHCs act as Health Home providers, which promise the reduction of high cost services, emergency room visits and inpatient hospitalizations. In order to be served in a Health Home, recipients must have a chronic condition, which includes a serious mental illness or serious emotional disturbance.

Lastly, community crisis services also assist with reducing unnecessary hospitalizations. Behavior Management Systems in Rapid City coordinates the operations of a Crisis Care Center. The facility provides access to immediate care for adults (18 years of age and older) with critical mental health episodes or need of substance use stabilization in the Black Hills area. The Center is open 24 hours per day, seven days per week and is staffed with one Qualified Mental Health Professional and two Emergency Medical Technicians at all times.

Southeastern Behavioral Health Care coordinates with Minnehaha and Lincoln Counties to operate a Mobile Crisis Team consisting of a counselor and a licensed psychological nurse who are on call 24 hours a day to meet with people in their moments of crisis.

Criterion 2: Mental Health System Data Epidemiology

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

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

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

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

Target Population (A)	Statewide Prevalence (B)	Statewide Incidence (C)
SMI	3.9%	25,000
SED	8%	8,412

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

The DBH does not calculate prevalence and incident rates, but relies on national data sources such as the National Surveys on Drug Use and Health (NSDUH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide prevalence information for mental health and substance use disorders. According to the NSDUH, in 2014 South Dakota's statewide prevalence rate for individuals with SMI was 3.9% or roughly 25,000 individuals. This percentage has not changed significantly since 2011. The DBH does not have a method to determine how many of the estimated 25,000 individuals with SMI may qualify for publically funded behavioral health services in South Dakota. Also, according to the SAMHSA State Prevalence Document, 8% or 8,412 youth were estimated to meet the diagnostic requirements for SED in 2015.

In the future, the DBH will be utilizing the State Epidemiological Outcome Work Group to look further into mental health and substance use disorders prevalence information with the intent of identifying the need to be supported through public funding. The DBH plans to use this prevalence data to help make informed funding decisions for behavioral health treatment service.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a. Social Services ☒ Yes ☐ No
b. Educational services, including services provided under IDE. ☒ Yes ☐ No
c. Juvenile Justice Services ☒ Yes ☐ No
d. Substance misuse prevention and SUD treatment services ☒ Yes ☐ No
e. Health and mental health services ☒ Yes ☐ No
f. Establishes defined geographic area for the provision of the services of such a system ☒ Yes ☐ No

The following coordination of services is detailed within Planning Step One to include:

- Child Welfare, Juvenile Services and Criminal Justice Coordination

- Medical/Dental Service Coordination
- Vocational and Educational Coordination
- Housing Coordination and Support
- Criminal Justice Initiative
- Juvenile Justice Reinvestment Initiative
- Correctional Resource Coordination
- Health Homes

Criterion 4: Targeted Services to rural and Homeless Populations and to Older Adult
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Describe your state's targeted services to rural and homeless populations and to older adults.
To ensure community-based behavioral health services across the state, including rural areas, the Behavioral Health Workgroup final report recommended a regional approach to ensure access to essential services. Essential services, as defined by the Workgroup are prevention services, assessment and referral, community crisis intervention, care coordination, supported living services, inpatient specialty services, outpatient specialty services and family supports.

In order to increase access to essential services, the Workgroup concluded with the selection of five regional areas. These regions mirror the five call center regions developed for the Aging and Disability Resource Connections. These regions were selected because they reflect locations where people access medical care and other necessary services across the state.
Current essential services within each region were assessed and critical caps were identified. The state continues to their progress towards meeting the recommendations given to ensure all essential services are provided within each identified region.

The Behavioral Health Services Regional Map:
http://dss.sd.gov/behavioralhealth/workgroup.aspx

To assist with homelessness, five of the 11 CMHCs receive Projects for Assistance in Transition from Homelessness funds to provide services to individuals with serious mental illness and/or co-occurring substance use disorders, who are homeless or at imminent risk of homelessness. Services include outreach, screening and diagnostic treatment, habilitation and rehabilitation, substance use assessments, case management, primary health care referrals, job training, education, housing supports and community mental health services such as medication management, supportive counseling and psychotherapy. Other services also provided include technical assistance in applying for housing assistance and financial support including security deposits and one-time rental assistance to prevent eviction.

To assist with the older adult population, South Dakota also has two assisted living centers that are designated specifically for individuals with serious mental illnesses. Service needs may be more intense for those who have significant medical issues and/or are homeless. Licensed through the Department of Social Services, Division of Adult Services and Aging, Cedar Village and Cayman Court are located in the Southeastern part of the State (Yankton and Sioux Falls, respectively). They have approximately a 48 bed capacity between the two of them, and are operated by the CMHCs in those areas. Individuals living in these assisted living centers receive Comprehensive Assistance with Recovery and Empowerment services through the CMHCs.

The DBH also assists with Preadmission Screening and Resident Reviews which is a federal mandate that ensures individuals are not inappropriately placed in nursing homes for long term care. All individuals who screen positive for a mental illness are referred for a Level II evaluation and the determination is completed by the DBH. A Level II review determines if the mental health needs of the individual can be met in the nursing facility or if the individual requires specialized services at the State Psychiatric Hospital.

Lastly, the HSC developed a clinical review process that provides psychiatric reviews/consultations to nursing facilities and assisted living centers. In order to assist with clients who have challenging behaviors or behavioral health needs, an HSC Clinical Review Team provides the nursing home or assisted living center with resources and interventions that may allow the client to live in the least restrictive environment possible.

Criterion 5: Management Systems

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

Describe your state's management systems.

The Division of Behavioral Health (DBH) consists of five separate programs: Prevention Program, Resource Coordination Program, Accreditation Program, Criminal Justice Initiative Program and Juvenile Justice Initiative Program. The DBH employs 80 staff and is the Single State Agency for South Dakota providing both mental health and substance use disorder treatment services.

Mental health services are provided on a fee-for-service basis through Medicaid, Block Grant, and state general funds. Funding utilized for mental health services include direct services to individuals with serious mental illnesses and children with serious emotional disturbances as well as outpatient services, emergency services, and services through the Indigent Medication Program. It is the state's intent to expend the Mental Health Bock Grant funding for Federal Fiscal Years 2018 and 2019 similar to how it has been expended in the past with the majority be

allocated for direct services, 10 percent to address early serious mental illness and 5 percent for administrative costs.

In regard to workforce development, the DBH supports professional training opportunities for mental health and substance use treatment professionals across the state and works with providers to determine training needs. The DBH contracts with the Central Rockies Addiction Technology Transfer Center (ATTC) to provide a variety of trainings, services and topics such as Motivational Interviewing, Corrective Thinking, American Society of Addiction Medicine Criteria and other statewide initiatives. Also, four times per year, the National American Indian and Alaska Native Addiction Technology Transfer Center through the University of Iowa, provides a 24 module Native American Curriculum training.

South Dakota also supports the training of behavioral health professionals in Adult and Youth Mental Health First Aid. Currently, adult Mental Health First Aid trainings are funded through the Garrett Lee Smith Suicide Prevention Grant and Youth Mental Health First Aid Trainings are funded through the "Now is the Time" Youth Mental Health Training Grant.

In May 2015, the Qualified Mental Health Professional (QMHP) training became available online and includes information regarding the involuntary commitment process, mental health status examinations, reviews South Dakota laws relative to inpatient hospitalizations; hearing procedures for QMHPs in the commitment process of an individual and an overview of the medical capabilities of the state psychiatric hospital. This follows Administrative Rule of South Dakota, Chapter 67:62:14.

The DBH supports SOAR (SSI/SSDI Outreach, Access, and Recovery) training efforts in South Dakota and encourages substance use disorder and mental health providers to train staff to better assist those who are homeless or at risk of homelessness in applying for SSI/SSDI benefits. Provider staff can access the 20 hour SOAR Online Training at any time and complete it at their own pace.

WebBGAS Logo

Skip Navigation

An error occurred

SAMHSA Logo

Environmental Factors and Plan

Substance Use Disorder Treatment

Criterion 1: Prevention and Treatment Services – Improving Access and maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. **Does your state provide:**
    a. A full continuum of services:
        i. Screening ☒ Yes ☐ No
        ii. Education ☒ Yes ☐ No
        iii. Brief Intervention ☒ Yes ☐ No
        iv. Assessment ☒ Yes ☐ No
        v. Detox (inpatient/social) ☒ Yes ☐ No
        vi. Outpatient ☒ Yes ☐ No
        vii. Intensive Outpatient ☒ Yes ☐ No
        viii. Inpatient/residential ☒ Yes ☐ No
        ix. Aftercare; recovery support ☒ Yes ☐ No
    b. Are you considering targeted services for veterans ☐ Yes ☒ No
    Expansion of services for:
        1. Adolescents ☐ Yes ☒ No
        2. Older Adults ☐ Yes ☒ No
        3. Medication-Assisted Treatment (MAT) ☒ Yes ☐ No

Criterion 2: Improving Access and Addressing Primary Prevention - see Environmental Factors and Plan, Primary Prevention

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. **Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?** ☒ Yes ☐ No
2. **Either directly or through an arrangement with public or private non-profit entities making prenatal care available to PWWDC receiving services?** ☒ Yes ☐ No
3. **Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?** ☒ Yes ☐ No
4. **Does your state have an arrangement for ensuring the provision of required supportive services?** ☒ Yes ☐ No
5. **Are you considering any of the following:**
    a. Open assessment and intake scheduling ☐ Yes ☒ No

b. Establishment of an electronic system to identify available treatment slots
☐ Yes ☒ No
c. Expanded community network for supportive services and healthcare
☐ Yes ☒ No
d. Inclusion of recovery support services ☐ Yes ☒ No
e. Health navigators to assist clients with community linkages ☐ Yes ☒ No
f. Expanded capability for family services, relationship restoration, custody issue
☐ Yes ☒ No
g. Providing employment assistance ☐ Yes ☒ No
h. Providing transportation to and from services ☐ Yes ☒ No
i. Educational assistance ☐ Yes ☒ No

The state is always considering ways to improve access and care for individuals needing behavioral health services. Many areas identified above are done at the local level by the contracted provider and are based on the needs of the community (e.g., pen assessment and intake scheduling). The DBH has considered developing a system to track available treatment slots, but the resources needed to support the effort are currently not available.

The DBH does serve as a resource for treatment providers and individuals seeking substance use services. The DBH supports two specialized intensive methamphetamine treatment programs which includes recovery supports as part of their program. The DBH also supports the efforts of Face It Together in order to meet the needs of individuals seeking peer/recovery supports for substance use disorders. In addition, treatment providers are expected to assist clients with employment goals, especially through the low-intensity residential treatment program where there is heavy emphasis on obtaining employment.

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

Pregnant women are at highest priority for admission to services. Clients meeting this status must be admitted to the program no later than 14 days from the initial screening. If the program does not have the capacity to admit the client on the date of such request, interim services must be provided no later than 48 hours from the initial screening. The referring provider will ensure the client is provided interim services until an alternative placement can be located.

The Division of Behavioral Health (DBH) complies with Section 1922(c) of the PHS Act and 45 CFR 96.124(e), which requires states to ensure that programs receiving funding for services also provide for or arrange for the provision of primary medical care, prenatal care, child care, primary pediatric care-including immunizations for children, gender specific treatment, therapeutic interventions which addresses relationship issues, sexual and physical abuse, and parenting and child care, sufficient case management and

transportation to ensure that women and their children have access to all services listed in this paragraph.

The DBH provides funding to two community based treatment programs for pregnant women and women with dependent children. Behavior Management Systems in Rapid City and Volunteers of America (VOA) in Sioux Falls both serve adult women. VOA also provides services to pregnant adolescents. Both programs accept clients from all 66 counties and provide medically monitored inpatient, low intensity residential, outpatient services, case management, aftercare and interim services.

The DBH modified the State Treatment Activity Reporting System (STARS) to allow the tracking of specific services provided to pregnant women. Also, language was written into each provider's contract to assure state compliance with the federal rules governing the notification of 90% program capacity. The capacity of each program is also tracked through STARS, including interim services. Tracking specific services provided and agency capacity level allows DBH to monitor utilization rates and to identify those service areas that are greatest in need.

The DBH Accreditation team conducts onsite reviews to ensure compliance with provider contract requirements and Administrative Rules of South Dakota (ARSD), Article 67:61 Substance Use Disorders. The review encompasses areas of governance, fiscal management, personnel training/qualifications, statistical reporting, client rights, quality assurance, case record content, medication administration and consumer outcome/satisfaction reports.

The accreditation review is conducted by an evaluation of client charts and agency policies and procedures, and through interviews with staff and clients. The accreditation team developed tools to evaluate compliance with case record documentation and other requirements. Based on the score of the onsite review, and the submission of an acceptable plan of correction when required, a program is granted a two or three-year accreditation period.

During the accreditation certificate period, the DBH may conduct follow-up calls and/or reviews with the agency for monitoring purposes and also provide technical assistance when needed, including a mid-point review for agencies with lower performance to assist them in evaluating the success of the implementation of their Plan of Correction to address identified areas of noncompliance.

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needs Prohibition, and Syringe Services Program

Persons who Inject Drugs (PWID)

1. **Does your state fulfill the:**
    a. 90 percent capacity reporting requirements ☒ Yes ☐ No
    b. 14-120 day performance requirement with provision of interim services ☒ Yes ☐ No
    c. Outreach activities ☒ Yes ☐ No
    d. Syringe services program ☒ Yes ☐ No
    e. Monitoring requirements as outlined in the authorizing statute and implementing regulation ☒ Yes ☐ No
2. **Are you considering any of the following:**
    a. Electronic system with alert when 90 percent capacity is reached ☐ Yes ☒ No
    b. Automatic reminder system associated with 14-120 day performance requirement ☐ Yes ☒ No
    c. Use of peer recovery supports to maintain contact and support ☐ Yes ☒ No
    d. Service expansion to specific populations (military families, veterans, adolescents, older adults). ☐ Yes ☒ No
3. **States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems**.

    Contracted substance use providers prioritize and provide outreach and intervention services to individuals identified as needing treatment for intravenous drug use. Clients are placed within 48 hours-14 days after a request for treatment (as per section 1923(a) 92) of the Public Health Services Act and 45 CFR 96.126 (b)). However, if an individual cannot be placed within 48 hours, the referring agency will provide interim services until a placement can be made.

    Each provider receiving Block Grant funds complies with the established referral process for this high risk population to facilitate access to services, testing, and the appropriate level of treatment. Language was written into each provider's contract to assure state compliance with the federal rules governing the notification of 90% program capacity. The capacity of each program is tracked through STARS.

    Each provider is required to develop, adopt and implement policies and procedures to ensure that each individual who requests and is in need of treatment for intravenous drug use is admitted to the program no later than 14 days from the initial screening. If the program does not have the capacity to admit the individual on the date of such request, interim services must be provided until an individual is admitted to a substance use treatment program. The purpose of interim services is to reduce the adverse health effects of such use, promote the health of the individual and reduce the risk of transmission of disease. At a minimum, interim services include counseling and

education about Human Immunodeficiency Virus (HIV) and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur. Interim services may also include referral for HIV or TB treatment services if necessary. Interim services must be made available to the individual no later than 48 hours from the initial screening.

In compliance with 42 U.S.C. 300x-23(a) (2) (A) (B), the DBH provides funding for treatment services for individuals who are unable to pay. All accredited treatment programs are notified on a yearly basis of the existence of this priority population and the process needed to secure the funds from DBH when needed. To ensure compliance with 4.42 U.S.C. 300x-23(b), DBH specifies in contract the requirement to conduct outreach activities for this specific population. The DBH monitors compliance through reviewing the data submitted to STARS and through regular on-site accreditation reviews.

Tuberculosis (TB)

1. **Does your state currently maintain an agreement, either directly or through arrangements with other public and non-profit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?** ☒ Yes ☐ No
2. **Are you considering any of the following:**
    a. Business agreement/MOU with primary healthcare providers ☐ Yes ☒ No
    b. Cooperative agreement/MOU with public health entity for testing and treatment ☐ Yes ☒ No
    c. Established co-located SUD professionals with Federally Qualified Health Centers. ☐ Yes ☒ No
3. **States are required to monitor program compliance related to activities and services for SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.**
    According to ARSD, 67:61:05:01, the TB screening requirements employees are as follows:
    a. Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test;

b. A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease;
c. Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of *Myobacterium tuberculosis*. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and
d. Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.

Substance use providers shall conduct an annual TB risk assessment on their employees to evaluate the risk for transmission of *mycobacterium tuberculosis* within their agency. The risk assessment utilizes the TB risk assessment worksheet developed by the South Dakota Department of Health. The risk assessment is based on the number of TB cases in the community (defined as the counties of residence for the staff and clients of the agency during the calendar year that is being assessed) and the number of active TB cases which were admitted to the agency. If TB infection control is an issue, the agency must develop a TB infectious control plan with appropriate policies and procedures.

Also, providers screen clients in the same manner as staff with a history of positive skin tests by asking the four required questions in the first 24 hours of admission: (1)Unexplained weight loss (2) Night Sweats (3) Productive Cough lasting three or more weeks (4) Unexplained fevers. If clients answer yes to any of these questions they are referred to a physician for further screening.

The DBH continues to monitor adherence during accreditation reviews by reviewing clinical and personnel files.

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

South Dakota is not a designated state for HIV early intervention services.

Syringe Service Programs

1. **Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes (42 USC 300x-**

31(a)(1)F)?
☒ Yes ☐ No

2. **Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?** ☐ Yes ☒ No
3. **Do any of your programs use SABG funds to support elements of the Syringe Services Program?**
   a. ☐ Yes ☒ No
   b. If yes, please provide a brief description of the elements and the arrangement.

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

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

Service Coordination

1. **Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?** ☒ Yes ☐ No
2. **Are you considering any of the following:**
   a. Identify MOUs/Business Agreements related to coordinated care for persons receiving SUD treatment and/or recovery services. ☐ Yes ☒ No

b. Establish a program to provide trauma-informed care. ☐ Yes ☒ No
c. Identify current and perspective partners to be included in building a system of care, e.g., FQHCs, primary healthcare, recovery community organizations, juvenile justice system, and adult criminal justice system and education. ☒ Yes ☐ No

Charitable Choice

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

The DBH continues to ensure there is equal opportunity for all organizations – both faith-based and nonreligious – to participate as partners in providing substance use treatment and prevention services to individuals and families. All faith-based programs contracting with DBH to provide substance use treatment and/or prevention services are required to provide notice to clients of their right to alternative services if they have an objection to faith-based programming. If an individual has an objection to faith-based programming, the DBH will work with the faith-based organization to transfer services to an alternative provider that is acceptable to the individual seeking services.

Referrals

1. **Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?** ☒ Yes ☐ No
2. **Are you considering any of the following:**
   a. Review and update of screening and assessment instruments. ☐ Yes ☒ No
   b. Review of current levels of care to determine changes or additions. ☒ Yes ☐ No
   c. Identify workforce needs to expand service capabilities. ☒ Yes ☐ No
   d. Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background. ☒ Yes ☐ No

Patient Records

1. **Does your state have an agreement to ensure the protection of client records?** ☒ Yes ☐ No
2. **Are you considering any of the following:**

a. Training staff and community partners on confidentiality requirements. ☐ Yes ☒ No
b. Training on responding to requests asking for acknowledgement of the presence of clients. ☐ Yes ☒ No
c. Updating written procedures which regulate and control access to records. ☐ Yes ☒ No
d. Review and update of the procedure by which clients are notified of the confidentiality of their records include the exception for disclosure. ☐ Yes ☒ No

The DBH ensures that state accredited providers comply with the confidentiality regulations in 42 U.S.C. 300x-53(b), 45 CFR 96.132 (e), 42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act requirements governing the confidentiality of medical records. The DBH includes rules and regulations regarding confidentiality of records in both ARSD and provider contracts. Compliance is accomplished through on-site accreditation reviews to ensure all information shared with other agencies/individuals has a signed release in the file prior to release of the information.

Independent Peer Review

1. **Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?**
   ☒ Yes ☐ No
2. **Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. 300x-52(a)) and 45 CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.**
   a. Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
      An estimated four providers have been identified to undergo an each independent peer review for Fiscal Years 2018 and 2019.
3. **Are you considering any of the following:**
   a. Development of a quality improvement plan. ☒ Yes ☐ No
   b. Establishment of policies and procedures related to independent peer review. ☒ Yes ☐ No
   c. Develop long-term planning for service revision and expansion to meet the needs of specific populations. ☒ Yes ☐ No
4. **Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?** ☐ Yes ☒ No

If yes, please identify the accreditation organization(s)

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

Criterion 7 and 11: Group Homes for Persons in Recovery and Continuing Education for Employees

Group Homes

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

Professional Development

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

Waivers

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

1. **Is your state considering requesting a waiver of any requirements related to:**
    a. Allocations regarding women ☐ Yes ☒ No
2. **Requirements regarding Tuberculosis services and Human Immunodeficiency Virus**
    a. Tuberculosis ☐ Yes ☒ No
    b. Early intervention services regarding HIV ☐ Yes ☒ No
3. **Additional agreements:**
    a. Improvement of Process for appropriate referrals for treatment ☐ Yes ☒ No
    b. Continuing education ☐ Yes ☒ No
    c. Coordination of various activities and services ☐ Yes ☒ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.
Substance Use Disorders: http://sdlegislature.gov/Rules/DisplayRule.aspx?Rule=67:61
Mental Health: http://sdlegislature.gov/Rules/DisplayRule.aspx?Rule=67:62

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ( ) Yes ( ) No

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

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

Footnotes:

13. Trauma - Requested

Narrative Question

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

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

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

It is suggested that states refer to SAMHSA?s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ( ) Yes ( ) No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ( ) Yes ( ) No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ( ) Yes ( ) No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight.

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

Footnotes:

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

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

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ( ) Yes ( ) No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient?s needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA?s activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ( ) Yes ( ) No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ( ) Yes ( ) No
3. Does the state purchase any of the following medication with block grant funds? ( ) Yes ( ) No
   - a) é Methadone
   - b) é Buprenophine, Buprenorphine/naloxone
   - c) é Disulfiram
   - d) é Acamprosate
   - e) é Naltexone (oral, IM)
   - f) é Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ( ) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA?s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

?Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.?

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

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

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☐ Psychiatric Advance Directives
   - c) ☐ Family Engagement
   - d) ☐ Safety Planning
   - e) ☐ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☐ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☐ Assessment/Triage (Living Room Model)
   - b) ☐ Open Dialogue
   - c) ☐ Crisis Residential/Respite
   - d) ☐ Crisis Intervention Team/Law Enforcement
   - e) ☐ Mobile Crisis Outreach
   - f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☐ WRAP Post-Crisis
   - b) ☐ Peer Support/Peer Bridges

c) é Follow-up Outreach and Support

d) é Family to Family Engagement

e) é Connection to care coordination and follow-up clinical care for individuals in crisis

f) é Follow-up crisis engagement with families and involved community members

g) é Recovery community coaches/peer recovery coaches

h) é Recovery community organization

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ( ) Yes ( ) No

   b) Required peer accreditation or certification? ( ) Yes ( ) No

   c) Block grant funding of recovery support services. ( ) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

      Yes, explained below.

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Administrative Rules of South Dakota (ARSD) Article 67:62 Mental Health, requires the implementation of recovery support services and defines recovery as a process of change through which an individual achieves improved health, wellness and quality of life. Provider contracts also detail the responsibility of providers to implement recovery skills to help individuals cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living. This may include, but not limited to:

   a. Ongoing assessment of the client's mental illness and co-occurring disorders symptoms and the client's response to treatment;

   b. Assessment of the client's mental illness symptoms and behavior in response to medication and monitoring for medication side effects;

   c. Education, when appropriate, of the client regarding his/her illness, medication prescribed to regulate the illness, and side effects of medications;

   d. Education about the hope of recovery with regard to mental illness and co-occurring issues.

   e. Assistance in developing social skills, skills to help client build relationships with landlords, neighbors, etc., and skills to address co-occurring issues;

   f. Symptom management efforts directed to helping each client identify personal strengths; recognize symptoms or occurrence patterns of his/her mental illness and co-occurring disorders; and develop methods (internal, behavioral, or adaptive) to help lessen the effects; and

   g. Psychological support (both on a planned and "as needed" basis) to help clients accomplish their independent living goals and to cope with the stresses of day-to-day living.

   Also, contract requires that services should be provided in a setting of the client's choosing and not just the office.
   In addition, the Behavioral Health Advisory Council (BHAC) includes representation of adults who have a serious mental illness (SMI) and also family members of adults who have a SMI or children who have a serious emotional disturbance (SED). One membership is for a youth (approximately 16 to 21 years of age) with SED and/or SUD or a youth who has a sibling with SED and/or SUD.

   To view a current list of BHAC members and Bylaws: http://dss.sd.gov/behavioralhealth/services/.
   The Division of Behavioral Health (DBH) also partners with the National Alliance on Mental Illness, South Dakota (NAMI-SD) to provide scholarships to individuals with mental illness who have limited financial resources for attending NAMI-SD's annual education conference. The DBH also provides speakers to keep attendees updated on transformation activities at the state level.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   ARSD, Article 67:61 Substance Use Disorders, requires the implementation of recovery support services and defines recovery as a process of change through which an individual achieves improved health, wellness and quality of life.

Provider contract requires recovery support services to be provided. Recovery supports are networks of formal and informal services developed and mobilized to sustain long term recovery for individuals and families. Recovery supports may include, but not limited to:

a. Home visiting;
b. Linking to community-based programs;
c. Support participation in medical/psychiatric care;
d. Child care and advocacy;
e. Self-help programs;
f. Peer and faith-based support groups;
g. Transportation;
h. Monitoring and outreach;
i. Parent education and child development; and
j. Employment services and job training.

The South Dakota Temporary Assistance for Needy Families funds recovery support services for the pregnant and parenting women's program at Behavior Management Systems in Rapid City.

The DBH funds recovery support services within the state's two specialized methamphetamine treatment programs.

In addition, the BHAC includes representation of adults recovering from substance use.

To view a current list of BHAC members and Bylaws: http://dss.sd.gov/behavioralhealth/services/.

5. Does the state have any activities that it would like to highlight?

In 2016, the DBH with technical assistance from the Substance Abuse and Mental Health Services Administration explored various potential funding and training structures that could support the development and sustainability of peer support services. The DBH continues to assess the feasibility of peer support services within the state as well as determining the funding component needed to support such activities.

In the meantime, in SD, Face It TOGETHER has a peer volunteer program that provides peer support services for people who have addiction issues. Face It TOGETHER: http://www.faceitsiouxfalls.org/it-s-a-disease. Also, the National Alliance on Mentally Illness – SD (NAMI-SD) provides a weekly peer support group for families and individuals with a serious mental illness. NAMI-SD: http://namisouthdakota.org/.

In addition, the DBH assists with scholarships for individuals who have a mental illness and have limited financial resources in order to attend the annual educational conference sponsored by NAMI. The DBH, CMHCs and NAMI continue to collaborate in ways that will support recovery efforts and provide education to clients and family members.

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

Footnotes:

Environmental Factors and Plan

Recovery

1. **Does the state support recovery through any of the following:**
    a. Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ☐ Yes ☒ No
    b. Required peer accreditation or certification? ☐ Yes ☒ No
    c. Block grant funding of recovery support services? ☒ Yes ☐ No
    d. Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ☒ Yes ☐ No

2. **Does the state measure the impact of your consumer and recovery community outreach activity?** ☐ Yes ☒ No

3. **Provide a description of the recovery and recovery support services for adults with SMI and children with SED in your state.**
    Administrative Rules of South Dakota (ARSD) Article 67:62 Mental Health, requires the implementation of recovery support services and defines recovery as a process of change through which an individual achieves improved health, wellness and quality of life.
    Provider contracts also detail the responsibility of providers to implement recovery skills to help individuals cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living. This may include, but not limited to:
    a. Ongoing assessment of the client's mental illness and co-occurring disorders symptoms and the client's response to treatment;
    b. Assessment of the client's mental illness symptoms and behavior in response to medication and monitoring for medication side effects;
    c. Education, when appropriate, of the client regarding his/her illness, medication prescribed to regulate the illness, and side effects of medications;
    d. Education about the hope of recovery with regard to mental illness and co-occurring issues.
    e. Assistance in developing social skills, skills to help client build relationships with landlords, neighbors, etc., and skills to address co-occurring issues;
    f. Symptom management efforts directed to helping each client identify personal strengths; recognize symptoms or occurrence patterns of his/her mental illness and co-occurring disorders; and develop methods (internal, behavioral, or adaptive) to help lessen the effects; and
    g. Psychological support (both on a planned and "as needed" basis) to help clients accomplish their independent living goals and to cope with the

stresses of day-to-day living.

Also, contract requires that services should be provided in a setting of the client's choosing and not just the office.

In addition, the Behavioral Health Advisory Council (BHAC) includes representation of adults who have a serious mental illness (SMI) and also family members of adults who have a SMI or children who have a serious emotional disturbance (SED). One membership is for a youth (approximately 16 to 21 years of age) with SED and/or SUD or a youth who has a sibling with SED and/or SUD.

To view a current list of BHAC members and Bylaws: http://dss.sd.gov/behavioralhealth/services/.

The Division of Behavioral Health (DBH) also partners with the National Alliance on Mental Illness, South Dakota (NAMI-SD) to provide scholarships to individuals with mental illness who have limited financial resources for attending NAMI-SD's annual education conference. The DBH also provides speakers to keep attendees updated on transformation activities at the state level.

4. **Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.**
ARSD, Article 67:61 Substance Use Disorders, requires the implementation of recovery support services and defines recovery as a process of change through which an individual achieves improved health, wellness and quality of life. Provider contract requires recovery support services to be provided. Recovery supports are networks of formal and informal services developed and mobilized to sustain long term recovery for individuals and families. Recovery supports may include, but not limited to:
    a. Home visiting;
    b. Linking to community-based programs;
    c. Support participation in medical/psychiatric care;
    d. Child care and advocacy;
    e. Self-help programs;
    f. Peer and faith-based support groups;
    g. Transportation;
    h. Monitoring and outreach;
    i. Parent education and child development; and
    j. Employment services and job training.

The South Dakota Temporary Assistance for Needy Families funds recovery support services for the pregnant and parenting women's program at Behavior Management Systems in Rapid City.

The DBH funds recovery support services within the state's two specialized

methamphetamine treatment programs.

In addition, the BHAC includes representation of adults recovering from substance use.

To view a current list of BHAC members and Bylaws: http://dss.sd.gov/behavioralhealth/services/.

5. **Does the state have any activities that it would like to highlight?**
In 2016, the DBH with technical assistance from the Substance Abuse and Mental Health Services Administration explored various potential funding and training structures that could support the development and sustainability of peer support services. The DBH continues to assess the feasibility of peer support services within the state as well as determining the funding component needed to support such activities.

In the meantime, in SD, Face It TOGETHER has a peer volunteer program that provides peer support services for people who have addiction issues. Face It TOGETHER: http://www.faceitsiouxfalls.org/it-s-a-disease. Also, the National Alliance on Mentally Illness – SD (NAMI-SD) provides a weekly peer support group for families and individuals with a serious mental illness. NAMI-SD: http://namisouthdakota.org/.

In addition, the DBH assists with scholarships for individuals who have a mental illness and have limited financial resources in order to attend the annual educational conference sponsored by NAMI. The DBH, CMHCs and NAMI continue to collaborate in ways that will support recovery efforts and provide education to clients and family members.

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

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court?s decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA?s mission to reduce the impact of M/SUD on America?s communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court?s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

   housing services provided. ( ) Yes ( ) No

   home and community based services. ( ) Yes ( ) No

   peer support services. ( ) Yes ( ) No

   employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

Footnotes:

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children?s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children?s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

---

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America?s #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

---

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ( ) Yes ( ) No

   b) Juvenile justice? ( ) Yes ( ) No

   c) Education? ( ) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes ( ) No

   b) Costs? ( ) Yes ( ) No

   c) Outcomes for children and youth services? ( ) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ( ) Yes ( ) No

   b) for youth in foster care? ( ) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   The development of partnerships with health, social services, education, and other state and local government entities is integral to the development of an integrated system of care.

   The state describes the integration of services within Planning Step One regarding the following:

   • Child Welfare, Juvenile Services and Criminal Justice Coordination
   • Medical/Dental Service Coordination
   • Vocational and Educational Coordination
   • Housing Coordination and Support
   • Criminal Justice Initiative
   • Juvenile Justice Reinvestment Initiative
   • Correctional Resource Coordination
   • Health Homes

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

The DBH's Accreditation Program monitors the system of care approach for the delivery of mental health and SUD services through on-site accreditation reviews. The accreditation monitoring consists of review of policies and procedures, individual charts, and interviews with families and individuals. Questions in the interview process include processes to determine methods the agency employs to create a system of care that is hopeful and empowering, respectful and welcoming, individual/family driven, culturally sensitive and integrated for individuals and families with co-occurring complex needs.

In addition, the DBH collaborated with the Unified Judicial System and the Department of Corrections in order to implement the Juvenile Justice Reinvestment Initiative (JJRI) Program. The intent of the JJRI program is to expand and provide evidence-based interventions to justice-involved youth within their community. Eleven CMHCs and Lutheran Social Services were trained in Functional Family Therapy, an evidence-based practice, and services began in January 2016. Training in Moral Reconation Therapy and Aggression Replacement Training services began in January 2017.

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

Footnotes:

Environmental Factors and Plan

Children and Adolescent Behavioral Health Services MHBG

1. **Does the state utilize a system of care approach to support:**
    a. The recovery and resilience of children and youth with SED? ☒ Yes ☐ No
    b. The recovery and resilience of children and youth with SUD? ☒ Yes ☐ No

Community Mental Health Centers (CMHCs) are required to provide an integrated system of care as described in contract language. Services must be individualized according the client's needs and strengths, while also being responsive to cultural differences and special needs. The process can involve parents/guardians, family members, friends and any professionals or advocates the individual wishes to be involved.

Administrative Rules of South Dakota (ARSD), Article 67:62 Mental Health, defines system of care as a coordinated network of community-based services and support organized to meet the needs of individuals with mental health issues and their families. CMHCs are required through ARSD to develop a plan which describes on organized community-based system of care for individuals with a mental disorder, including co-occurring disorders.

In addition, Lewis and Clark Behavioral Health Services, Yankton public schools, Court Services and Child Protection Services initiated a pilot project in the fall of 2014 to strengthen the local system of care. The goal was to implement a wrap-around approach driven by child/family teams for high risk youth who have severe emotional problems. The project is unique because the focus is on placing the school system in a leadership role in the implementation of a wrap-around approach within a system of care. Serving as a single point of contact, the LCBHS Care Coordinator works with school systems to identify students at risk; assists students' families to develop strength based goals, and assists families with connecting to supports and agencies who can provide the resources to accomplish these goals. The first two years of the pilot program were funded through a Janssen pharmaceutical settlement. LCBHS also contributes $4,000 per year for flex funding, used as a resource to support families and their needs. The pilot project results indicated that many services and supports provided to the families were either low-cost or no-cost.

2. **Does the state have an established collaboration plan to work with other child and youth serving agencies in the state to address behavioral health needs?**
    a. Child Welfare? ☒ Yes ☐ No
    b. Juvenile Justice? ☒ Yes ☐ No
    c. Education? ☒ Yes ☐ No

Child Welfare, Juvenile Services, and Criminal Justice Coordination
The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections, and CMHC Directors continue collaborative efforts to improve the referral and service delivery system for children who are referred by UJS or CPS to a CMHC. The DBH supports these collaborative efforts by coordinating both system-wide conversations and local conversations, if needed.

Educational Coordination
CMHCs work closely with school personnel in the identification and early intervention of children who have a serious emotional disturbance as defined under the Individuals with Disabilities Education Act and South Dakota Codified Law. In addition, CMHCs provide mental health services in many schools across the state and work with school counselors and teachers to provide early interventions and to develop of system of support for youth in their communities. They also work with youth, families and Individual Education Plan teams to ensure that needed mental health services are being provided and that the child is receiving an appropriate education, despite mental health issues or other learning disabilities. CMHCs also offer groups regarding life skills and building self-esteem, and education for youth, teacher, and counselors regarding early identification and interventions.

3. Does the state monitor its progress and effectiveness, around:

a. Service utilization? ☒ Yes ☐ No
b. Costs? ☒ Yes ☐ No
c. Outcomes for children and youth services? ☒ Yes ☐ No

Utilization and Cost:
The DBH utilizes an electronic system called STARS (State Treatment Activity Reporting System) to track service utilization and costs. The STARS also collects individual demographics and service information.

Outcome Measurement:
Data and outcome reporting is identified as a critical gap and need within the State of South Dakota. In 2015, the DBH, in conjunction with the Council of Mental Health Center Directors, Inc. and the Council of Substance Abuse Directors, Inc. and representatives from CMHCs and Substance Use Disorder (SUD) treatment providers, formed a Data and Outcomes Work Group (DOWG).

The DOWG reviewed federally required data elements and national outcome measures as well as data and outcomes collected by the DBH. As a result, the DOWG agreed upon a comprehensive data collection and analysis process to measure the impact of behavioral health services. This methodology allows the monitoring and reporting of outcome measures on a variety of levels including, but not limited to the individual client, the provider and funding sources at both state and federal levels.

In Fiscal Year (FY) 2017, the DBH began collecting and monitoring outcomes measures and performance indicators for all adults receiving services within the public mental

health system. The DOWG then reconvened and started developing tools to measure outcomes and performance indicators for all youth and family members of youth clients receiving services. The goal is to implement the youth and family tools by FY 2018.

4. **Does the state provide training in evidence-based:**
    a. Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families. ☒ Yes ☐ No
    b. Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No

5. **Does the state have plans for transitioning children and youth receiving services:**
    a. To the adult behavioral health system? ☒ Yes ☐ No
    b. For youth in foster care? ☒ Yes ☐ No

6. **Describe how the state provides integrated services through the system of care (social services, education services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.).**
    The development of partnerships with health, social services, education, and other state and local government entities is integral to the development of an integrated system of care.

    The state describes the integration of services within Planning Step One regarding the following:

    - Child Welfare, Juvenile Services and Criminal Justice Coordination
    - Medical/Dental Service Coordination
    - Vocational and Educational Coordination
    - Housing Coordination and Support
    - Criminal Justice Initiative
    - Juvenile Justice Reinvestment Initiative
    - Correctional Resource Coordination
    - Health Homes

7. **Does the state have any activities related to his section that you would like to highlight?**
    The DBH's Accreditation Program monitors the system of care approach for the delivery of mental health and SUD services through on-site accreditation reviews. The accreditation monitoring consists of review of policies and procedures, individual charts, and interviews with families and individuals. Questions in the interview process include processes to determine methods the agency employs to create a system of care that is hopeful and empowering, respectful and welcoming, individual/family driven, culturally sensitive and integrated for individuals and families with co-occurring complex needs.

In addition, the DBH collaborated with the Unified Judicial System and the Department of Corrections in order to implement the Juvenile Justice Reinvestment Initiative (JJRI) Program. The intent of the JJRI program is to expand and provide evidence-based interventions to justice-involved youth within their community. Eleven CMHCs and Lutheran Social Services were trained in Functional Family Therapy, an evidence-based practice, and services began in January 2016. Training in Moral Reconation Therapy and Aggression Replacement Training services began in January 2017.

A detailed description of the JJRI can be found in Planning Step One.

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

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ( ) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

   The Division of Behavioral Health's Prevention Program received two federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) that focuses on suicide prevention. One grants is called South Dakota's "Now is the Time" Project Aware Training Initiative and runs from 2015 to 2018. The initiative's focus is on increasing the mental health literacy of adults who interact with 12 to 18 year old adolescents. Under the Project Aware Training Initiative we have trained 12 behavioral health professionals as Youth Mental Health First Aid Instructors. In turn, these 12 trainers have trained approximately 565 people as Youth Mental Health First Aiders who have made 104 referrals for youth at risk for suicide to receive additional assistance.

   The other grant is the South Dakota Youth Suicide Prevention Grant which runs from 2014 to 2019. The grant's focus is on youth at risk for suicide, with the target population being from 10 to 24 years old. Partnerships with hospitals were established to provide extended follow-up services to youth admitted to emergency departments and inpatient psychiatric units for suicide attempts or suicidal ideation. As of April 2016, there have been 598 total clients enrolled in the program with 31 of those clients being readmits.

   A detailed description of each grant can be found in Planning Step One.

3. Have you incorporated any strategies supportive of Zero Suicide? ( ) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ( ) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ( ) Yes ( ) No

   If so, please describe the population targeted.

   The Screening, Brief Intervention and Referral to Treatment (SBIRT) Grant targets adults coming in for their annual medical visit. Besides being screened for alcohol and drug use, they are also given the Patient Health Questionnaire-9 and if there is a high score on the screening tool, they are referred to treatment.

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

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

Footnotes:

Environmental Factors and Plan

Suicide Prevention - MHBG

1. **Have you updated your state's suicide prevention plan in the last two years?**
   ☐ Yes ☒ No
2. **Describe activities intended to reduce incidents of suicide in your state.**
   The Division of Behavioral Health's Prevention Program received two federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) that focuses on suicide prevention. One grants is called South Dakota's "Now is the Time" Project Aware Training Initiative and runs from 2015 to 2018. The initiative's focus is on increasing the mental health literacy of adults who interact with 12 to 18 year old adolescents. Under the Project Aware Training Initiative we have trained 12 behavioral health professionals as Youth Mental Health First Aid Instructors. In turn, these 12 trainers have trained approximately 565 people as Youth Mental Health First Aiders who have made 104 referrals for youth at risk for suicide to receive additional assistance.

   The other grant is the South Dakota Youth Suicide Prevention Grant which runs from 2014 to 2019. The grant's focus is on youth at risk for suicide, with the target population being from 10 to 24 years old. Partnerships with hospitals were established to provide extended follow-up services to youth admitted to emergency departments and inpatient psychiatric units for suicide attempts or suicidal ideation. As of April 2016, there have been 598 total clients enrolled in the program with 31 of those clients being readmits.

   A detailed description of each grant can be found in Planning Step One.

3. **Have you incorporated any strategies supportive of Zero Suicide?** ☒ Yes ☐ No
4. **Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?**
   ☒ Yes ☐ No
5. **Have you begun any targeted or statewide initiatives since the FFY 2016- FFY2017 plan was submitted?** ☒ Yes ☐ No
   a. If so, please describe the population targeted?
      The Screening, Brief Intervention and Referral to Treatment (SBIRT) Grant targets adults coming in for their annual medical visit. Besides being screened for alcohol and drug use, they are also given the Patient Health Questionnaire-9 and if there is a high score on the screening tool, they are referred to treatment.

      A detailed description of the SBIRT Grant can be found in Planning Step One.

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

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state?s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state?s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state?s ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ( ) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

   If yes, with whom?

   NA

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   Child Welfare, Juvenile Services, and Criminal Justice Coordination
   The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections, and CMHC directors continue collaborative efforts to improve the referral and service delivery system for children who are referred by UJS or CPS to a CMHC. The DBH supports these collaborative efforts by coordinating both system-wide conversations and local conversations, if needed.

   The following coordination of services between state and local entities are detailed within Planning Step One to include:

   • Child Welfare, Juvenile Services and Criminal Justice Coordination
   • Medical/Dental Service Coordination
   • Vocational and Educational Coordination
   • Housing Coordination and Support
   • Criminal Justice Initiative
   • Juvenile Justice Reinvestment Initiative

• Correctional Resource Coordination
• Health Homes

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

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

Footnotes:

Environmental Factors and Plan

Support of State Partners - MHBG

1. **Has your state added any new partners or partnerships since the last planning period?** ☐ Yes ☒ No

2. **Has your state identified the need to develop new partnerships that you did not have in place?** ☐ Yes ☒ No
   a. If yes, with whom?

3. **Describe the manner in which your state and local entities coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.**

   Child Welfare, Juvenile Services, and Criminal Justice Coordination
   The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections, and CMHC directors continue collaborative efforts to improve the referral and service delivery system for children who are referred by UJS or CPS to a CMHC. The DBH supports these collaborative efforts by coordinating both system-wide conversations and local conversations, if needed.

   The following coordination of services between state and local entities are detailed within Planning Step One to include:
   - Child Welfare, Juvenile Services and Criminal Justice Coordination
   - Medical/Dental Service Coordination
   - Vocational and Educational Coordination
   - Housing Coordination and Support
   - Criminal Justice Initiative
   - Juvenile Justice Reinvestment Initiative
   - Correctional Resource Coordination
   - Health Homes

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

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council?s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

      The Behavioral Health Advisory Council (BHAC) meets at least four times per year to review, monitor and evaluate the implementation of the behavioral health services plan and service system while providing suggested methods to evaluate the quality of that service network.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — Yes / No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — Yes / No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The BHAC performs the following functions:

   • Development and modification of state or federal mental health plans;
   • Promoting greater coordination of planning and service delivery efforts among federal, state, local, or private agencies involved in the mental health service delivery network;
   • Advising on and addressing policy issues related to the allocation of federal and state funds to the mental health centers in the state and the South Dakota Human Services Center (single state psychiatric inpatient facility);
   • Providing input on matters concerning regulation, staff requirements, administration, audit and record keeping, and services to be provided by mental health centers and the South Dakota Human Services Center;
   • Identification of needed program and service expansion and achievement of the highest possible quality service
   • Provide input regarding statewide needs in substance abuse prevention and treatment
   • Promote coordination and planning activities between state and local government agencies and private providers
   • Review and provide input on the studies for prevention, treatment, and rehabilitation of drug and alcohol abuse
   • Advise on all functions delegated to the state office

   The BHAC supports the Division of Behavioral Health (DBH) with the planning, coordination and development of the state comprehensive behavioral health services plan. The BHAC advocates on behalf of persons served to ensure their highest attainable degree of independence in the least restrictive environment, productivity, community integration and quality of services.

The BHAC also advises DBH on statewide treatment, prevention, and rehabilitation needs within the current behavioral health system. The BHAC's duties of planning for behavioral health service delivery include informing and reviewing the Combined Behavioral Health Assessment and Plan. The BHAC is responsible for reviewing the State Plan before it is submitted and are sent a copy for their review, to make comments and to share with their constituents. A BHAC meeting is then held to discuss the plan.

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

Meeting minutes and agendas can be found at : http://dss.sd.gov/behavioralhealth/services/ and http://boardsandcommissions.sd.gov/Meetings.aspx?BoardID=55.

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Environmental Factors and Plan

State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - MHBG

1. **How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).**
    a. What mechanism does the state use to plan and implement substance use prevention, SUD treatment and recovery services?
    The Behavioral Health Advisory Council (BHAC) meets at least four times per year to review, monitor and evaluate the implementation of the behavioral health services plan and service system while providing suggested methods to evaluate the quality of that service network.

    b. Has the Council successfully integrated substance use prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ☒ Yes ☐ No

2. **Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?**
    ☒ Yes ☐ No
    BHAC members are appointed by and serve at the pleasure of the Governor. No less than 50 percent of the membership consists of individuals who are non-state employees or providers of mental health services. A total of 27 members include; 14 consumer/family representatives/advocacy and13 provider/state.

    The BHAC incorporates diversity in representation and strives for equal membership of substance use and mental health consumer/family membership, service providers and state employees.

    To view a current list of BHAC members and Bylaws:
    http://dss.sd.gov/behavioralhealth/services/.

3. **Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.**

    The BHAC performs the following functions:
    - Development and modification of state or federal mental health plans;

- Promoting greater coordination of planning and service delivery efforts among federal, state, local, or private agencies involved in the mental health service delivery network;
- Advising on and addressing policy issues related to the allocation of federal and state funds to the mental health centers in the state and the South Dakota Human Services Center (single state psychiatric inpatient facility);
- Providing input on matters concerning regulation, staff requirements, administration, audit and record keeping, and services to be provided by mental health centers and the South Dakota Human Services Center;
- Identification of needed program and service expansion and achievement of the highest possible quality service
- Provide input regarding statewide needs in substance abuse prevention and treatment
- Promote coordination and planning activities between state and local government agencies and private providers
- Review and provide input on the studies for prevention, treatment, and rehabilitation of drug and alcohol abuse
- Advise on all functions delegated to the state office

The BHAC supports the Division of Behavioral Health (DBH) with the planning, coordination and development of the state comprehensive behavioral health services plan. The BHAC advocates on behalf of persons served to ensure their highest attainable degree of independence in the least restrictive environment, productivity, community integration and quality of services.

The BHAC also advises DBH on statewide treatment, prevention, and rehabilitation needs within the current behavioral health system. The BHAC's duties of planning for behavioral health service delivery include informing and reviewing the Combined Behavioral Health Assessment and Plan. The BHAC is responsible for reviewing the State Plan before it is submitted and are sent a copy for their review, to make comments and to share with their constituents. A BHAC meeting is then held to discuss the plan.

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Christy Alten-Osmera	Providers		Keystone Treatment Center Canton SD, 57013 PH: 605-335-7711	calten@crchealth.com
Phyllis Arends	Parents of children with SED	NAMI South Dakota	PO Box 88808 Sioux Falls SD, 57109 PH: 605-271-1871	namisd@midconetwork.com
Kristi Bunkers	State Employees		Department of Corrections Sioux Falls SD, 57106 PH: 605-362-3592	Kristi.Bunkers@state.sd.us
Daniele Dosch	Parents of children with SED		1019 Fulton Street Rapid City SD, 57701 PH: 605-718-0747	ddosch@rushmore.com
Wendy Figland	Parents of children with SED		520 E 54th St Mitchelle SD, 57301 PH: 605-770-2740	figlandfamily@santel.net
Chuck Frieberg	State Employees	Unified Judicial System, Division of Trial Court Services	500 E Capitol Pierre SD, 57501 PH: 605-773-3511	Charles.Frieberg@ujs.state.sd.us
LeLewis Gipp	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Indian Health Services	115 4th Ave SE Aberdeen SD, 57401 PH: 605-226-7457	lelewis.gipp@ihs.gov
Joyce Glynn	Providers		25044 Cedar Butte Road Belvidere SD, 57521 PH: 605-441-5389	mgmcoalition@gwtc.net
Jane Grant	Parents of children with SED		30626 446th Ave Mission Hill SD, 57046 PH: 605-661-2223	sunnyjargon337@icloud.com
Bernie Grimme	State Employees	Department of Human Services, Division of Rehabilitation Services	E. Hwy 34, Hillsview Plaza Pierre SD, 57501 PH: 605-773-6284	bernie.grimme@state.sd.us
Katherine Jaeger	Parents of children with SED		260 Courtyard Drive #213 Dakota Dunes SD, 57049 PH: 605-209-8954	jaeger_katherine@yahoo.com
Lois Knoke	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1601 Ohio Ave SW #209 Huron SD, 57350 PH: 605-350-2320	ljknoke@hur.midco.net
			703 3rd Ave SE	

Susan Kornder	Providers	Northeastern Mental Health Center	Aberdeen SD, 57401 PH: 605-225-1014	skornder@nemhc.org
Kori Kromminga	Parents of children with SED		1324 W Wicklow Court Sioux Falls SD, 57108 PH: 605-334-5240	klk720@gmail.com
Ann Larsen	State Employees	Department of Education	800 Governors Drive Pierre SD, 57501 PH: 605-773-3134	Ann.Larsen@state.sd.us
Dianna Marshall	Others (Not State employees or providers)	South Dakota Advocacy Services	1575 N LaCrosse St, Suite K Rapid City SD, 57701 PH: 605-342-3808	marshald@sdadvocacy.com
Belinda Nelson	Providers	Community Counseling Services	357 Kansas, SE Huron SD, 57350 PH: 605-352-8596	benelson@ccs-sd.org
Jayne Parson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3304 Colony Loop Ft. Pierre SD, 57532 PH: 605-222-2221	jparsons@cacsnet.org
Roseann Peterson-Olson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		21163 456th Ave Arlington SD, 57212 PH: 605-983-5726	rose.olson@hotmail.com
Lorraine Polak	Others (Not State employees or providers)	South Dakota Housing Authority (Housing Agency)	PO Box 1237 Pierre SD, 57501 PH: 605-773-3181	lorraine@sdhda.org
Susan Sandgren	Providers	Three Rivers Mental Health/CD Center	PO Box 447 Lemmon SD, 57638 PH: 605-374-3862	threerivers@sdplains.com
Ellen Washenberger	Family Members of Individuals in Recovery (to include family members of adults with SMI)		421 15th Ave NE Aberdeen SD, 57401 PH: 605-226-3086	ewashen@lsssd.org
Sheila Weber	Providers	Lutheran Social Services	705 E 41st St, Suite 200 Sioux Falls SD, 57105 PH: 605-357-0105	Sheila.Weber@LssSD.org
Emily Williams	Federally Recognized Tribe Representatives		Indian Health Services Aberdeen SD, 57401 PH: 605-226-7791	Emily.Williams@ihs.gov
Tiffany Wolfgang	State Employees	Department of Social Services - Mental Health	811 E 10th St Sioux Falls SD, 57103 PH: 605-367-5236	Tiffany.Wolfgang@state.sd.us
Jane York	Family Members of Individuals in Recovery (to include family members of adults with SMI)		152 Lewis and Clark Trail Yankton SD, 57078 PH: 605-665-2680	giyork@vyn.midco.net

Footnotes:

The Advisory Council has one vacant position:
1. A youth with SED and/or SUD or a youth who has a sibling with SED and/or SUD.

Bernie Grimme is with the Division of Rehabilitation services (State Vocational Rehabilitation Agency) under the Department of Human Services.

The Mental Health Agency is under the Department of Social Services, Tiffany Wolfgang.

Lorraine Polak is with the South Dakota Housing Development Authority and is considered the Housing Agency.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	27	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	6	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	15	
State Employees	5	
Providers	6	
Federally Recognized Tribe Representatives	1	
Vacancies	0	
Total State Employees & Providers	12	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The draft State Plan was distributed to Advisory Council members for their review and also discussed at council meetings throughout the year. Members are encouraged to share the draft plan with others to solicit comments. This includes consumer and family representatives who share the draft plan with individuals within their local communities as well as other consumer/family advocates.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	(•) Yes ( ) No
b)	Posting of the plan on the web for public comment?	(•) Yes ( ) No
c)	Other (e.g. public service announcements, print media)	(•) Yes ( ) No

If yes, provide URL:

http://dss.sd.gov/behavioralhealth/services/

http://boardsandcommissions.sd.gov/

Footnotes:

Environmental Factors and Plan

Public Comment on the State Plan

1. **Did the state take any of the following steps to make the public aware of the plan and allow for public comment?**
   a. Public meetings or hearings? ☒ Yes ☐ No

      The Behavioral Health Advisory Council meets no less than four times per year to support the Division of Behavioral Health (DBH) with the planning, coordination and development of the state's behavioral health service plan. Meetings are open to the public and notice is posted on the DBH's website, http://dss.sd.gov/behavioralhealth/services/ and the State of South Dakota's Boards and Commissions Portal, http://boardsandcommissions.sd.gov/ at least 10 days prior to the meeting as set forth in South Dakota Codified Law 1-25-1.1. The agenda and supporting materials are also posted during that time. Interested persons may attend the meeting or written comments can be mailed to the DBH prior to the meeting.

   b. Posting of the plan on the web for public comment? ☒ Yes ☐ No
      If yes, provide URL
      http://dss.sd.gov/behavioralhealth/services/
      http://boardsandcommissions.sd.gov/

   c. Other (e.g. public service announcements, print media) ☒ Yes ☐ No

      A request for public comment of the state plan is posted in the following newspapers: Sioux Falls Argus Leader, Aberdeen American, Capital Journal, Huron Daily Plainsman and the Rapid City Journal.