Appendix I. DE System "Map"/ Service Inventory

To better understand the menu of substance use prevention and treatment services for youth in Delaware, HMA worked with DPBHS to compile an inventory of services offered.

Service	Providers
Mobile Outpatient Services	• A Center for Mental Wellness • A Seed of Hope Counseling Center • Coastal Counseling and Consulting Services LLC • CORAS Wellness & Behavioral Health • Creative Change Counseling • Delaware Guidance Services • Devereux Community Services • Jewish Family Services • Journey Wellness and Consulting Group • Journeys, LLC • Kaleidoscope Family Solutions • New Behavioral Network • NorthNode Group Counseling • Synergy Consulting and Psychotherapy Practice • Your Center, LLC
Therapeutic Support for Families (TSF)	• A Center for Mental Wellness • A Seed of Hope Counseling Center • Coastal Counseling and Consulting Services LLC • Creative Change Counseling • Delaware Guidance Services • Jewish Family Services • Journey Wellness and Consulting Group • Journeys, LLC • Kaleidoscope Family Solutions • New Behavioral Network • NorthNode Group Counseling • Synergy Consulting and Psychotherapy Practice • Your Center, LLC
Family-Based Services (FBS)	• CORAS Wellness & Behavioral Health • Delaware Guidance Services • Devereux Community Services
Multisystemic Therapy (MST)	• A Center for Mental Wellness
Functional Family Therapy (FFT)	• Cayuga Centers • Youth and Families First • Vision Quest
Family Peer Support Services (FPSS)	• Autism Delaware • Champions for Youth's Mental Health
Wraparound Services	• Wraparound DE

Appendix II. DPBHS Admission Data

Total Admissions Per Fiscal Year

FY20–FY22

	FY20	FY21	FY22
Adjunctive Services	58	30	52
Crisis Bed, MH	45	34	21
Day Hospital, MH	*536*	441	523
Day Treatment, MH	36	2	1
Family Based Mental Health Service	100	115	72
Family Peer Support Services	169	127	126
High Fidelity Wraparound	38	10	-
Inappropriate Sexual Behavior	-	-	2
Inpatient Hospital, MH	1,429	1,053	1,295
Language Services/Interpretation	17	4	4
Mobile Response and Stabilization Services	3,494	2,695	3,147
Multi-Systemic Therapy	32	25	34
Outpatient - Functional Family Therapy	37	32	46
Outpatient Services (SA)	40	14	4
Outpatient Services, MH	867	562	526
PRTF	72	56	36
Residential Treatment (SA)	3	1	-
Residential Treatment, MH	43	29	32
Targeted Case Management	-	48	54
Therapeutic Support for Families	539	346	323
Transportation	43	25	39
Youth Intervention and Response Svc	40	12	24
Total Admissions	**7,638**	**5,661**	**6,361**

Appendix IX. Delaware Focus Groups Key Findings

Need for SUD training among all stakeholders including providers, educators, judges, etc.	• Stakeholders across all focus groups and interviews expressed a desire to better understand SUD and how to serve youth. Participants agreed they would participate in training and need more data and guidance to understand the treatment options that are available, the best evidence-based programs, and the science of SUD. • Judges need better education about correcting SUD-related behaviors and the best evidence-based options for preventing recidivism. • Several stakeholders noted that entry-level SUD workers need more required training, education, or certification.
Coordination between partners	• Judicial partners specifically requested quarterly updates from DPBHS on the treatment options available to them. • DPBHS should be more engaged in legal actions involving youth going to court and give a report on their history with DPBHS. If DPBHS wants an outcome for a youth, let the judges know what that is. • Many have tried to put the pieces together, but nothing cohesive or shared out. Lots of people doing lots of things, but no communication between those prevention programs/resources. This is a big problem. • There is and always has been a disconnect between DPBHS and DSAMHS.
Workforce instability	• Stakeholders across the system are experiencing a workforce crisis, mirroring the healthcare crisis across the country. While there are not enough trained BH/SUD professionals, people are also leaving the workforce for more flexible jobs and better pay. Additionally, there is a lot of turnover and inconsistency in staffing and a lack of a pipeline from student to worker. These factors create a difficult environment to build trust and rapport with youth and their families.
Challenges providing a full continuum of care	Stakeholders described a variety of challenges to providing a full continuum of care for youth, including: • Workforce: There are not enough providers with SUD training (specifically youth and adolescent focused) at every level of care. While there are some SUD providers, it is not typically their specialty. The providers do not exist to meet the needs of youth and many providers do not serve youth. This leads to many youths being placed out of state. • Stakeholders expressed a desire for a database of providers and their specialties. • Treatment: Treatment options covering all ASAM levels of care. There is a need for lower levels of treatment that is not being met for marijuana use and vaping. • Facilities: While there are few programs and facilities in Delaware that treat substance use in youth, there are even fewer accessible options in Sussex County. • ASAM LOC: Many stakeholders view the ASAM levels of care as the standard and would like Delaware to adopt them. While DE does not use the ASAM levels or care for assessment and placement, they do use the CASII (used at intake and with care coordination), which some stakeholders noted was a similar tool. • There are not inpatient programs, there are long waitlists, need transition to the adult system, kids with specific needs (trauma) and who need specialized care. • Data: DE is not gathering enough data about the substance use needs of youth or evaluating the effectiveness of interventions. Services have been disappearing because there is the idea that there is not the need for them.

	• Telehealth: Telehealth has been helpful to create more continuity for the therapist/child relationship. • Referrals: Very few SUD referrals for kids. Providers are not seeing or getting referrals either. • Prevention: There is only so much that can happen on the state level in DE with education because local education has control.
Reluctance to give SUD diagnosis	Participants noted that youth are most frequently using marijuana, which providers are additionally reluctant to diagnose. Some participants expressed that based on age (how young) or quantity of marijuana use could be considered a problem or a diagnosis, while others said that any use under 18 years old is a problem. Additionally, noting that youth SUD tends to be ignored while the mental health diagnosis is treated until a major crisis erupts. • For kids arrested and in the community it may take six months before they get an assessment. For those that are detained they get to see a psychologist in the facility. This assessment is not supposed to happen until they are adjudicated.
The prevalence and normalization of marijuana and vaping is a barrier to treatment	• Stakeholders spoke about the increasing prevalence and normalization of marijuana and vape (marijuana and THC) use among youth without understanding the associated dangers and health risks. • Though legalization of marijuana does not apply to youth, it has still normalized it for youth, who no longer see it as an issue. • Youth are in an environment where their family and friends are using. It is at home and at school. • Address the home environment because parents are using marijuana at home. Participants described it as "fighting a battle with youth and society." • Schools spoke about vaping being the number one issue in schools, and they do not know how to discipline it. Access is too easy. • Lack of stigma for drug use, and it is often the opposite. • Many youths are high-risk, have a history of abuse and trauma, and describe drug use as a coping mechanism. • Many providers and parents have the sense that "we have bigger problems than marijuana use." Stakeholders described the most common drugs as marijuana, vape, and alcohol.
Funding mechanisms do not incentivize providers to offer a full continuum of care	• Funding streams for substance use treatment and prevention do not incentivize providers to offer a continuum of care. • System used to be more robust, but when program funding moved to fee-for-service reimbursement (unbundled), the amount of time providers can spend per patient decreased. • No longer a budget for an entire program. This is when treatment centers began shutting down. • Mobile outpatient difficult to provide since there is not higher reimbursement than office-based services, but more time is needed for travel. • Funding was labeled as sporadic, not distributed across the state, not strategic, and ad hoc. • Stakeholders agreed that it would be helpful to have a rate comparison with nearby regions.
Treatment barriers for youth	• Barriers to treatment for youth including, transportation, cost, insurance (especially for private insurers), the school-day, treatment stigma among their peers, language barrier, and social determinants of health. • Immigrant youth and youth from minority groups (Hispanic/Latino, Asian, Middle Eastern) are not accessing services.

	• System and services are not prepared to be culturally and linguistically appropriate and parents are often reluctant to consider services.

Appendix X. Connecticut Performance Outcomes for Adolescents

Performance Outcomes for Adolescent Outpatient Substance Use Services, PIE Data, FY2021				
METRIC	ACRA-AAC % (N)	MDFT % (N)	MST % (N)	MST-EA % (N)
Number Admitted/Served in FY2021	176	715	222	45
Outcomes for Client who Discharged in FY21	133	367	107	25
Abstinence/Reduction in Substance Uses	73% (52)	83% (303)	92% (89)	61% (15)
Living at Home at Discharge	96% (128)	99% (363)	100% (107)	92% (23)*
Improvements in School Attendance	87% (62)	91% (332)	95% (102)	^
No New Arrests	93% (66)	92% (336)	98% (105)	96% (24)
***Includes transitional living home for MST-EA** **^Not applicable – data not captured for this service**				

Appendix XI. DPBHS Strategic Plan 2023-2025: Goal 3

		Description	Key Activities	Time Frame	Responsible Leads	Key Implementers	Progress Indicators
Goal	**3**	**Expand and Fully Integrate Data-driven Decision Making to Maintain a Culture of Continuous Performance Improvement**					
Objective	**3.A**	**Develop and Communicate Dashboard**					
Implementation Strategies	3.A.1	Identify key indicators	Review data available via internal and external sources (e.g. existing PBH reports, FOCUS data, state and national data, national standards for behavioral health data reporting), survey key stakeholders for input regarding key indicators	Q3 CY 2023	Leadership Team	IMC	achieve consensus on initial set of data points for dashboard, obtain feedback on selected data points from stakeholders
	3.A.2	Determine how key indicators will be shared	Establish plan for which indicators are public facing and which are used for internal decision making, determine who will have access, how access will be provided	Q3 CY 2023	Leadership Team	IMC	label idetnified indicators as public facing or internal, establish plan for data sharing
	3.A.3	Identify dashboard design specifications	Identify any software and/or user interface needs	Q4 CY 2023	IMC	IMC	Technology needed has been purchased, any needed funding secured
	3.A.4	Build the dashboard	Mock dashboard created and tested; dashboard is reviewed and input solicited, defects are resolved	Q2 CY 2024	IMC	IMC, Leadereship Team	Test runs are problem free, modifications made based on input
	3.A.5	Share dashboard data with internal and external stakeholders	Identify key stakeholders to whom information is disseminated; establish frequency for data update; develop communiation strategies for dissemination, idetnify analytics to track views	Q3 CY 2024	Leadership Team	IMC	Dashboard is accessible; analytics are reviwed; information is updated per schedule
Objective	**3.B**	**Use data for quality improvement efforts**					
Implementation Strategies	3.B.1	Establish a data driven culture within PBH	Add data corner to division newsletter, quarterly email blasts about data to staff; onboarding for staff using FOCUS includes training on importance of data integrity; discuss data importance in NEO, performance management plan has data indicators that are communicated to staff and partners and monitored by Leadership Team	Q4 CY 2024	Leadership Team	CARF Committee, Supervisors, IMC, Leadership Team	improvement in data quality (e.g. reduction in unknown race, gender, etc.in FOCUS), CARF committee quarterly presentation to Leadership on performance management plan data, data performance indicators on performance plans
	3.B.2	Ensure data quality	Review data integrity to assess quality/accuracy; identify barriers to better quality/accuracy; implement strategies to address data integrity issues	Q1 CY 2025	Leadership Team	CQICU; IMC	Data quality improves; efforts are made to address data quality issues
	3.B.3	Data is reviewed and accurately interpreted	Establish plan for review of data and development of quality assurance targets; establish benchmarks for comparison on key data elements; build technical skills of staff on data interpretation	Q1 CY 2024	Leadership Team	Quality Management Committee, CARF Committeee, CQICU, IMC	Data is reviewed per plan, annual review and update of benchmarks; process for review/validiation of data occurs before publication of data; Establishment of QM Committee, update to QM policy, identify training needs, staff complete training as needed
	3.B.4	Data improvement activities are implemented	QM committee leads PDSA or similar approach for CQI with Leadership; makes recommendations to leadership twice per year for quality improvement targets	Q2 CY 2024	Leadership Team	Quality Management Committee, CARF Committeee, CQICU, IMC	Annual reporting of quality improvement activities