DSCYF
Department of Services for Children, Youth & Their Families

DIVISION OF PREVENTION AND BEHAVIORAL HEALTH SERVICES (DPBHS)

Substance Use Treatment System: Current state and recommendations for meeting the needs of Delaware's youth with substance use challenges

2024

Contents

Executive Summary

The Delaware Division of Prevention and Behavioral Health Services (DPBHS), within the Department of Services for Children, Youth and Families (DSCYF), engaged Health Management Associates, Inc. (HMA), in August of 2023 to review its publicly funded substance use treatment system—part of its overall youth's behavioral health continuum of care. HMA collaborated with DPBHS leadership to implement a three-phase mixed-methods approach that included a literature review, a scan of similar-size states in the region, and stakeholder engagement to collect quantitative and qualitative data in Delaware.

The review included the Division's screening and assessment processes, access to services, and continuum of care. The system evaluation included an appraisal of the present system based on interviews with key stakeholders from the DSCYF and DPBHS, youth, advocates, providers (current and former), school-based health center staff, and family court. In addition, HMA interviewed high-level leadership from two regional states—Rhode Island and Connecticut—with similar youth system structures and reviewed the systems of selected other states.

The goal of this report is twofold. First, it is designed to help stakeholders better understand the landscape of youth substance use services in Delaware and to help inform the Division's efforts to fill service gaps. The research and planning process included review of the system's substance use disorder (SUD) screening processes and assessment of the youth-focused service array, use of services, and any available system data. Second, the report offers actionable recommendations that build on existing infrastructure and fill gaps in services to ensure cultural competence, linguistically appropriate, and equitably accessible for Delawareans.

Key Findings

- **Consistent with DPBHS findings and review, stakeholders identified a need to improve access to the continuum of behavioral healthcare, including substance use and co-occurring services for youth.**
- **Providers' approaches to screening for youth substance use in the community varies significantly, and few use any evidence-based screening tools.**
- **Several stakeholder groups support DPBHS's diligent efforts to develop a transparent, data-driven process that would allow agencies to track metrics to monitor and assess behavioral health outcomes for youth to better guide services and programming.**
- **Both nationally and across Delaware, the significant treatment workforce shortage contributes to gaps in meeting the needs of youth with SUD and co-occurring disorders.**

- **The legalization of marijuana and flood of flavored e-cigarette and vaping products have influenced a perception of low-level risk and harm to youth who use these and other substances. Coordinated and increased prevention messaging and efforts focused on substance misuse and abuse among youth across state agencies are needed.**
- **Stakeholders noted a lack of coordination in the SUD system, and many consumers and stakeholders reported being unaware of the available youth behavioral health services and ways to access care. Many internal and external stakeholders in the youth behavioral health system expressed confusion about accessing youth treatment services, whether through managed care organizations (MCOs) or DPBHS, and about the availability of those services.**
- **The Division is committed to promoting and providing the community standard of care for youth with substance use challenges and problems.**

Delaware Youth Substance Use System Assessment Overview

DPBHS provides an array of prevention, early intervention, and behavioral health services statewide. The Division serves Delaware youth (17 years old and younger) and their families, promoting safe and healthy children and teens, nurturing families, and communities, supporting social and academic success, and improving identification of needs.

The vision for all children and families to be strong, resilient, and live in supportive communities and our mission to develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care, are what drives us to continuously improve our services and reach our vision.

The Division assists youth and their families with access to preventive and behavioral health services, actively convenes partners, and facilitates communication across departments and sectors. DPBHS also administers statewide crisis services for youth and families, manages inpatient psychiatric hospitalization for eligible youth, operates several residential programs (e.g., residential treatment, crisis beds) for youth with higher levels of behavioral care needs, and authorizes and coordinates more intensive treatment services based on youth eligibility and need. For Medicaid-eligible youth who need outpatient behavioral health services, the Medicaid MCOs cover up to 30 therapy sessions. The Division authorizes and oversees all services beyond 30 sessions, including more intensive community-based levels of care, psychiatric hospitalization, and residential care.

Project Goals:

- **Assess Delaware youth behavioral health services, particularly for SUD, and its system of care.**
- **Conduct a scan of national research and states to inform best practices and policies.**
- **Provide recommendations for improving the Delaware youth SUD system.**

DPBHS's leadership and core staff are committed to the Division's vision of developing a comprehensive system that encompasses prevention, early intervention, and behavioral health services statewide for youth and their families. DPBHS contracted with Health Management Associates, Inc. (HMA), to examine the Division's substance use continuum of services, including a review of screening practices and the scope of prevention and treatment services to make recommendations that will improve the system of care. DPBHS was interested in information from other state public behavioral health systems and opportunities to bring innovative best practices to the state.

To address the complex needs of young Delawareans, particularly with respect to substance use, stakeholders were asked to share their perspectives to develop key recommendations. HMA's process involved reviewing relevant national research, conducting focus groups, interviewing select state officials, and surveying Delaware stakeholders. The HMA team interviewed senior administrators from Rhode Island and Connecticut and reviewed relevant materials from Oregon's (and selected other jurisdictions) youth behavioral health system of care to identify strengths and opportunities for improvement. The Division collaborated with HMA in planning and designing all research and stakeholder engagement activities. The recommendations presented in this report are intended to generate this collaborative, multisector approach to youth substance use prevention and treatment.

Recommendations fall within the following six broad strategic areas:

1. **Enhance capacity to serve youth and families by expanding access to all American Society of Addiction Medicine (ASAM) levels of care.** The public behavioral health system would benefit from strengthening the system of care for youth with substance use challenges and problems. Expanding to a full continuum of ASAM levels of care is critical to addressing youth-specific clinical needs. The state will need to enhance the system's ability to consistently use an evidence-based framework to screen and assess for level of care (LOC) and strategically address workforce gaps. A future recommendation includes a study of the actual costs for providing SUD treatment to youth that includes payer mix, staffing, administrative support, infrastructure, IT, measurement of quality and outcomes, and fidelity to treatment.

2. **Require use of standardized SUD screening and assessment tools for referrals to DPBHS and within the DPBHS provider network.** Increase the use of validated screening and assessments within the DPBHS provider network and with key referrals services to DPBHS to identify youth with substance use problems, then match and track referrals to the continuum of care. Screening practices across providers vary significantly, and those that do screen often use internally developed assessments rather than validated instruments.

3. **Increase consistent widespread prevention of substance use messaging among DPBHS, local school districts, and the Department of Education (DOE).** With the legalization of recreational marijuana for adults ages 21 and older, the prevalence of vaping has risen and concerns about the risk of harm from marijuana use have declined, underscoring the need for stronger prevention efforts. Though considerable prevention

efforts are in place across the state, the messaging often is poorly coordinated and inconsistent across organizations. The Division is committed to coordinating its prevention messages and piloting efforts with partners.

4. **Continue efforts to develop a transparent data-driven monitoring system and continuous quality improvement (CQI) process.** DPBHS is steadfast in its desire to be a performance improving organization. The Division must continue its efforts to establish clear metrics, extracting data and then using this information to inform system needs, processes, and outcomes. Although the State has several interagency committees and initiatives that include youth behavioral health issues and services, few interagency subcommittees are *focused* on youth substance use and co-occurring conditions. Successful states have deployed a multiagency approach to coordinate service array, monitoring, policy, and trends in youth behavioral health. This work may include identifying both public and commercial treatment services, developing a behavioral health workforce that is trained to treat youth with substance use challenges, and ensuring that the services provided are best practice and evidence based.

5. **Build the SUD and co-occurring workforce using incentives and creative credentialing and certification approaches.** Amid COVID-19, Delaware, consistent with the nation, has experienced significant healthcare workforce shortages, particularly among behavioral health providers, pediatric specialists, and other practitioner with expertise in treating SUD. It is critical that providers receive the necessary training, competencies, and skills to effectively identify, refer, and treat youth with SUD. This work may include partnering with the certification and licensing boards, Division of Substance Abuse and Mental Health Services (DSAMHS), Division of Public Health (DPH), and institutions of higher learning to offer state-of-the-art training (e.g., evidence-based SUD screening and assessment) and certifications to the clinical workforce to improve screening, assessment, and treatment interventions for substance use treatment for youth and the transition-age population.

6. **Increase coordination between key stakeholders and engagement with youth/families regarding accessing services authorized and provided by DPBHS and the Medicaid MCOs.** In Delaware, youth behavioral health treatment is secured from and funded by one of several agencies, including the Department of Services for Children, Youth and Their Families (DSCYF) and the Division of Medicaid and Medical Assistance (DMMA), and co-managed by Medicaid MCOs. Given the sizeable portion of Delaware youth enrolled in Medicaid, the multiple agencies involved, and the role of managed care in coordinating behavioral health services, this recommendation focuses on improving the timeliness of assessments, referrals, and coordination of behavioral health benefits for youth and families.

Literature Review, National Scan of Exemplar States, and Delaware

HMA implemented a three-phase, mixed-methods approach that involved: (1) a literature review, (2) a scan of states, and (3) Delaware stakeholder engagement to collect qualitative and qualitative data on the youth SUD system of care.

Phase 1

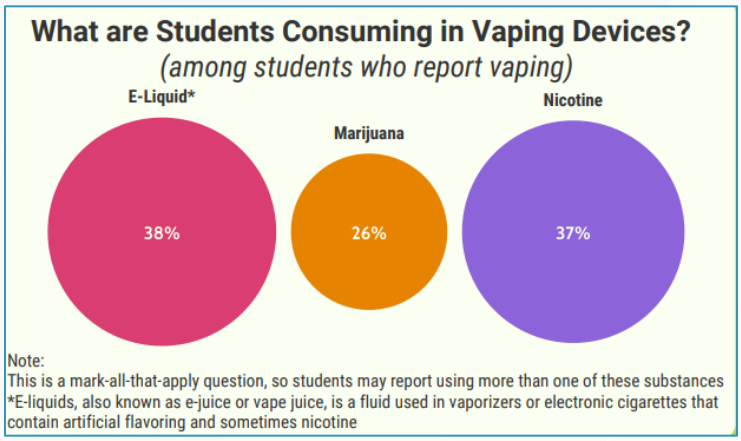
Literature Review

HMA reviewed published research encompassing Delaware-specific youth behavioral health services, use of SUD services as well as national data and trends. This review included more than 20 published reports, research, and materials focused on youth SUD models, best practices, and outcomes to identify recommendations for Delaware.

Delaware Data and Trends

Before looking at the national trends for substance use and youth, it is important to examine how Delaware's youth are trending on substance use.

Figure 1: Delaware Youth Risk Behavior Survey, Vaping in the Past-Month



Delaware's youth comprise about 21.1 percent of the state's nearly one million population, according to the most recent KIDS COUNT data.[1] Data from the Delaware School Survey (DSS) shows that 20 years ago, more than one-third of Delaware's 11th graders reported that they use cigarettes; however, in 2021, only about 3 percent of these individuals report past-month cigarette usage.[2] Unfortunately, Delaware youth now report greater use of e-cigarettes and other electronic vaping devices rather than traditional tobacco products. This is very consistent with trends across the country. Findings from 2019 Delaware Youth Risk Behavioral Survey indicate that 43 percent of high school students have tried vaping at some point in their life, and more than one in four (28%) vape regularly.

Alcohol misuse remains a significant concern that presents extensive public health risks and significant social costs. Data from the Delaware State Epidemiological Outcomes Workgroup and the most recent Youth Risk Behavior Surveys (YRBS) illustrate that alcohol remains the most reported substance that students throughout the state use. Though the number of Delaware youth in alcohol treatment is low, more than one in five Delaware

[1] University of Delaware Center for Community Research & Service. KIDS COUNT in Delaware. 2023. Available at: https://www.bidenschool.udel.edu/ccrs/research/kids-count-in-delaware. Accessed February, 2024

[2] Delaware State Epidemiological Outcomes Workgroup. The 2022 Delaware Epidemiological Profile Substance Use, Mental Health, and Related Issues. 2022. Available at: FINAL-2022-Epi-Report-30-Nov-22.pdf (bpb-us-w2.wpmucdn.com). Accessed February, 2024

respondents ages 12 and older report binge drinking within the past month (2019–2020).[3] The highest rates are among 18–25-year-olds, often referred to as transition-age young adults. In 2019, the Treatment Episode Data Set (TEDS) indicated that alcohol was the primary substance reported at admission among 10.7 percent of patients receiving publicly funded treatment in Delaware, and it was identified as a secondary substance in another 8.2 percent of admissions[4].

Delaware decriminalized possession of less than an ounce of marijuana for adults ages 21 and older in 2015 and legalized recreational marijuana for these same individuals 21 and older during the 2023 legislative session. Since then, the perception of risk of harm from marijuana use has declined.[5] Moreover, 54 percent of 12th grade respondents to the 2019 Delaware YRBS reported using marijuana at least once, and 39 percent of all high school student respondents reported such use.[6] In addition, 4.3 percent of adolescents ages 12–17, admitted to using marijuana at some point, increasing to 12.2 percent among 18–20-year-olds[7].

The data suggest the importance of expanding the focus on marijuana use among youth and transition-age individuals. These data are consistent with research showing that SUD often begins in adolescence. Most adults who develop an SUD report they started using substances as teenagers.[8] Nationally, more than 9 in 10 individuals receiving SUD treatment report that their first use of substances occurred by young adulthood, with alcohol and marijuana[9] being the first substances they typically used.[10] The knowledge that alcohol and marijuana are still prevalent among youth in Delaware, coupled with the high young adult overdose rates in Delaware, indicates the need to continue monitoring substance use and overdose trends among youth.

The Delaware Drug Monitoring Initiative is a multiagency collaborative that closely tracks the state's overdose data. Dating back to 2020 (the onset of COVID-19) through the third quarter of 2023, overdose deaths for people younger than 20 years old have remained low but consistent (2020=3, 2021=2, 2022=3, 2023=1); however, the value of prevention among

[3] Substance Abuse and Mental Health Services Administration. Treatment Episode Data Set: Admissions (TEDS-A). Client-Level Substance Use Data. 2019. Available at: https://www.datafiles.samhsa.gov/dataset/treatment-episode-data-set-admissions-2019-teds-2019-ds0001. Accessed February, 2024

[4] 2019 TEDS was the most recently available complete dataset. For both admissions and discharges data sets, states that had 2021 counts less than 50 percent of past three-year average (i.e., average of 2018, 2019, and 2020 counts) were excluded from this report.

[5] Substance Abuse and Mental Health Services Administration. 2020 National Survey on Drug Use and Health (NSDUH) Releases. Available at: https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases. Accessed February, 2024

[6] Centers for Disease Control and Prevention. 2019. Youth Online: High School Youth Risk Behavior Survey Data. Available at https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=C&SID=MS&QID=M14&LID=DE&LID2=SL&YID=2019&YID2=SY&SID=&EYID=&HT=QQ&LCT=LL&COL=S&ROW1=N&ROW2=N&TST=false&C1=&C2=&SC=DEFAULT&SO=ASC&VA=CI&CS=Y&DP=1&QP=G&FG=G1&FA=A1&FR=R1&FS=S1&FSC=P1&FSI=I1

[7] 2019 TEDS data was the most recently available complete data set. For both admissions and discharges data sets, states that had 2021 counts less than 50 percent of past three-year average (i.e., average of 2018, 2019, and 2020 counts) were excluded from this report.

[8] US Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016

[9] Schulenberg JE, Johnston, LD, O'Malley PM, Bachman JG, Miech RA, Patrick ME. *Monitoring the Future National Survey Results on Drug Use, 1975–2017: Volume II, College Students and Adults Ages 19–55.* Ann Arbor, MI: Institute for Social Research, University of Michigan; 2017.

[10] Monitoring the Future | A continuing study of American youth

youth remains salient, as people ages 20–24 has significantly higher numbers of overdose deaths (2020=24, 2021=10, 2022=18).[11]

Nationally, a National Institute on Drug Abuse (NIDA) analysis of Centers for Disease Control and Prevention (CDC) and US Census Bureau data indicate a dramatic rise in overdose deaths among teens in 2010 to 2021 and overdose deaths have remained elevated well into 2022. Although Delaware is fortunate to still have low levels of overdoses among youth, these statistics suggest the importance of closely monitoring and treating Delaware's transition-age young adults for substance use.

National Trends and Recommendations

Tracking national substance use trends is critical as individual states examine their own substance use trends. The results from SAMHSA's 2022 National Survey on Drug Use and Health (NSDUH) [12] showed that 922,000 adolescents ages 12–17 in 2022 experienced a co-occurring major depressive episode (MDE) and substance use disorder (SUD) in the past year. Among these individuals, 71.6 percent (≈660,000) received either substance use or mental health treatment in the past year, whereas 28.4 percent (≈262,000) received neither type of care. Among adolescents with co-occurring MDE and SUD, an estimated 49.3 percent (≈454,000) received only mental health treatment, 1.5 percent (≈14,000) received only SUD treatment, and 20.8 percent (≈192,000) received both SUD and mental health treatment. Delaware's relatively low numbers of youth receiving formal treatment for substance use (and co-occurring conditions) is consistent with national trends.

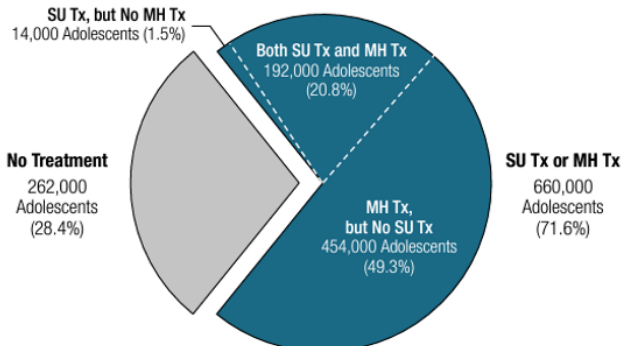


Figure 2. Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adolescents Aged 12 to 17 with Past Year Substance Use Disorder and Major Depressive Episode (MDE); 2022

treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

The evidence reveals that adolescents with SUDs are more likely to have experienced trauma than other adolescents. Given these linkages, it is critical to acknowledge the role trauma plays in the lives of adolescents and their families and to adopt tools and strategies that address violence, abuse, and neglect.

Furthermore, youth SUD services (including prevention) often are delivered in non-traditional healthcare settings (e.g., school, primary care) and many providers have yet to

[11] Delaware Information & Analysis Center. Delaware Drug Monitoring Initiative Reports: Annual 2020; Annual 2021; Annual 2021; Quarter 1 2023; Quarter 2 2023; Quarter 3 2023). Available at: https://dediac.org/(X(1)S(1h0ujwztaaiobsssixw2yh42))/default.aspx?AspxAutoDetectCookieSupport=1. Accessed February, 2024

[12] Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality. 2023. Available at: https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report. Accessed February, 2024

receive training to effectively screen and address substance use.[13] Nationally, only one in four adolescent residential treatment centers offers buprenorphine, a medication to treat Opioid Use Disorder.[14] As these youth become transition aged, the continuum of care for young adults with SUD is fragmented[15] highlighting the importance of early intervention for youth with substance use challenges. Providers in traditional medical and mental health settings frequently lack the training and comfort level needed to conduct comprehensive assessments of youth with SUD and ensure that these clients receive developmentally appropriate, evidence-based care, including pharmacotherapy. This situation often leads to delayed diagnosis and treatment. A panel of experts that Boston Medical Center's Grayken Center for Addiction convened emphasized early intervention for young adults with SUD, comprehensive and tailored services, access to pharmacotherapy (when indicated), voluntary access to treatment, continuous engagement, and assurance of quality care.[16]

SAMHSA recommends universal screening for substance use, brief intervention, and/or early intervention models (e.g., Screening, Brief Intervention, and Referral to Treatment [SBIRT]) as part of routine healthcare.[17] Adolescents are the population at greatest risk of experiencing substance use-related acute and chronic health consequences. Collaborating with primary care (e.g., family medicine professionals, internists, pediatricians, and nurses) to incorporate screening and brief intervention whenever possible is a tremendous opportunity to intervene early with youth who may be developing substance use challenges. One recent study concluded that the beneficial effects of utilizing SBIRT in a primary care setting with adolescents may persist into young adulthood.[18]

Phase 2: Scan of Other State Models

The following is a review of states with similar populations and state agency infrastructure models, as well as those with robust youth-specific SUD systems. HMA's research included an assessment of the state's youth SUD continuum, data collection, outcomes, reporting, and funding systems (when available). It is important to note that no state's continuum of substance use prevention and treatment services for youth is without challenges. Despite DPBHS's best efforts, Delaware faces many of these same challenges and issues. DPBHS leadership remains committed to addressing and improving its public behavioral health system.

All states share similar concerns about sufficient financial resources, workforce shortages, and overall infrastructure. Leaders in Connecticut and Rhode Island who were interviewed

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[13] Hadland SE, Yule AM, Levy SJ, Hallet E, Silverstein M, Bagley SM.. Evidence-Based Treatment for Young Adults with Substance Use Disorders. *Pediatrics*. 2021;147(Suppl 2):S204-S214. doi: 10.1542/peds.2020-023523D.

[14] NIDA. 2023, June 13. Only 1 in 4 adolescent treatment facilities offer buprenorphine for opioid use disorder. Retrieved from https://nida.nih.gov/news-events/news-releases/2023/06/only-1-in-4-adolescent-treatment-facilities-offer-buprenorphine-for-opioid-use-disorder on 2024, April 5

[15] Evidence-Based Treatment of Young Adults with Substance Use Disorders | Pediatrics | American Academy of Pediatrics (aap.org)

[16] Evidence-Based Treatment of Young Adults with Substance Use Disorders | Pediatrics | American Academy of Pediatrics (aap.org)

[17] Substance Abuse and Mental Health Services Administration. Screening, Brief Intervention, and Referral to Treatment. Updated August 12, 2022. Available at: www.samhsa.gov/sbirt. Accessed February, 2024

[18] Sterling et al. (2022). Young Adult Substance Use and Healthcare Use Associated With Screening, Brief Intervention and Referral to Treatment in Pediatric Primary Care. Journal of Adolescent Health, Volume 71, Issue 4, S15 - S23

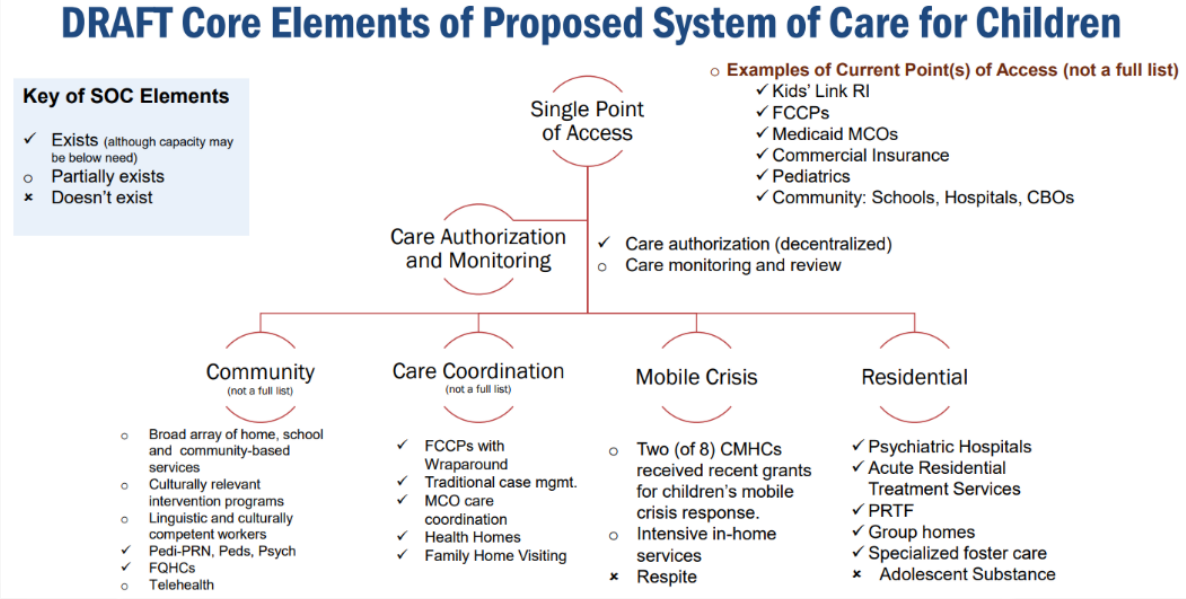
said their systems benefitted from having a robust adolescent SUD continuum of care based on the ASAM Levels of Care (LOC) framework, including the intention to work toward the soon to be released adolescent and transition-aged volume in the fourth edition of ASAM's standards. Applying these guidelines may assist Delaware's efforts to improve its youth substance use treatment system.

Rhode Island

The Rhode Island Division of Children, Youth, and Families (DCYF) has statutory authority for all youth behavioral health service. The Executive Office of Health and Human Services (EOHHS)/Medicaid is the largest state funder of behavioral health services for youth, and the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), has authority over adult behavioral health and substance use providers, substance abuse services for youth, and transitional services for youth. The state also has a cross-agency behavioral health youth cabinet. Rhode Island's MCO's (like in Delaware's) are critical in managing SUD treatment services. Treatment resources were largely moved to Medicaid authority during the shift toward implementing the Affordable Care Act. The Rhode Island Medicaid Division issues MCO contract requirements, enabling increased quality of care and access.

In addition, Rhode Island licenses and audits agencies for quality, including managing the tools used for screening and assessment. Each provider receives a quarterly visit that includes training with site staff. As in Delaware, oversight and responsibility for treatment services lies with multiple agencies or authorities, which makes it challenging to plan for and achieve the goals for youth behavioral health. Rhode Island has proposed redesigning the system of care to address this fragmentation (see Figure 3).

Figure 3: Rhode Island System of Care Proposed Redesign



Of note, Rhode Island trained providers in 7 Challenges and Brief Challenges—a motivationally enhanced evidence-based program that can be offered in outpatient,

intensive outpatient, telehealth, home-based, school based, group home, residential, inpatient, partial hospitalization, and juvenile justice settings. BHDDH and the University of Rhode Island used a SAMHSA grant (2015–2022) to implement the training program and later sustained it as a Medicaid-reimbursable service. At present, four provider sites and seven private practitioners who work in other sites are supported. Further, teachers and administrators refer students to the Brief Challenges Program. Seven Challenges was adopted statewide (including with MCO providers) and uses standardized screening tools and assessments that are embedded in the electronic health record (EHR). The state plans to integrate 7 Challenges into its certified community behavioral health clinic (CCBHC) model.

SAMHSA grant funding was used to expand outpatient services in Rhode Island eight years ago, funding four providers including the juvenile justice school. Though most services are outpatient, Bradley Hospital has a residential program for youth, with mental health conditions as their primary diagnosis. Interviewees noted workforce shortages (particularly in adolescent psychiatry), competencies for youth counselors, and waitlists across levels of care as challenges for the system. Another significant concern in Rhode Island and across the nation is the ubiquity of vaping and e-cigarettes among youth. Adolescent overdose rates were reportedly low (similar to rates in Delaware), with four to five adolescents dying from overdose events annually.

Connecticut

The Connecticut Department of Children and Families (DCF) system of care for youth covers all ASAM levels of care and has been in place for the past 20 years. Prevention services have been in place for 10 years and new investments in recovery support services have developed in the last five years. Connecticut DCF partnered with multiple state agencies through the development of a Section 1115 SUD waiver demonstration project. These groups meet regularly to discuss trends, system challenges, and opportunities for collaboration.

The interviewee, a high-level administrator, emphasized DCF's oversight and partnership with providers, including designated state agency staff as the primary contact for providers in each geographic region. Oversight includes continuous quality improvement (CQI) monitoring, weekly check-ins and monthly meetings with providers, and a monthly SUD trends and program census report. Monthly meetings, providers and state staff collaborate to address barriers. State program leads also provide six-month and one-year reports to the legislature that describe key performance indicators, utilization, data by program, and trends in youth SUD and outcomes. Additionally, Connecticut has a provider forum including clients, providers, and people with lived experience to describe and address treatment barriers.

Connecticut DCF offers SUD outpatient, intensive in-home and residential levels of care, and evidence-based interventions (see Table 1). Connecticut uses the STRIDE (Successful Transitions in Developing Empowerment) program, embedded in six outpatient clinics to continue treatment in the community. Early intervention includes adolescent SBIRT. Adolescent SUD programming includes a community reinforcement approach that involves adaptation of multidimensional family recovery for opioids and several adaptations of multisystemic therapy (MST). Many providers also use validated tools like CRAFFT, GANEQ,

Ohio Scales, and Screening to Brief Intervention (S2BI). Referrals can come from anyone, but substance use specialists work in each child welfare office and are familiar with the best services for youth. Connecticut also provides a variety of evidence-based services to caregivers to mitigate parental substance use.

Table 1: Connecticut Description of DCF-Funded Adolescent

Program Type: Name	Target Population & Descriptions	Catchment Area
Clinic-based outpatient: Adolescent Community Reinforcement Approach / Assertive Continuing Care	Adolescents age 12-17 years, who have an identified substance use issue and meet American Society of Addiction Medicine (ASAM) criteria for outpatient level of care.	14 clinic sites across 6 teams with statewide coverage
Intensive in-home: ASSERT Treatment Model (ATM) for youth opioid use	Comprehensive treatment and recovery program for adolescents and young adults up to age 21 years inclusive, with opioid use and related behavioral and emotional problems. ATM provides MDFT treatment, access to Medication Assisted Treatment (MAT) and up to 12 months of continuing care after MDFT discharge using the Recovery Management and Supports model.	Four (4) teams serving DCF regions 3, 4, 5, 6
Intensive in-home: Multidimensional Family Therapy (MDFT)	Family-based comprehensive treatment for children and adolescents age 9-18 years old with substance use, or are at risk of substance use, and have related behavioral and emotional problems.	18 teams across 7 providers; with 4 of these providers also offering a specialty protocol for youth and young adults with opioid use disorders
Intensive in-home: Multi-Systemic Therapy (MST)	Adolescents age 12-17 with a DSM-5 diagnosis who exhibit antisocial, acting out, substance using, and/or delinquent behaviors.	DCF and CSSD jointly fund 12 teams across 4 providers covering the entire state
Intensive in-home: MST Emerging Adult (MST-EA)	Emerging adults age 17-21 with serious mental illness and/or substance use, with or without a trauma history. The young adult must be aging out of foster care or involved in the child welfare system; have stable housing or a plan to achieve stable housing; and co-referred to DMHAS behavioral health services.	DCF Area Offices served include Milford, Bridgeport, Waterbury, New Britain, Hartford and Manchester
Residential for males: Rushford Academy	Six-month residential program for adolescent males. Individual and group therapy is offered using the Seven Challenges curriculum.	Six (6) beds at Rushford in Durham
Residential for males: MDFT Residential Program	Four-month residential program for committed delinquent males ages 14-18 with mild to moderate substance use treatment needs. MDFT offers integrated mental health and substance use treatment to improve educational and emotional functioning, and to promote community and family re-engagement.	Eight (8) beds at Connecticut Junior Republic in Litchfield
Recovery Support: Youth Recovery CT	Curriculum-based virtual and in-person recovery support groups to youth and their families	49 groups available statewide

Phase 3: Delaware Landscape Substance Use Assessment

Delaware's Youth's Behavioral Health Service's System

Service Mix

Historically, DPBHS had a robust continuum of services (outpatient through short-term residential) for youth with substance use challenges. Statewide outpatient, intensive outpatient, and day/part-day treatment programs were previously available and contracted through the Division and Department. Youth needing higher-level care for their substance use issues were treated at nearby, out-of-state programs, and then discharged to community-based care.

> A review of selected Medicaid data and PBH admissions data were made available for review. Delaware Medicaid provided a data set of three years of utilization data. Requests for data sets from DPBHS Continuous Quality committee were requested but were not available at the time of this report.

In the past 15 years, multiple cumulative factors have contributed to the gradual change in the mix of services authorized (e.g., reimbursed) in Delaware's youth behavioral health treatment system. This change has ultimately led providers to reduce the scope of services they are able to provide for clients who need SUD treatment. As the result of a shift in the new state plan, several key SUD-focused outpatient providers eventually stopped serving youth, thereby reducing the already small pool of youth SUD providers. The shift of reimbursement from program-funded and state-only funding to a fee-for-service Medicaid model based on allowed charges was a significant operational and financial change for many community providers. This change in funding occurred across the country as more states were able to leverage and maximize the federal share of Medicaid.

In Delaware, providers noted that state-funded services better allowed them to have the necessary administrative and quality assurance staff, the ability to train staff in evidence-based practices (EBPs), and generally pay unlicensed and licensed clinicians a more affordable wage. Many community-based substance use treatment programs were unable to adapt and changed to providing the allowed (and reimbursed) service mix. Consequently, many critical providers found it impossible to sustain youth substance use treatment operations. The eventual reduction of youth treatment options for substance use has ultimately eroded the workforce specializing in youth substance use treatment.

Today, services are largely provided in non-specific community-based services that lack a specific focus on substance use. As more traditional intensive outpatient (IOP) services and day treatment services for youth substance use were replaced in the service mix (to mobile outpatient and therapeutic aid), a gap developed in those available levels of care for youth with substance use and/or co-occurring disorders. As a result, ASAM LOC 2.0–4.0 levels of care are virtually nonexistent for youth with substance use problems in Delaware. Residential care is still provided on a case-by-case basis.

As highlighted later in the report, many stakeholders have raised concerns about the lack of treatment options available to youth and the inability to refer individuals to the appropriate

levels of care. It is important to note that DPBHS, despite continued efforts to contract for community-based substance use services, has been unable to attract providers to bid for comprehensive SUD treatment services. The Division also has struggled to incentivize the recruitment and retention of youth substance use treatment specialty providers. DPBHS has offered various youth and adolescent SUD training to the provider community, but uptake has been slow, and interest in these sessions has been low. DPBHS recognizes that dedicated, focused substance treatment services for youth are limited and must be addressed.

Referral, Intake and Provision of Services

In reviewing the intake forms required for referral to the Division, HMA found no requirement for referring agencies (or individuals) to submit standardized SUD screening results, although several questions in the referral packet address youth substance use. Acceptance for DPBHS care coordination and services is based on review of the materials and then completion of the CASII (Child and Adolescent Service Intensity Instrument) by DPBHS staff. CASII is evidence-based and designed to capture all the treatment/service needs of the child and adolescent presenting with behavioral health, medical, and developmental conditions. DPBHS then uses the results of the packet, completed CASII, and input from the family to design a treatment plan and make a referral. The CASII is completed regularly (every 90 days) to determine progress.

DPBHS reported that the Division has clinical necessity parameters for each level of care it authorizes. (Although HMA did not review these parameters, several providers indicated they were unsure or unclear about what those guidelines specify.) DPBHS staff contact and engage the family in selecting the appropriate service and provider. Stakeholder interviews highlighted that clients who need DPBHS services often are clinically complex and present acute clinical problems, perhaps requiring more intense levels of intervention than currently offered.

BH Workforce

The Division also has struggled to recruit and retain youth SUD providers to the State. As noted above, DPBHS has offered various youth substance use trainings to the provider community, with providers showing little interest in these sessions. Nevertheless, provider stakeholders indicated an interest in additional youth-focused trainings. As DPBHS strengthens its SUD services and LOC, it will be critical to have the clinical workforce to treat youth needing higher levels of care.

Most recently, DPBHS applied for but was not awarded a grant to develop providers to treat youth with co-occurring post-traumatic stress and SUD. DPBHS recognizes that dedicated and focused substance treatment providers for youth are limited. Stakeholders also highlighted significant variation in the availability of services for youth, with downstate areas having few (if any) treatment resources.

COVID-19 increased the burdens on an already taxed behavioral health provider community, mirroring the healthcare crisis across the country. In our interviews, Delaware stakeholders, like those in other states, said that the combination of an insufficient supply of trained BH/SUD professionals and many people leaving the workforce for more flexible

jobs and better pay poses a major challenge. Compounding these hurdles are high turnover rates, inconsistent staffing, and the lack of a pipeline from behavioral health student to practitioner. In response, to these nationwide issues, SAMHSA is planning to offer $5.4 million to fund Provider's Clinical Support System Universities,[19] which will help train students in health professional programs to get more training in caring for patients with substance use disorder. If the funding is approved, this program may provide an opportunity for DPBHS to collaborate with other state systems and local universities.[20]

System Data

HMA reviewed the 2020–2022 DPBHS Admission's Data (Appendix II); however, it is difficult to compare service provided with the ASAM LOC or make conclusive statements of need. The data does note that very few substance use inpatient and outpatient services were coded (provided) in each of the three years presented. As the Division continues to improve its ability to analyze system and utilization data, the coding of data needs to reflect the specific ASAM LOC (for SUD services) and standardized across the system. Prevalence data based on diagnosis is often unreliable due to providers submitting a primary mental health diagnosis, but not necessarily a substance use diagnosis. DPBHS has some data for outcome (e.g., CASII change), but the data does not allow for teasing out outcome by diagnosis.

A review of the 2023–2025 DPBHS Strategic Plan clearly delineates the value of collecting data and extracting information from the system to fully integrate data-driven decision making and maintain a culture of continuous performance improvement. Although the indicators were unavailable for review at this time, the Division is in the process of developing a data dashboard and key performance behavioral health indicators (see Appendix XI) for monitoring.

Focus Group, Interview and Survey Findings

Selected key stakeholder interviews, focus groups, and surveys were a central component of this project. HMA and DPBHS collaborated to develop focus group and interview guides specific to each stakeholder type. Additionally, personalized outreach was conducted to recruit interviewees and focus group participants. HMA facilitated seven focus groups across a spectrum of 64 stakeholders. The team hosted a two-hour in-person youth focus group with 20 participants. In addition to focus groups, HMA conducted seven key informant interviews with Delaware state partners.

Stakeholder Interviewee Type	Number of Interviewees
Justice	3
Behavioral Health Agency	2
Education State Agency	1
Providers	17
Healthcare	9
Justice	4
Education	4
Advocate	6
DPBHS Staff	5
Youth	20

[19] Substance Abuse and Mental Health Services Administration. Providers Clinical Support System–Universities (PCSS-Universities). Updated March 18, 2024. Accessed February, 2024 https://www.samhsa.gov/providers-clinical-support-system-pcss-universities

[20] Lovett L. CMS' New Guidance to Medicaid Directors Opens Door to More Behavioral Health Providers. *Behavioral Health*. February 27, 2024. Available at: https://bhbusiness.com/2024/02/27/cms-new-guidance-to-medicaid-directors-opens-door-to-more-behavioral-health-providers/. Accessed February, 2024

To collect additional data, HMA and DPBHS staff developed a brief survey for distribution to supervisory/leadership staff at the Division of Youth Rehabilitative Services (DYRS) and the Division of Family Services (DFS) to obtain further information from DSCYF staff who did not participate in the group or individual stakeholder interviews. A total of 12 staff members completed the survey (DYRS, 11 and DFS, 1).

Although qualitative responses and perceptions are often difficult or challenging to quantitatively substantiate or may run counter to available data, DPBHS is cognizant of the important role stakeholder input and perceptions play in the overall system. Qualitative analysis of the interviews, focus groups with Delaware stakeholders, and survey data revealed the following themes (some overlapping) and possible opportunities for improvement.

Treatment System

- Participants indicated they need additional treatment options for all ASAM LOC, particularly for residential SUD and step-down care.
- Participants (several stakeholder groups, including those who work with or in the family court system) noted a limited understanding of how to access treatment and the services available for families and consumers.
- Many stakeholder groups noted they did not fully understand services authorized and coordinated by DPBHS versus those provided by Medicaid MCOs.
- Participants expressed a need for specialized outpatient programs for marijuana and tobacco use and more expertise in treating these conditions among DPBHS network providers.
- Participants noted that few programs and facilities in Delaware treat substance use in youth, with even fewer accessible options in Sussex County.
- Stakeholder groups have perceptions of long waitlists *(While DPBHS data suggests there were waiting lists in the past, there has been significant reduction in wait time for many levels of care/services.).*
- Need for additional specialized programs for transition-age youth and youth with specific needs, such as trauma counseling.
- The fee-for-service payment structure and limited funding streams for substance use treatment and prevention make offering a full continuum of care for youth challenging for providers.
- Participants shared that reimbursement for mobile outpatient services remains challenging for program sustainability.

Barriers to Treatment

- Stakeholders noted barriers including, lack of transportation, service availability only during school-day hours, stigmatization from their peers, social determinants of health needs, and language barriers for people who speak Spanish or Creole and use sign language.
- Participants identified hesitancy among immigrant youth and youth from minority groups (Hispanic/Latino, Asian, Middle Eastern) to receive treatment.

- Participants noted that some treatment providers (and services) may not be culturally competent, which has resulted in parents being reluctant to consider additional services.
- Stakeholders noted that youth have concerns about peer perceptions for seeking treatment for substance use.

SUD Training and Competency

- Stakeholders agreed the need to offer more opportunities for training and capacity-building among providers, educators, judges, and attorneys.
- Stakeholders desire more training and skills to better support the youth with whom they work to improve their understanding of the stigma toward SUD treatment, the neuroscience of addiction, the effectiveness of medication-assisted treatment (MAT), and co-occurring disorders in youth.
- Stakeholders struggle to find information about treatment resources and referral processes for youth and their families.
- Participants noted the limited training, education, and certification for entry-level behavioral health paraprofessionals (e.g., therapy aides, psychiatric techs)
- Stakeholders lacked understanding about diagnosing and treating cannabis abuse as a disorder.
- Stakeholders expressed that youth SUD tends are ignored during mental health treatment, often until a major crisis occurs.
- Stakeholders vary widely in how they code substance use diagnosis among youth, with some coding for a primary mental health diagnosis and other for SUD.

Coordination among Partners

- Participants want increased information sharing between DPBHS and judicial partners focused on SUD trends, utilization, and treatment options for youth.
- Although DPBHS case managers appear in court hearings with their clients and report on the histories of youth, goals, and treatment information, participants noted a discrepancy between what is presented and what the court needs to make a determination.
- Stakeholders noted both the need for more clinical services for transition-age youth (between 17-18) who may soon age out of the youth behavioral health system as well as increased coordination between DSAMH and DPBHS to provide these services.
- Stakeholders want additional coordination of prevention efforts between DOE, local school districts, DPBHS, and other partners. Several stakeholders noted that prevention efforts are poorly integrated.

Data

- Stakeholders said insufficient data are available regarding the substance use needs of youth (e.g., screening for prevalence) or to evaluate the effectiveness of interventions.

- Participants noted that many providers do not capture primary, secondary and tertiary diagnoses upon intake or changes during treatment, contributing to low identification and referral of youth with SUD to providers who may be able to assist.

Perceived Risks and Harms of Substance Use

- All stakeholders communicated the increased prevalence and normalization of marijuana and vaping among youth.
- Participants described the legalization of marijuana has normalized cannabis use for youth, who no longer view it as problematic.
- All stakeholders emphasized the lack of understanding of the potential serious side effects and health outcomes of marijuana use and vaping among youth and their families.
- Stakeholders described peer pressure for youth to use marijuana or vape.
- Participants noted that providers and families often perceive marijuana and/or vaping as the "least" of a child's problems.

Workforce

- Stakeholders emphasized the ongoing workforce challenges and revenue stressors after the COVID-19 pandemic.
- Stakeholders noted that the supply of youth and adolescent providers with SUD training is inadequate at every level of care.
- Participants said that providers struggle to find treatment options for youth in Delaware, often placing them in out-of-state facilities.
- Participants noted a lack of accessible information related to professionals with SUD specialty certification.

Recommendations and Implementation Plan

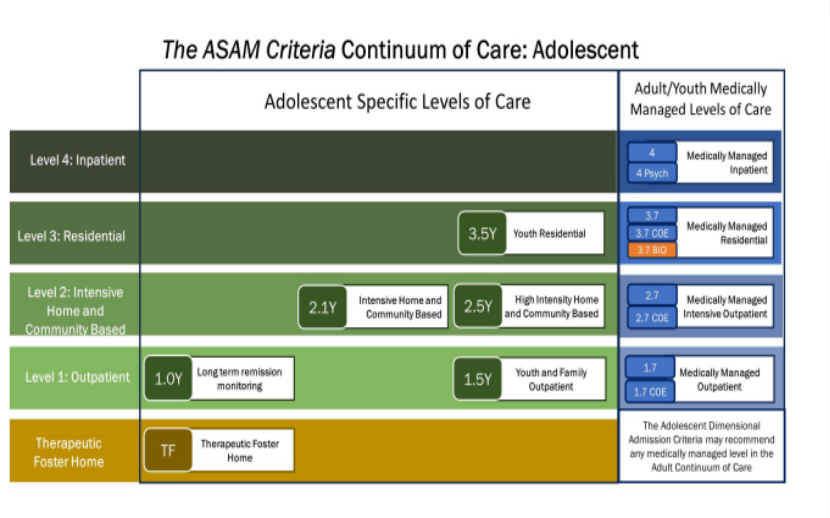
Recommendation 1: Enhance capacity to serve youth and families by expanding access to all American Society of Addiction Medicine (ASAM levels of care.

For the past 15 years, Delaware's behavioral health treatment system, specifically for youth with substance use problems, has undergone a series of significant changes. The system has very few substance use-specific treatment and providers for youth with substance use problems. Those youth who may need focused substance use or co-occurring mental health treatment, will be served in one of DPBHS more intensive community treatment program, such as mobile outpatient services, often with an assigned therapeutic aid. Unfortunately, the literature does not highlight any reliable means of determining the appropriate service mix (and ASAM LOC) and ratio of either community-based or residential SUD care for Delaware's over 200,000 youth. Rather, the service mix must be based on continuously analyzing the national and state-specific data trends from reliable research and surveys (see above) and, more specifically, individual youth assessment data.

ASAM established national standards for conducting a comprehensive assessment of 10 multidimensional factors and determining the appropriate level of addiction treatment for

individuals. The ASAM 4th edition includes an additional volume: Framework for the Adolescent and Transition Age Youth. Public comment has been solicited and the volume will soon be finalized. It is anticipated the volume will emphasize the role of co-occurring mental health and behavioral conditions among all patients, particularly adolescent and transition-age youth. The volume is expected to focus on providing integrated care for those co-occurring conditions. Of equal importance, care "should be consistent with the Systems of Care approach."[21] Both DSCYF and DPBHS have identified the System of Care approach in their strategic plans, indicating their strong commitment to this tactic.

Figure 4: The ASAM Criteria Continuum of Care: Adolescent



With the ASAM LOC framework, adolescent addiction treatment programs will be expected to provide six integrated psychiatric services and skilled mental health interventions. This framework will improve the likelihood that adolescents with severe psychiatric symptoms are identified and connected to a higher level of individualized care than traditional adolescent outpatient addiction treatment programs offer.

Attracting programs to provide a full continuum of care will require DPBHS to strategically plan how to incentivize and encourage providers to be responsive to youth substance use challenges. Because the Division has struggled with provider interest in bidding for new services, meeting the needs of youth with substance use problems will require a dedicated, focused, and innovative approach. For example, Delaware might consider following the state-community partnership road map that Oregon has developed (see Appendix III). Through this model, strategies are in place to expand the co-occurring substance use continuum for youth and young adults. The collaborative is researching and developing enhanced payment models and rates to address co-occurring conditions and providing one-time start-up funding for programs. These residential providers are being supported with innovative co-occurring models and trauma-informed care approaches.

Recommendation 2: Require use of standardized SUD screening and assessment tools for referrals to DPBHS and within the DPBHS provider network.

Key stakeholders mentioned that pediatricians and community-based behavioral health providers rarely use standardized validated screening and assessment tools for SUD, and its use is not a requirement for referral to DPBHS. Although all providers indicated they

[21] Waller RC, Gomez-Lunda S, Fortuna LR, Hadland SE, Metz P. Proposed Framework for the Adolescent and Transition Age Youth Volume of The ASAM Criteria – 4th Edition. December 2023. Available at: https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/quality-science/proposed-framework-adolescent-volume-asam-criteria_final-for-public-comment-121523.pdf?sfvrsn=cbe1dd7d_1 . Accessed February, 2024.

uncover substance use problems in their own intakes, this information cannot be reliably captured.

Delaware providers and school-based health centers (operated outside of the authority of DPBHS) play a unique and critical role in proactively screening and helping youth with potential substance use challenges and other risky behaviors. Although all public high schools have funded school-based health centers, only some local school districts have those centers in middle schools. Those that do (high school and middle school) are often seen as important partners in triaging and referring youth with behavioral health problems to the appropriate behavioral health service.

Massachusetts and other states prioritize the use of early interventions such as SBIRT. In 2016, these jurisdictions mandated that public schools engage in substance use prevention and education.[22] DPBHS might consider engaging DOE and local school districts and the school-based health centers in discussions about evidence-based screening for SUD and early intervention strategies for youth who may have substance use challenges and connect them with treatment resources to prevent more problematic use in young adulthood.

HMA recommends that all DPBHS providers be required to administer and interpret evidence-based screening tools and that all referrals to DPBHS services should undergo standardized and validated substance use screening. Delaware could consider a process like the one used in Connecticut, which used its Youth's Behavioral Health Workgroup to review SUD screening measures and establish criteria, including (Appendix XVII).

- Valid and reliable methods that are applicable to all youth and families, including people from diverse racial, ethnic, cultural, and linguistic backgrounds.
- Brief and easy to administer and score.
- Available at low or no cost and in multiple languages
- Administration and scoring by non-degreed staff when needed.

Delaware may consider the following validated assessment tools:

- CRAFFT (2.1), which is available in self-reported or clinician-administered formats for youth ages 12-21 to identify substance use, risky behaviors associated with substance use; includes vaping, tobacco, and nicotine use questions[23]
- The National Institute on Drug Abuse's S2BI and Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD are used to assess SUD risk in youth ages 12–17. They are available in self-reported or clinician-administered formats and generally takes less than two minutes to complete[24]

Recommendation 3: Increase consistent widespread prevention of substance use messaging among DPBHS, school districts, and the Department of Education (DOE.

[22] 193rd General Court of the Commonwealth of Massachusetts. An Act Relative to Substance Use, Treatment, Education, and Prevention. Approved March 14, 2016. Available at: https://malegislature.gov/Laws/SessionLaws/Acts/2016/Chapter52. Accessed February 3, 2024.

Nationally, recreational marijuana legalization policies have forced public health, behavioral health, and school officials to address rising cannabis use among middle and high school students, exacerbated by ease of access, and complicated by a diversity of consumption methods.

This research, combined with these new policies, highlights a critical need to clarify policies and increase prevention education focused on young Delawareans. Research indicates that as the perceived risk of marijuana use continues to decline, communities can anticipate increased rates of use among adolescents.

> The National Survey on Drug Use and Health documented a decline in the percentage of 12- to 17-year-olds who perceived that there is "great risk" in smoking marijuana monthly or once or twice a week., as decreases in perceived risk typically precede or occur at the same time as increases in use.

Stakeholders repeatedly discussed the increase in vaping among youth, lower perceived risk of harm, and the need for common screening and interventions to address youth substance use, particularly marijuana. Staff working with students emphasized a significant concern that student e-cigarette use, and vaping have become normalized, despite school prohibition. Though schools supply some prevention education and resources, several of the school based health center staff interviewed indicated the need for consistent messaging regarding such use and the ability to make referrals for those with clinical needs related to e-cigarette use and/or vaping.

Prevention strategies offer the opportunity to reduce the impact of substance use and mental health disorders, helping families ensure early intervention, delayed onset of first use, and avoidance of higher costs for behavioral health treatment. As noted, key stakeholders expressed significant concerns about the prevalence of marijuana use and lower perceived risk of harm from illicit substances among youth. The decrease in perceived risk among youth, compounded with young adult substance-related overdose rates in Delaware, calls for greater focus on, and investments in, education and prevention.

Because youth are using a range of substances, including marijuana, alcohol, and prescription drugs, prevention efforts must address the likelihood of poly-substance use, rather than focusing exclusively on specific substances. This effort should include a coordinated cross-sector approach, stemming from a well-developed partnership between DPBHS, DOE, other child serving state divisions and local school districts, coupled with the use of surveillance data to identify substance use trends to inform future prevention efforts. Strategies should include culturally competent and consistent messaging that specifically addresses under-resourced communities and fosters statewide prevention activities accessible to youth.

Prevention strategies have come a long way since the Just say "No" and Drug Abuse Resistance Education (D.A.R.E.) campaigns. Programs that focus solely on risk do not generally resonate with adolescents.[25] Social media plays an increasingly significant role in perceptions of risk and substance use. Prevention efforts are becoming more holistic and

[25] Abrams Z.. More Teens than Ever Are Overdosing. Psychologists Are Leading New Approaches to Combat Youth Substance Misuse. *Monitor on Psychology*. 2024;*55*(2). Available at: https://www.apa.org/monitor/2024/03/new-approaches-youth-substance-misuse. Accessed March 1, 2024.

are incorporating how other addictive behaviors such as gaming, gambling, and risky behaviors such as unprotected sex share many of the same characteristics and are often rooted in trauma, parental substance misuse/abuse, and personality factors, such as sensation-seeking and impulsivity. [26]

The literature is now highlighting that a more traditional prevention curriculum may be best for some young people, and for others, a harm reduction approach may be more effective. Harm reduction efforts for adults have proven effective in saving lives, reducing disease transmission, and helping people connect with treatment. For youth, evidence is emerging that similar approaches, often called "Just Say Know," can be effective in improving knowledge about the effects of substances and curtailing drug use. [27]

Recommendation 4: Continue efforts to develop a transparent data-driven monitoring system and continuous quality improvement (CQI process.

Although the State has several interagency committees and initiatives that include youth services (e.g., Behavioral Health Consortium, Addiction Action Committee) and committed DPBHS leadership focused on responding to behavioral health needs, few interagency subcommittees focus solely on youth substance use and co-occurring conditions. Successful states have deployed a multiagency approach to coordinate service array, monitoring, and policies focused on youth behavioral health. This interagency approach allows states to track key performance indicators, system gaps, overdoses, and behavioral health services utilization. It also facilitates interagency collaboration to share cross-system resources and leverage additional resources to develop braided and blended funding and track upstream outcomes across systems.

This work may include identifying both public and commercial treatment services, developing a workforce of behavioral health practitioners who are trained to treat youth with substance use challenges, and ensuring services provided are best practices and evidence based. Exemplary states have well-defined and measurable CQI systems that inform the larger system.

Oregon, for example, has a comprehensive methodology that uses data to publicly monitor its treatment system. Adopting this type of approach would allow DPBHS to assess the full spectrum of effective supports — from prevention to intensive acute care — to ensure the service array is responsive to the unique needs of each young person and their family. DPBHS may want to closely examine the Recommendations section of the Oregon model included in Appendix III to consider for planning and implementation purposes.

Recommendation 5: Build the SUD and co-occurring workforce using incentives and creative credentialing and certification approaches.

Substantive staffing gaps and barriers were mentioned during HMA's meetings with providers. Staffing shortages have affected all provider contracts, which present a substantial barrier to clients being seen in a timely manner. Connecticut discussed several strategies to address its workforce challenges, which include a standing item during BH

[26] Ibid.
[27] Fischer NR. School-Based Harm Reduction with Adolescents: A Pilot Study. *Substance Abuse Treatment Prevention Policy*. 2022;17(79). Available at: https://doi.org/10.1186/s13011-022-00502-1. Accessed February, 2024

provider meetings focused on workforce, staffing, retention, and recruitment approaches. Additional ideas include tracking interviewees and candidates' reasons for turning down positions, offering incentives for specialized staffing credentials, and offering loan forgiveness and stipends for childcare and housing.

Effective strategies also include offering interprofessional consultation with existing adolescent SUD professionals to improve access to specialists in child and adolescent behavioral health. Oregon, for example, used special state funds to pay for unlicensed professionals to receive clinical supervision and increase the workforce. Licensed staff operating in a fee-for-service environment are often uncompensated for providing supervision. Other states have implemented strategies to expand the list of equivalency requirements to determine eligibility for a provisional license, based on a scope of practice comparison for psychologists, social workers, marriage and family therapists, mental health counselors, and SUD professionals. Regular workforce reports are shared with the legislature to track and monitor progress and outcomes.

DPBHS will need to continue to make a long-term commitment to ongoing training of evidence-based practices for treating youth with substance use problems. Providers have commented that workforce shortages, and Fee for Service (FFS) billing does not readily allow for sending available staff for training. Providers noted that without some type of additional funding and incentives, they must focus on maintaining operations through billable services. Stipends that would cover billable services missed for competency-based training should be encouraged. Funding sources could include the Opioid Settlement Funds or grants. DPBHS has been assertively applying for system grants and has an excellent track record of obtaining practice-change grants.

It is important to note in Illinois' Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children,[28] the state established the Provider Access and Training Hub (PATH) in collaboration with the University of Illinois (Appendix XIII). PATH was designed to increase training, coaching, and mentoring for providers who work with youth. DPBHS may consider collaborating with the local universities and colleges on training the next generation workforce and increase the SUD competencies of its current provider network.

Recommendation 6: Increase coordination between key stakeholders and engagement with youth/families regarding accessing services authorized and provided by DPBHS and the Medicaid MCOs.

Oversight, financing, and coordination of the youth behavioral health system is spread across multiple agencies (DMMA and DSCYF/DPBHS). Low to moderate behavioral health services for youth who enrolled in Medicaid are managed by the MCOs and DPBHS oversees acute services for eligible youth. Medicaid MCOs administer benefits for up to 30 outpatient behavioral health visits for youth with public insurance, and the Division oversees benefits for more than 30 outpatient visits and for all other levels of care, including outpatient, partial hospitalization, intensive outpatient, psychiatric hospital, and residential

[28] Weiner DA. *Blueprint for Transformation: A Vision for Improved Behavioral Health for Illinois Children*. Illinois Children's Behavioral Health Transformation Initiative. February 2023. Available at: https://www2.illinois.gov/sites/gov/Documents/childrens-health-web-021523.pdf. Accessed March 21, 2024.

services. Despite a working understanding between DMMA and DPBHS, this siloing of benefits, processes, and structures is complex and often creates challenges for families seeking services for their children. Based on stakeholder feedback, both the DMMA MCOs as well as DPBHS can improve public communication and messaging (e.g., community fairs/meetings, social media, publications) about service eligibility, as well as how to access clinical services. As often families are seeing treatment services during periods of stress, system efforts to improve communication materials regarding who to specifically contact may help families feel more comfortable reaching out for assistance.

Several interviewees noted a lack of understanding of referral, treatment, and prevention resources available to youth. Despite DPBHS's ongoing efforts, consumers of services and state agency representatives shared these concerns, noting they were largely unaware of ways to access resources and the availability of treatment services. During the stakeholder interviews it was anecdotally reported that when families and others first call DPBHS seeking outpatient services provided through the MCOs, they often find the experience frustrating, which only increases barriers to care.

Because the Medicaid population can change month to month, HMA recommends that this public education be ongoing throughout the year. DPBHS could consider collaborating with DMMA to develop a joint communication campaign and a periodic survey with constituents to help determine its effectiveness. DPBHS could consider developing a dedicated (or updated) communication campaign for the public and key stakeholders regarding the role and services authorized or provided through DPBHS.

Despite the noted good efforts and intentions between all parties (DMMA, DPBHS), significant challenges remain for youth and families seeking treatment services. Addressing these issues may require a formal process for DPBHS and DMMA to develop public-facing communication materials that explain: 1) the specific role of the Medicaid MCOs in raising enrollee awareness of behavioral health outpatient services; 2) how members can access services, including limits on quantity of counseling sessions or days of treatment and *when* to first contact DPBHS for services (e.g., crisis services, inpatient hospitalization, etc.); and 3) ways to resolve issues, including follow up and coordination when a Medicaid-eligible youth with coverage for outpatient services is in crisis and needs urgent DPBHS services.

A thorough analysis of these processes and the communication materials available to members, MCO providers (e.g., physicians and behavioral health providers), and other involved stakeholders (e.g., schools, court, federally qualified health centers), would appear to be warranted. Families, youth, and advocacy voices should be included in this review to learn from their experiences to improve the referral and treatment system.

Recommendation 1: Enhance capacity to serve youth and families by expanding access to all American Society of Addiction Medicine (ASAM) levels of care.		
Goals	**Activities**	**Timeframe (short < 6 months, mid > 6-12, long +12 months)**
Develop a phased-in approach to modernize treatment for youth and family SUD and co-occurring conditions at community-based and residential acute care facilities	Strongly consider as a standalone goal in DPBHS Strategic Plan with *dedicated* internal resources and/or subject matter expert(s) overseeing and reporting progress to leadership. Develop a request for information (RFI) seeking details from providers regarding their capacity to deliver ASAM 4th Edition Level 2 IOP through level 3.7 medical monitoring (high intensity). Identify funding (e.g., state budget initiatives, marijuana tax funding) to support infrastructure, enhanced co-occurring rates, IT, and training of staff, including Opioid Settlement Funds, Substance Abuse Prevention Treatment Recovery Services (formerly SAPTBG), SAMHSA grants.	Mid- to long-term
Assess the total cost of care to provide full ASAM to youth.	Consider forming a workgroup composed of providers, representatives from DMMA, and other key payers to discuss the costs associated with delivering additional ASAM LOC.	Long-term
Review intake processes and use of evidence-based screenings and assessments mapped to LOC and staff training	Assess workflows, intake, and redesign processes for assignment to service level. Train internal staff in administering evidence-based screenings/assessments and determining all ASAM LOC. Consider re-educating providers on care coordination and how levels of care are decided.	Mid-term
Adopt the ASAM LOC framework and train DE state staff in use of the assessment.	Training considerations: a. Costs associated with ASAM assessments. (See Appendix XVI) b. Update necessary regulations to align with ASAM 4th edition	Mid-term
Embed SUD prevention activities in any decision to plan and implement a CCBHC model in the state	If the state chooses to implement a CCBHC model, prevention activities must be integrated throughout the services provided.	Short- to mid-term
Examine public funded value-based payment and incentives models to increase scope of treatment services	Review possible models: a. Vermont Value-Based Payment Measures-including children 0-17 (https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/VBP_CY2023_Designated_Agencies.pdf) b. NYS Medicaid VPB Children's Subcommittee presentation (https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-11-18_vbp_models.pdf)	Mid-term

	c. Explore Value-Based Payment Models for Medicaid Child Health Services from Bailit Health (bailit-vbp-final_20160713.pdf (uhfnyc.org)) d. Integrated Care for Kids (InCK) Model (Integrated Care for Kids (InCK) Model | CMS)	
Review service continuum for youth with substance use challenges aging out of the children's system.	DPBHS may wish to create a workgroup with DSAMH, DMMA and the MCOs to improve the availability of SUD treatment services as youth transition out of the DPBHS system.	Mid-term

Recommendation 2: Require use of standardized SUD screening and assessment tools for referrals to DPBHS and within the DPBHS provider network.		
Goals	**Activities**	**Timeframe (short < 6 months, mid > 6-12, long +12 months)**
Require DPBHS providers to use evidence-based, validated screening tools (e.g., CRAFTT, SBIT2, ASSIST) Require all referrals for DPBHS (as indicated) to use a standardized substance use screen for youth. Work with DMMA to encourage MCO providers to adopt the use of evidence-based substance use screening for youth.	Develop a list of screening tools for consideration, offers training and resources for providers.	Mid-term
Provide training to providers focused on tools and data capturing to develop measurement-based care approaches	Identify costs of training, in-state SMEs, and a timeline for offering curriculum Identify sources of stipends/funding (e.g., opioid settlement funds, cannabis tax) to providers for training and certification in substance use assessment and treatment for youth	Mid- to long-term
Enhance providers' ability to incorporate assessment data into designing treatment planning (and impact outcomes)	Identify best practices for using provider EHRs and data to enhance providers' abilities to adopt measurement-based care approaches. Consider a pilot of incentivizing providers for adopting measurement-based care models	Mid- to long-term
Following emphasis of improved standardized SUD screening across the system, collaborate with school based health center staff to refine the referral process for community-based treatment to the MCOs and DPBHS	Present to school based health center staff the value of SUD screening with evidence-based tools and link to community-based treatment. Assess costs of training for school based health center staff in evidence-based SUD screening Consider a pilot with one local school district and measure identification of substance use problems and referrals to community-based treatment. Coordinate with DOE and local school boards.	Long-term

Recommendation 3: Increase consistent widespread prevention of substance use messaging among DPBHS, school districts, and the Department of Education (DOE).		
Goals	**Activities**	**Timeframe (short < 6 months, mid > 6-12, long +12 months)**
Develop or leverage an existing interagency workgroup composed of DPBHS, DSAMH, DPH, and DOE to enhance marketing/media campaign	Assess the feasibility of new or existing workgroup.	Short-term
Develop and launch a comprehensive youth substance use prevention media campaign focused on social norms using multiple-mediums.	Engage youth in developing a media campaign that reflects their voices, using strategies such as the 84 Movement (the84.org) and the Truth Initiative Campaigns (see Appendix XII). - Develop social media campaigns using Instagram and other platforms. - Develop campaigns targeted at fentanyl use and overdose prevention campaigns. - Engage youth in testing of messaging. Explore Stanford University's Research and Education to Empower Adolescents and Young Adults to Choose Health (REACH) for examples of free, **evidence-based** prevention**,** intervention, and cessation programs for elementary, middle, and high school students. Programs include curricula on cannabis, alcohol, vaping, fentanyl, and other drugs, as well as programs designed to help youth cope with stress (which often contributes to use) https://med.stanford.edu/halpern-felsher-reach-lab/preventions-interventions.html.	Mid-term
Establish a public campaign centered on brief early intervention programs, such as 7 Challenges and SBIRT to increase school and parent understanding of the benefits of screening and intervention.	Coordinate with school districts, school boards and school-based health centers around the benefits of early interventions.	Long-term
Create a structure for sustainable and flexible funds for prevention efforts.	Identify existing funding and opportunities to restructure.	Mid-long term
Plan an impactful media campaign that addresses the low perception of risk associated with alcohol and prescription drug misuse.	Identify additional funds. Explore the feasibility of an RFI to hire a communications firm targeting prevention messaging	Long-term
Create a child and youth SUD prevention framework in	Identify existing groups in the State that can be leveraged to embed these priorities.	Mid- long term

collaboration with DSAMH and other advisory groups.	– Identify stakeholders/members committed to advancing these goals. – Establish key tasks and associated timelines. – Involve youth in crafting the messages.	
Leverage Delaware Council on Gambling Problems (DCGP) youth education program to target youth with or developing problematic gambling behaviors and youth gaming disorder.	Meet with DCPG. Request DCPG to in-service DPBHS staff and train provider network.	Short- to mid-term
Develop menu of youth SUD EBPs and incentivize use among providers—Adolescent Community Reinforcement Approach (A-CRA), 7 Challenges, etc.	Research EBPs, costs, and training to implement. Identify RFI or RFP process, timeline, and budget.	Short- to mid-term

Recommendation 4: Continue efforts to develop a transparent data-driven monitoring system and continuous quality improvement (CQI process.		
Goals	**Activities**	**Timeframe (short term < 6 months, mid > 6-12, long +12 months)**
Establish public dashboards that are reviewed quarterly and annually.	Consider providing a provider scorecard on variables such as referral to provider, timeliness to service, length of stay by service and waitlists. Review how periodic and trended CASII results can be shared with individual providers and aggregated for system review.	Short- to mid-term
Establish key performance indicators KPIs and monitor youth SUD trends, utilization, and overdoses; flag ED visits for youth with SUD codes.	Consider reporting on progress on DPBHS Leadership agendas. Re-evaluate timelines for goals in strategic plan (See Connecticut, Rhode Island, and Oregon)	Short-term
Report on existing data collection tools (e.g., CASII).	Determine what specific metrics will be required, monitored, and reported. Produce quarterly reports for review	Short-term
Continued engagement and advocacy on established cross-agency committees such as Addiction Action Committee (AAC) and Behavioral Health Consortium (BHC).	The Division may consider inventorying all the committees and subcommittees it has representation on, along with those that they either have no or minimal representation. Whenever possible (and to maximize the Division's human resources), priority should be on representation for cross-agency committees *that will maximize access to additional resources and collaboration/partnership opportunities.* Consider a uniform **brief** report-back template to leadership for Division committee representatives following each meeting to address areas such as: committee/subcommittee alignment with the Division's strategic goal(s), resource opportunities, immediate and long-term impact for the Division, and next steps. The Division may entertain additional representation on the BHC Treatment and Stigma subcommittees.	Short-term

	Continued focus on resource opportunities made available through the Opioid Settlement funds available to the state.	
Use US Department of Agriculture Overdose Detection Mapping Application Program (ODMAP) data to track ODs by community.	Coordinate with data team to establish a process and mechanism to track data.	Short-term

Recommendation 5: Build the SUD and co-occurring workforce using incentives and creative credentialing and certification approaches.		
Goals	**Activities**	**Timeframe (short < 6 months, mid > 6-12, long +12 months)**
Enhance training, curriculum development for prevention specialists and SUD providers-creating ASAM co-occurring models	Assess costs and capacity of DE universities and hospitals to train and deliver behavioral health services. Review how some states (e.g., California, New York) are using a Centers for Excellence model to retool the workforce and support workforce training (https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/PCD_BH-CONNECT-RFI.aspx) http://www.ideas4kidsmentalhealth.org/ebtdc-staff.html)	Mid- to long-term
Adopt Project ECHO focused on youth's BH and SUD	Explore feasibility of a Project ECHO training (s) focused on screening, assessment, and treatment for youth SUD	Mid-term
In consultation with DSAMH, expand the list of equivalency requirements to determine eligibility for a provisional license based on a scope of practice comparison	Review regulations and requirements to assess scope	Long-term
Increase workforce incentives for SUD certifications	Identify costs associated with providing incentives such as tuition reimbursement	Mid-term
Explore incentives for clinical supervision of unlicensed individuals; loan repayment incentives for BH staff	Identify costs and budget. See Oregon model (Appendix III)	Mid-term
Assess interstate compacts and licensure reciprocity for delivery of telehealth service for severe workforce shortages (e.g., child psychiatrist, addiction medicine)	Review regulations Examine interstate compacts	Mid- to long-term
Explore additional opportunities to increase SUD providers, and in particular youth and adolescent prescribers.	Explore opportunities with DPH and the Delaware Child Psychiatry Access Program (DCPAP) on potential telehealth platform opportunities to increase access of pediatric psychiatry services for the Division's provider network. Follow SAMSHA's planning and implementation for Provider's Clinical Support System Universities, as there may be opportunities to build the behavioral health workforce. https://www.samhsa.gov/providers-clinical-support-system-pcss-universities	Mid-term

Recommendation 6: Increase coordination between key stakeholders and engagement with youth/families regarding accessing services authorized and provided by DPBHS and the Medicaid MCOs.		
Goals	**Activities**	**Timeframe (short < 6 months, mid > 6-12, long +12 months)**
Enhance coordination and timely sharing of information and matching of youth to services among DPBHS and the MCOs	Develop business process maps for care assignment into DPBHS and the MCOs. Identify timeliness standards and coordination of care management for transitions of care.	Mid- to long-term
Ensure metrics being monitored of provider network by the PA unit is not only assessing contractual compliance, utilization, and outcomes, but also providing actionable feedback on service gaps (e.g., LOC) and needs.	Annually review monitoring metrics for consistency with Delaware-specific SUD youth data (e.g., Delaware Youth Risk Behavior Survey, National Survey on Drug Use and Health, KIDS COUNT, Monitoring the Future) and trends from increased standardized SUD screening and assessment practices. Monitor regional and national data trends with those of state-specific data on SUD for system planning. Identify workflows, leads, and contract standards for standardization and regular reporting timelines. As increased standardized screening and assessment for SUD increases throughout the system, the Division should regularly monitor the data for diagnostic trends and care needs.	Mid- to long-term
Work with Medicaid MCOs to ensure that the public SUD system (Medicaid and DPBHS) has a robust care continuum.	Establish reporting mechanisms for referrals and tracking among DPBHS and MCOs.	Mid- to long-term
Enhance communication strategy for youth and families to include ways to access care, availability of benefits and providers.	Develop marketing materials with the managed care plans and Division.	Mid-term
Establish ongoing outreach and engagement activities and leads within DPBHS. Consider additional collaboration with Family Court and DHSS to educate those systems (and consumers) about the public youth SUD screening,	Establish regular meetings to share treatment resources, referral process. Consider semi-annual informational presentations to family court, public defenders, and Deputy Attorney General	Mid-term

assessment, treatment, and services	Consider targeted (and ongoing) communication materials on accessing the youth public behavioral health system to appropriate DHSS' divisions (e.g., DSS, DPH, DSAMH).	

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