NEVADA'S BEHAVIORAL HEALTH COMMUNITY INTEGRATION STRATEGIC PLAN

July 2018

ACKNOWLEDGEMENTS

The Nevada Division of Public and Behavioral Health would like to thank the following individuals for their contributions to this important strategic process:

Vanessa Alpers
Department of Health and Human Services

Sharon Chamberlain
Northern Nevada HOPES

Debora Cline
Division of Child and Family Services

Karri Couste
Division of Child and Family Services

Evelia Duncan
Advocate

Steve Fisher
Division of Welfare and Supportive Services

Jessica Flood
Regional Behavioral Health Coordinator

Robyn Gonzalez
Division of Health Care, Financing, and Policy

Joelle Gutman
Regional Behavioral Health Coordinator

Marta Jensen
Division of Health Care, Financing, and Policy

Edrie LaVoie
Lyon County Human Services

Sheila Leslie
Regional Behavioral Health Coordinator

Naomi Lewis
Division of Welfare and Supportive Services

Katherine Mayhew
Division of Child and Family Services

Kyra Morgan
Public Health Informatics and Epidemiology

Cody Phinney
Division of Health Care, Financing, and Policy

Helen Robertson
Aging and Disability Services Division

Ariana Saunders
Regional Behavioral Health Coordinator

Kim Schlesener
Division of Welfare and Supportive Services

Dena Schmidt
Aging and Disability Services Division

Shannon Sprout
Division of Health Care, Financing, and Policy

Karen Taycher
Nevada PEP

Alexis Tucey
Department of Health and Human Services

Richard Whitley
Department of Health and Human Services

Dr. Stephanie Woodard
Division of Public and Behavioral Health

Kelly Wooldridge
Division of Child and Family Services

DuAne Young
Division of Public and Behavioral Health

Social Entrepreneurs, Inc., a company dedicated to improving the lives of people by helping organizations realize their potential, provided support in the development of this plan.

TABLE OF CONTENTS

Acknowledgements i

Executive Summary 2

Background 7

Guiding Principles 8

Situational Analysis 9

Community Integration Self-Assessment Tool 10

Data Collection 12

Priorities 14

Goals and Strategies 15

Implementation Planning 18

EXECUTIVE SUMMARY

In 2016, the Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) began a planning process to develop a strategic plan that would address assuring, providing, regulating, and funding behavioral health in Nevada. This planning process was driven by completion of a framework to further Olmstead Plan development in the state. The State of Nevada Aging and Disability Services Division (ADSD) is the lead entity for implementation of the plan. As a result of discussions with key stakeholders in Nevada, a decision was made to integrate behavioral health into the evolving Olmstead Plan framework.

SAMHSA approved a technical assistance (TA) request from DPBH and Behavioral Health Community Services to support state staff by increasing understanding of the Olmstead decision and its implications for state action and creating a framework for Olmstead Plan development in the state. As part of this TA, DPBH utilized the Community Integration Self-Assessment (CISA) tool to conduct a self-assessment of its current performance related to the degree of behavioral health community integration. Data was collected from a number of public and state sources to inform the assessment.

Department of Health and Human Services Strategic Framework for Community Integration

The State of Nevada has elected to integrate community integration efforts into the updated State Olmstead plan to serve as the Department of Health and Human Services (DHHS) Strategic Framework for Community Integration.

Mission

The mission of the DHHS Strategic Framework is to ensure that Nevadans have the opportunity to achieve optimal quality of life in the community of their choice.

Vision

The vision is that Nevadans, regardless of age or ability will enjoy a meaningful life led with dignity and self-determination.

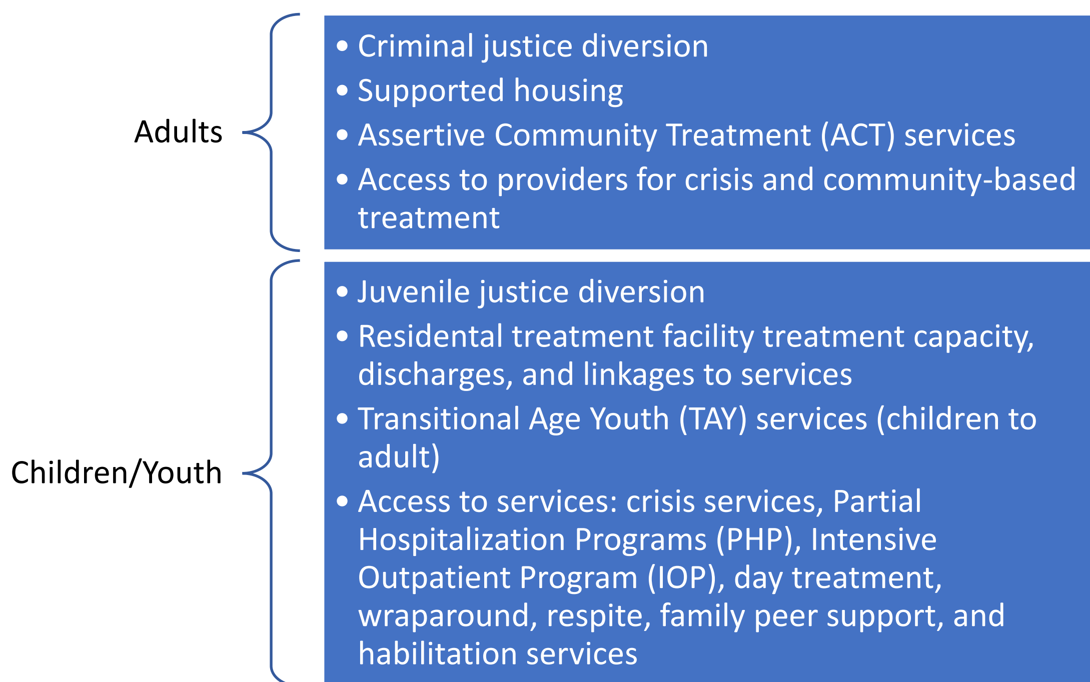
Guiding Principles

The DHHS Strategic Framework has adopted the following guiding principles:

- Independence: People should have options and the ability to select the manner in which they live
- Access: People's needs are identified and met quickly
- Dignity: People are viewed and respected as human beings
- Integration: People can live, work, and play as part of their community
- Quality: Services and supports achieve desired outcomes
- Sustainability: Services and supports can be delivered over the long term so individuals can be self-sufficient

Priorities

After reviewing results of the self-assessment, a planning body prioritized categories for adults and children/youth that guided development of the strategic plan:



System Goals and Strategies

After priority categories were determined, the planning members then identified three system goals with specific strategies to address the adult and children/youth populations.

System Goal 1: Ensure there is a continuum of high quality recovery support and care to achieve and maintain stability.	
Strategies - Adults	**Strategies – Children/Youth**
➢ Provide training, implementation, fidelity, and funding to ensure Assertive Community Treatment (ACT), such as Forensic Assertive Community Treatment (FACT) and Modified Assertive Community Treatment (MACT) statewide, including a rural ACT service. ➢ Expand Certified Community Behavioral Health Clinics (CCBHC) in communities statewide. ➢ Make housing more readily available for people with Serious Mental Illness (SMI)	➢ Develop the Division of Child and Family Services (DCFS) as a lead authority in children's behavioral health services for the State of Nevada (policy and standards development, technical assistance, performance-based contracts, and quality improvement). ➢ Develop DCFS as a "safety net" provider of children's mental health services (i.e., services that have been identified as not available in the community or there is an

System Goal 1: Ensure there is a continuum of high quality recovery support and care to achieve and maintain stability.	
Strategies - Adults	**Strategies – Children/Youth**
by providing training, implementation, fidelity, and funding for evidence-based supportive housing practices. ➢ Explore a supports-based budgeting for supportive housing. ➢ Use data to improve quality of care and outcomes. ➢ Ensure that quality measurement efforts include mental health. ➢ Improve linkage of data to improve services. ➢ Maximize the capacity of the behavioral health workforce. ➢ Develop state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI. ➢ Implement population health payment models in health benefit programs. ➢ Adequately fund the full range of services needed by people with SMI. ➢ Pay for psychiatric and other behavioral health services at rates equivalent to other health care services. ➢ Provide reimbursement for outreach and engagement services related to mental health care. ➢ Fund adequate home-and community-based services for adults with SMI.	insufficient number of providers to meet the need). ➢ Expand availability of community-based children's mental and behavioral health services that are consistent with the System of Care's (SOC) Principles and Values. ➢ Identify current public funding sources that are associated with the provision of children's behavioral health services and/or workforce development. ➢ Ensure providers are trained on SOC implementation including criteria for high fidelity wraparound. ➢ Establish a well-coordinated plan for clients prior to aging out of children's services so that young adults do not go without mental health services. ➢ Enhance family driven supportive services. ➢ Develop state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for children/youth with Serious Emotional Disturbance (SED). ➢ Adequately fund the full range of services needed by children/youth with SED. ➢ Fund adequate home-and community-based services for children and youth with SED.

System Goal 2: Ensure individuals have access to appropriate, timely services in the most integrated setting based on a self-determination plan.	
Strategies - Adults	**Strategies – Children/Youth**
➢ Provide ACT statewide, including a rural ACT service. ➢ Provide community-based treatment and trauma informed interventions. ➢ Provide community outreach and case management, including using SSI/SSDI Outreach, Access, and Recovery (SOAR) approach. ➢ Develop a memorandum of understanding (MOU) to identify the transition age youth (TAY) lead and the roles and responsibilities of other entities providing services. ➢ Provides supports and services to family members and caregivers. ➢ Ensure SMI screening to occur in all primary care settings. ➢ Ensure coordinated specialty care is available statewide for individuals experiencing FEP. ➢ Ensure integrated services are readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders.	➢ Provide Wraparound In Nevada (WIN) High Fidelity services to the top 5% of children/youth who meet the criteria. ➢ Provide case management and clinical services to children with SED. ➢ Provide crisis services through the "Mobile Crisis Program" to children and conduct sustainability planning for the program. ➢ Provide PHP, IOP, day treatment, respite, and family peer support. ➢ Provide First Episode Psychosis (FEP) intervention. ➢ Prioritize early identification and intervention services for children, youth, and young adults. ➢ Ensure SED screening occurs in all primary care settings. ➢ Expand availability of community-based children's behavioral health services that are consistent with SOC Principles and Values.

System Goal 3: Ensure a system that prevents inappropriate incarceration, hospitalization, institutionalization, or placement.	
Strategies - Adults	**Strategies – Children/Youth**
➢ Ensure intervention teams are utilizing data-driven risk assessments by utilizing the Crisis Intervention Team (CIT) assessment for diversions. ➢ Implement care transition interventions for the forensic SMI population such as discharge clinics and re-entry to community-based providers. ➢ Utilize Assisted Outpatient Treatment (AOT) as a diversion strategy. ➢ Utilize telehealth to work with partners in emergency rooms to de-escalate individuals with SMI. ➢ Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization. ➢ Reassess civil commitment standards and processes. ➢ Establish standardized assessments for level of care and monitoring of consumer progress. ➢ Support interventions to correspond to all stages of justice involvement (consider all points included in the sequential intercept model). ➢ Develop an integrated crisis response system to divert people with SMI from the justice system. ➢ Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail. ➢ Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities.	➢ Develop DCFS as an emergency response, assessment, and care coordination entity. ➢ Expand the service array in communities, including in-home services to decrease Residential Treatment Center (RTC) placement. ➢ Develop an in-state option for children who require a higher level of care. ➢ Develop school partnerships with behavioral health providers. ➢ Develop a data system to track if fewer children with SED are being sent out of state and the ability of Managed Care Organizations (MCO) to quickly and appropriate serve children. ➢ Develop an integrated crisis response system to divert children/youth with SED from the justice system. ➢ Expand availability of community-based children's behavioral health services that are consistent with SOC principles and values.

BACKGROUND

Since the 1999 Olmstead decision, Nevada has made significant progress to ensure persons with disabilities are able to live in the community setting of their choice. Nevada developed a statewide plan to address the need for community supports for people with disabilities who are in segregated settings and to prevent future unnecessary segregation. The 10-year Olmstead plan was approved by the Legislature in 2003 and expired in 2013.

The Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) recently completed the process of creating a framework to further Olmstead Plan development in the state. The State of Nevada Aging and Disability Services Division (ADSD) is the lead entity for implementation of the plan. As a result of discussions with key stakeholders in Nevada, a decision was made to integrate behavioral health into the evolving Olmstead Plan framework. This decision was informed by notable data points, including:

- In 2015, the prevalence rate of adults age 18 or older with a serious mental illness (SMI) was 4.3 percent or 91,893 individuals, slightly higher than the U.S. rate of 4.0 percent. [1]
- 28,589 persons were served by State Mental Health Agencies (SMHA) in Nevada during 2015 which equates to 31 percent of the adult population with SMI.[2]
- The number of children with serious emotional disorder (SED) increased from 339 children in 2012 to 411 in 2015.
- The number of at-risk populations served by Juvenile Justice and the state foster care system was 8,096 children in 2016. This number has remained nearly constant since 2012.

WHAT IS THE OLMSTEAD DECISION?

On June 22, 1999, the US Supreme Court ruled in the landmark Olmstead v. L.C. decision that unnecessary segregation and institutionalization of people with disabilities is a form of discrimination and prohibited under the Americans with Disabilities Act (ADA).

To remedy or avoid such discrimination, states are required to provide integrated community services and supports for people with disabilities who are otherwise entitled to segregated services, when:

1. The state treatment professionals reasonably determine that community placement is appropriate;
2. The person does not oppose such placement; and
3. That placement can be reasonably accommodated, taking into account resources available to the state and the needs of others receiving state disability services.

[1] Substance Abuse and Mental Health Services Administration (SAMHSA). 2015. Serious Mental Illness in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2014 and 2015.
[2] Center for Mental Health Services (CMHS) Uniform Reporting System. 2015. Total Clients Served by SMHA System.

Interest from the Department of Justice (DOJ) has elevated Olmstead implementation as a priority nationally, and statewide within Nevada. The DOJ conducts investigations to determine why people are institutionalized, and if institutionalization is needed, whether they are receiving adequate and appropriate care to ensure timely return and integration back to the community. Their approach includes examining discharge planning, as well as community capacity to ensure adequate and appropriate services and supports in an integrated setting.[3]

Mission

The State of Nevada has elected to integrate community integration efforts into the updated State Olmstead plan to serve as the Department of Health and Human Services (DHHS) Strategic Framework for Community Integration. The mission, vision, and guiding principles in the State's Olmstead plan align well with the behavioral health system and have been adopted in the Community Integration Strategic Plan. This collaborative effort has resulted in one unified comprehensive Olmstead/community integration plan for Nevada.

The mission of the DHHS Strategic Framework is to ensure that Nevadans have the opportunity to achieve optimal quality of life in the community of their choice.

Vision

The vision is that Nevadans, regardless of age or ability will enjoy a meaningful life led with dignity and self-determination.

Guiding Principles

The DHHS Strategic Framework has adopted the following guiding principles:

- **Independence**: People should have options and the ability to select the manner in which they live
- **Access**: People's needs are identified and met quickly
- **Dignity**: People are viewed and respected as human beings
- **Integration**: People can live, work, and play as part of their community
- **Quality**: Services and supports achieve desired outcomes
- **Sustainability**: Services and supports can be delivered over the long term so individuals can be self-sufficient

Additional guiding principles identified by the Community Integration Planning Body are to ensure transformation, innovation and transparency. Collective buy-in and agreement on systems change is imperative to the successful implementation of the Community Integration Strategic Plan. And lastly, that the plan needs to provide culturally and linguistically appropriate services (CLAS).

[3] Ted Lutterman. Development of a Community Integration Self-Assessment (CISA) tool for State Governments. November 14-15, 2016.

SITUATIONAL ANALYSIS

SAMHSA provided technical assistance (TA) to DPBH and Behavioral Health Community Services in support of work that would help increase understanding of the Olmstead decision and its implications for state action as well as creating a framework for Olmstead Plan development in the state.

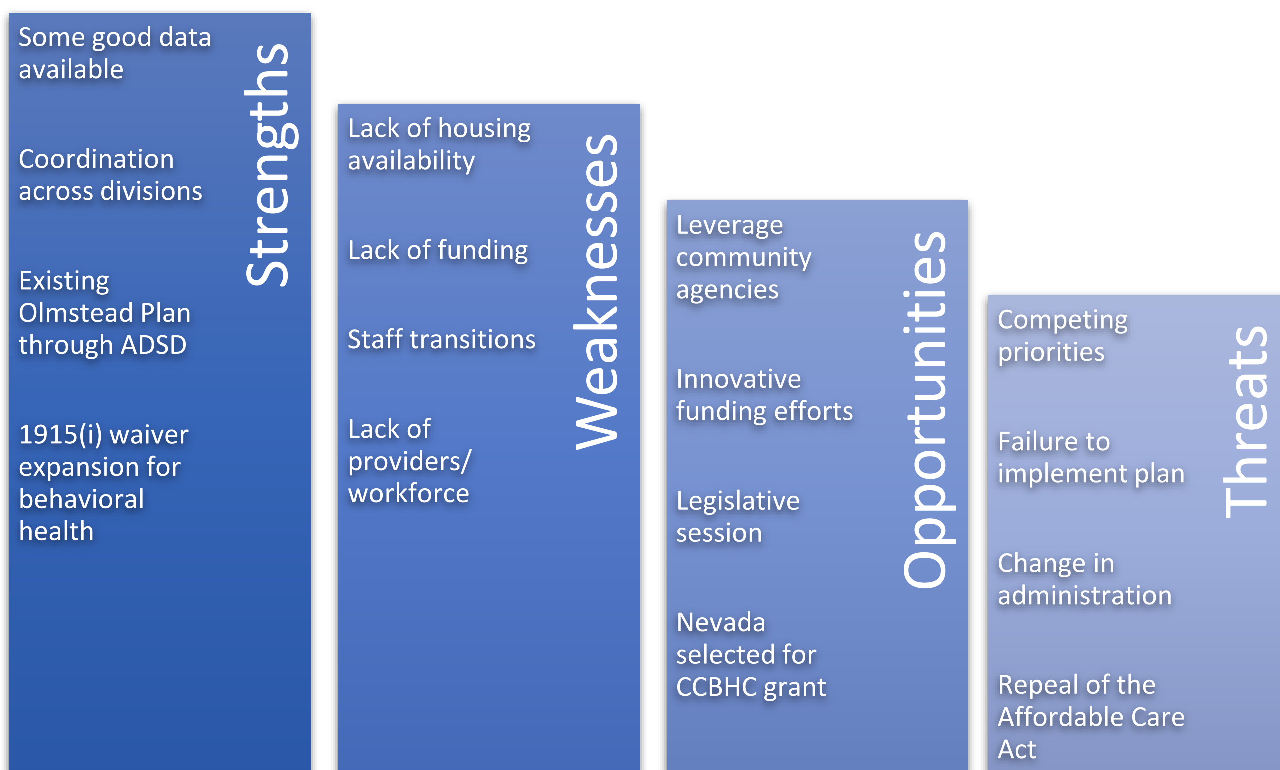
The Nevada Behavioral Health Community Integration Mini Policy Academy was held in Carson City, NV on November 14th and 15th, 2016 with representatives participating from the Nevada DHHS, including DPBH, Community Services, Division of Health Care Financing and Policy (DHCFP), Division of Child and Family Services (DCFS), and the Director of the National Alliance on Mental Illness Nevada. Social Entrepreneurs, Inc. participated in the Policy Academy, as they are working with the Aging and Disability Services Division (ADSD) on the development of their Olmstead/community integration plan. TA was provided by the National Association of State Mental Health Program Directors Research Institute (NRI) and a consultant from Healthcare Systems Consulting, Inc.

Participants at the Mini Policy Academy reviewed quantitative and qualitative data and discussed a common vision, the Olmstead planning process, and how systems should work together to support community integration for individuals with disabilities. This group formed the basis of the Community Integration Strategic Planning body, which included representation from both State and community-based agencies. This planning group oversaw development of the Community Integration Strategic Plan.

SWOT Analysis Results

During the Mini Policy Academy hosted in November 2016, a strengths, weaknesses, opportunities, and threats (SWOT) analysis was conducted. As Nevada moves forward with implementing the Olmstead plan, the SWOT analysis can help guide strategic efforts to develop and support community integration for individuals with behavioral health disorders and other disabilities. The analysis includes both internal and external factors that may influence the planning efforts as well as the execution of the plan over time.

The results of the analysis, as seen on the following page, can be leveraged over time to use strengths to capitalize on opportunities, and address weaknesses to decrease threats and promote opportunities. The full results of the SWOT analysis can be found in Appendix B.



Community Integration Self-Assessment Tool

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed a self-assessment tool to measure community integration by proactively identifying states' strengths and weaknesses around integrations for persons with behavioral health issues.

The Community Integration Self-Assessment (CISA) tool was piloted by eight states over a span of two years and was also reviewed by the United States Department of Justice (US DOJ), the Department of Housing and Urban Development (HUD), and the National Disability Rights Network on behalf of state protection and advocacy organizations.[4] It provides an evaluation of Olmstead as it stands related to child and adult behavioral health, including:

- Current state of the state in policy and practice
- What policies are supportive of Olmstead or that could be strengthened related to Olmstead

The CISA tool requires a cross-system collaborative approach within state agencies that offer community services and supports. The tool suggests collecting data not only from mental health client data systems, but from Medicaid, health, housing, social services, and criminal justice agencies.

[4] Ibid.

The process for the development of the CISA was also shared during the Mini Policy Academy and included an overview of the CISA. The CISA provides a menu of indicators states can use to conduct a self-assessment of their current performance related to the degree of community integration across the following domains:

The goal in using the CISA tool is for all states to assess where there are statewide service gaps through an Olmstead lens and ultimately, improve the individualized level of community integration.

Mini Policy Academy participants reached consensus that integrating behavioral health into the ADSD plan is the desired pathway for developing a single state Olmstead plan. Integrating behavioral health with the guiding principles and critical issues identified by the ADSD planning group appeared to make sense given how well they align with behavioral health priorities. It was determined that other key stakeholders such as those from vocational rehabilitation, education, law enforcement, etc. will be engaged in the implementation planning process as needed.

Steps were developed to immediately begin examining some multi-year trend data based on the indicators from the CISA, focusing on the following domains of within the recommended settings (e.g., state hospitals, nursing homes, adult care homes, residential treatment centers, jails, and other settings):

1) Financing and Resources
2) Movement to the Community and Recidivism
3) Community Capacity

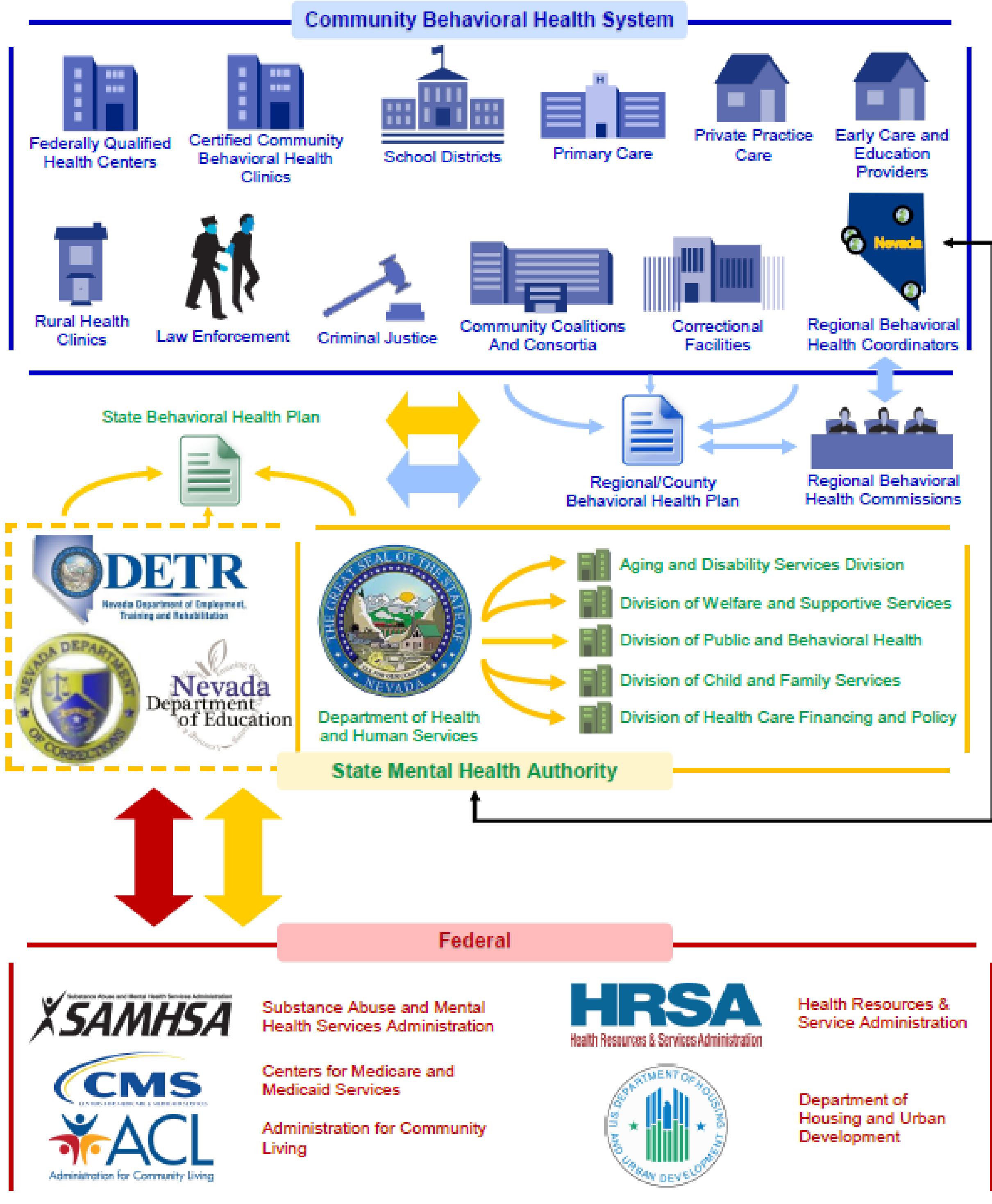
4) At-Risk Population

These domains were selected by participants at the Mini Policy Academy based on the availability of data collected in the state of Nevada.

Data Collection

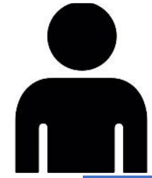
The data collected to inform the four priority domains were obtained from a number of sources including the U.S. Census Bureau, SAMHSA, HUD, Medicaid, the Nevada Uniform Reporting System (URS), the Nevada Division of Welfare and Supportive Services, the Nevada Division of Child and Family Services (DCFS), Division of Health Care Financing and Policy (DHCFP), and DPBH through the Office of Public Health Informatics and Epidemiology (OPHIE).

A graphic was developed by the planning group to illustrate a model for how the community behavioral health system, SMHA, and federal partners should work to address community integration. Utilizing both the state behavioral health plan, and the county/regional behavioral health plans, the community behavioral health system works with the SMHA to ensure that the goals and strategies for community integration for children/youth and adults are implemented. In addition, technical assistance is provided through federal partners. The graphic is presented on the following page.


Community Behavioral Health System
Federally Qualified Health Centers
Certified Community Behavioral Health Clinics
School Districts
Primary Care
Private Practice Care
Early Care and Education Providers
Rural Health Clinics
Law Enforcement
Criminal Justice
Community Coalitions And Consortia
Correctional Facilities
Regional Behavioral Health Coordinators
State Behavioral Health Plan
Regional/County Behavioral Health Plan
Regional Behavioral Health Commissions
DETR
Nevada Department of Employment, Training and Rehabilitation
Nevada Department of Education
Department of Health and Human Services
Aging and Disability Services Division
Division of Welfare and Supportive Services
Division of Public and Behavioral Health
Division of Child and Family Services
Division of Health Care Financing and Policy
State Mental Health Authority
Federal
SAMHSA
Substance Abuse and Mental Health Services Administration
HRSA
Health Resources & Services Administration
Health Resources & Service Administration
CMS
Centers for Medicare and Medicaid Services
ACL
Administration for Community Living
Department of Housing and Urban Development

PRIORITIES

The Community Integration Strategic Planning members reviewed and prioritized key categories for planning for both adults and children/youth. They are presented below:



Adults

- Criminal Justice diversion
- Supported housing
- Assertive Community Treatment (ACT) services
- Access to providers for crisis and community-based treatment

Children/Youth

- Juvenile justice diversion
- Residential Treatment Facility treatment capacity, discharges and linkages to services
- Transitional Age Youth (TAY) services (children to adult)
- Access to services: crisis services, Partial Hospitalization Programs (PHP), intensive Outpatient Program (IOP), Day Treatment, Wraparound, Respite, Family Peer Support, and Habilitation Services

Goals and Strategies

Three system goals were identified to address the priorities for adults and children/ youth. They are presented below along with proposed strategies to achieve the goal.

System Goal 1: Ensure there is a continuum of high quality recovery support and care to	
Strategies - Adults	**Strategies – Children/Youth**
➢ Provide training, implementation, fidelity, and funding to ensure Assertive Community Treatment (ACT), such as Forensic Assertive Community Treatment (FACT) and Modified Assertive Community Treatment (MACT) statewide, including a rural ACT service. ➢ Expand Certified Community Behavioral Health Clinics (CCBHC) in communities statewide. ➢ Make housing more readily available for people with Serious Mental Illness (SMI) by providing training, implementation, fidelity, and funding for evidence-based supportive housing practices. ➢ Explore a supports-based budgeting for supportive housing. ➢ Use data to improve quality of care and outcomes. ➢ Ensure that quality measurement efforts include mental health. ➢ Improve linkage of data to improve services. ➢ Maximize the capacity of the behavioral health workforce. ➢ Develop state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI. ➢ Implement population health payment models in health benefit programs. ➢ Adequately fund the full range of services needed by people with SMI.	➢ Develop the Division of Child and Family Services (DCFS) as a lead authority in children's behavioral health services for the State of Nevada (policy and standards development, technical assistance, performance-based contracts, and quality improvement). ➢ Develop DCFS as a "safety net" provider of children's mental health services (i.e., services that have been identified as not available in the community or there is an insufficient number of providers to meet the need). ➢ Expand availability of community-based children's mental and behavioral health services that are consistent with the System of Care's (SOC) Principles and Values. ➢ Identify current public funding sources that are associated with the provision of children's behavioral health services and/or workforce development. ➢ Ensure providers are trained on SOC implementation including criteria for high fidelity wraparound. ➢ Establish a well-coordinated plan for clients prior to aging out of children's services so that young adults do not go without mental health services. ➢ Enhance family driven supportive services. ➢ Develop state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for

System Goal 1: Ensure there is a continuum of high quality recovery support and care to achieve and maintain stability.	
Strategies - Adults	**Strategies – Children/Youth**
➢ Pay for psychiatric and other behavioral health services at rates equivalent to other health care services. ➢ Provide reimbursement for outreach and engagement services related to mental health care. ➢ Fund adequate home-and community-based services for adults with SMI.	children/youth with Serious Emotional Disturbance (SED). ➢ Adequately fund the full range of services needed by children/youth with SED. ➢ Fund adequate home-and community-based services for children and youth with SED.

System Goal 2: Ensure individuals have access to appropriate, timely services in the most integrated setting based on a self-determination plan.	
Strategies - Adults	**Strategies – Children/Youth**
➢ Provide ACT statewide, including a rural ACT service. ➢ Provide community-based treatment and trauma informed interventions. ➢ Provide community outreach and case management, including using SSI/SSDI Outreach, Access, and Recovery (SOAR) approach. ➢ Develop a memorandum of understanding (MOU) to identify the transition age youth (TAY) lead and the roles and responsibilities of other entities providing services. ➢ Provides supports and services to family members and caregivers. ➢ Ensure SMI screening to occur in all primary care settings. ➢ Ensure coordinated specialty care is available statewide for individuals experiencing FEP. ➢ Ensure integrated services are readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders.	➢ Provide Wraparound In Nevada (WIN) High Fidelity services to the top 5% of children/youth who meet the criteria. ➢ Provide case management and clinical services to children with SED. ➢ Provide crisis services through the "Mobile Crisis Program" to children and conduct sustainability planning for the program. ➢ Provide PHP, IOP, day treatment, respite, and family peer support. ➢ Provide First Episode Psychosis (FEP) intervention. ➢ Prioritize early identification and intervention services for children, youth, and young adults. ➢ Ensure SED screening occurs in all primary care settings. ➢ Expand availability of community-based children's behavioral health services that are consistent with SOC Principles and Values.

System Goal 3: Ensure a system that prevents inappropriate incarceration, hospitalization, institutionalization, or placement.	
Strategies - Adults	**Strategies – Children/Youth**
➢ Ensure intervention teams are utilizing data-driven risk assessments by utilizing the Crisis Intervention Team (CIT) assessment for diversions. ➢ Implement care transition interventions for the forensic SMI population such as discharge clinics and re-entry to community-based providers. ➢ Utilize Assisted Outpatient Treatment (AOT) as a diversion strategy. ➢ Utilize telehealth to work with partners in emergency rooms to de-escalate individuals with SMI. ➢ Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization. ➢ Reassess civil commitment standards and processes. ➢ Establish standardized assessments for level of care and monitoring of consumer progress. ➢ Support interventions to correspond to all stages of justice involvement (consider all points included in the sequential intercept model). ➢ Develop an integrated crisis response system to divert people with SMI from the justice system. ➢ Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail. ➢ Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities.	➢ Develop DCFS as an emergency response, assessment, and care coordination entity. ➢ Expand the service array in communities, including in-home services to decrease Residential Treatment Center (RTC) placement. ➢ Develop an in-state option for children who require a higher level of care. ➢ Develop school partnerships with behavioral health providers. ➢ Develop a data system to track if fewer children with SED are being sent out of state and the ability of Managed Care Organizations (MCO) to quickly and appropriate serve children. ➢ Develop an integrated crisis response system to divert children/youth with SED from the justice system. ➢ Expand availability of community-based children's behavioral health services that are consistent with SOC principles and values.

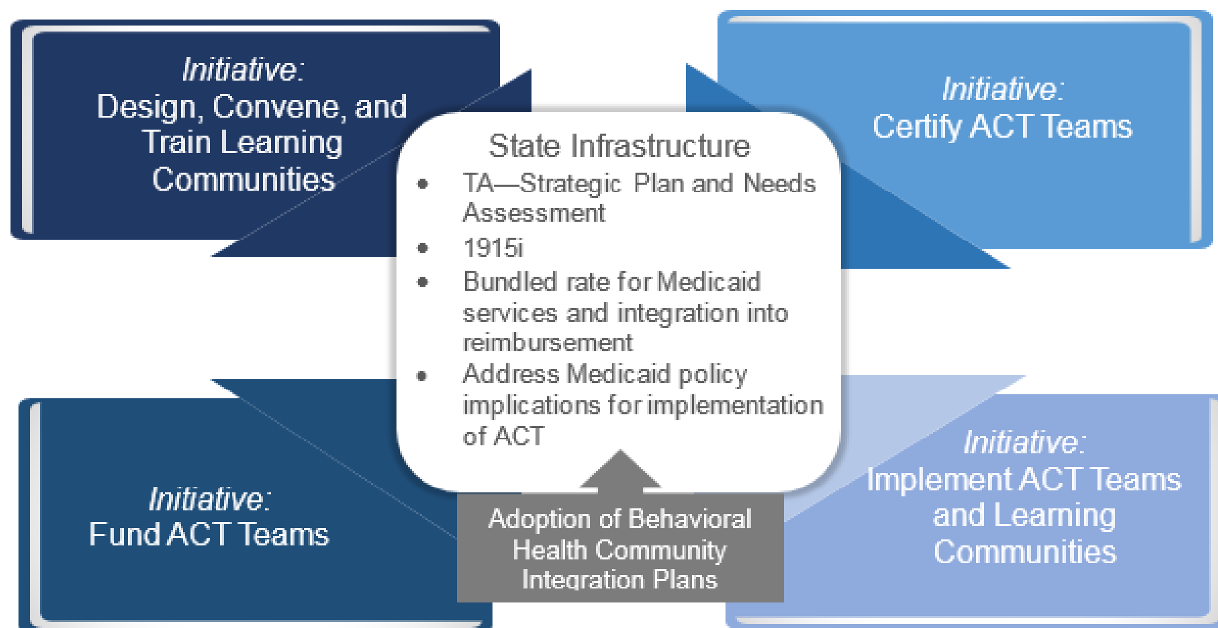
IMPLEMENTATION PLANNING

In 2018, DPBH requested technical assistance from SAMHSA to address Supported Housing and ACT implementation. The TA will address three of the four Adult priorities, specifically:

- Design, financing, and delivery of high-quality behavioral health treatment services and supports, including Supported Housing
- Full implementation of high fidelity Assertive Community Treatment (ACT) services statewide
- Establishment of a full, sustainable continuum of care to allow individuals with disabilities related to SMI/SED to be able to have choice in the communities they live and services and supports to allow them to live independently to the greatest extent possible, including access to providers for crisis and community-based treatment

SAMHSA approved the TA request and began working with DPBH on Phase 1 of the request in April 2018 to identify an ACT model that best fits the needs of the state. Included in this phase of the TA is establishment of the infrastructure needed to support statewide implementation of ACT including configuration of the bundled rate for Medicaid services and integration into reimbursement and addressing Medicaid's policy implications for implementation of ACT. SAMHSA will also work with DPBH to provide Supported Housing TA.

The four initiatives that will be covered under ACT implementation are:



DPBH will develop a separate implementation plan to address criminal justice diversion for the adult population.