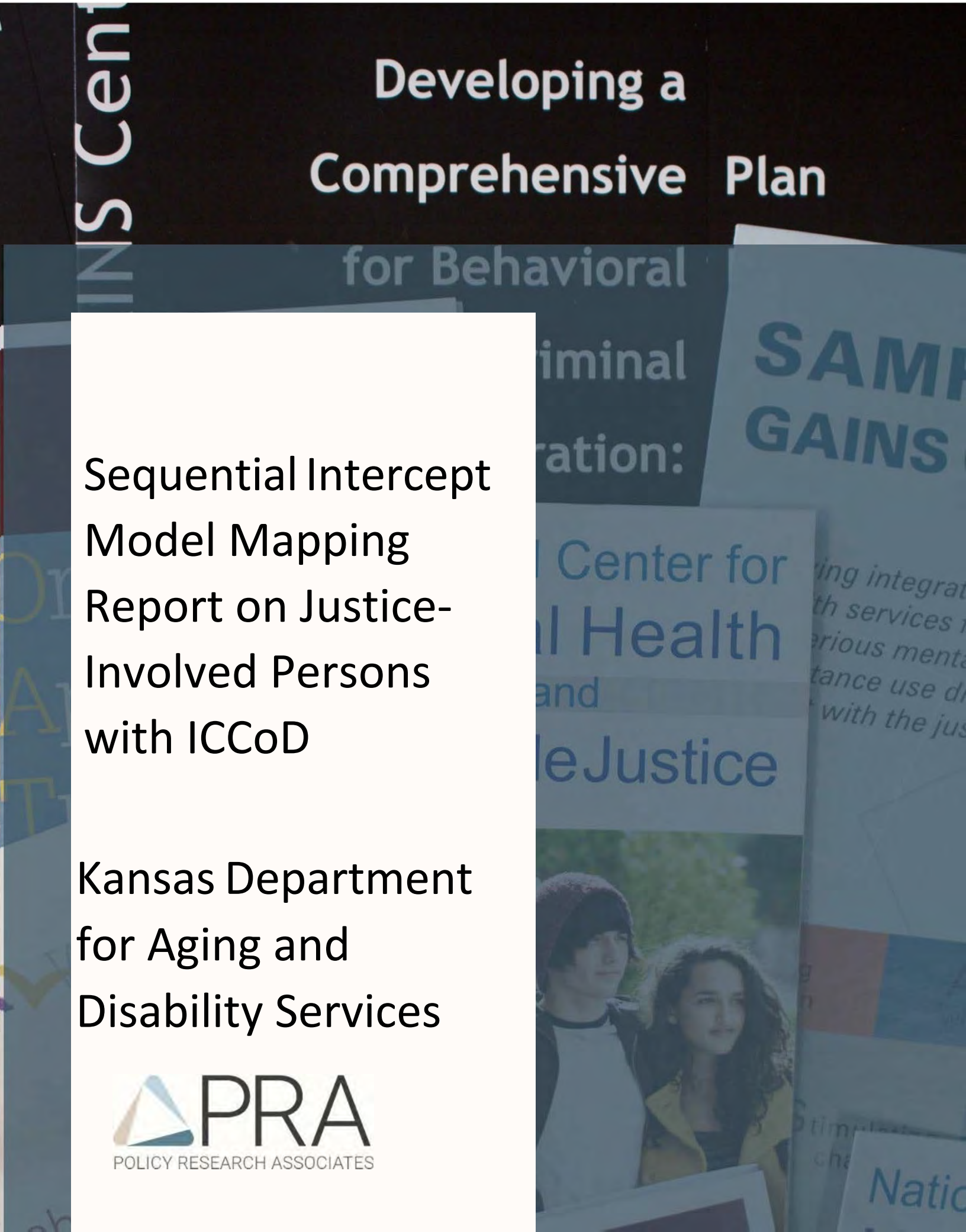

Sequential Intercept Model Mapping Report on Justice-Involved Persons with ICCoD

Kansas Department for Aging and Disability Services

PRA
POLICY RESEARCH ASSOCIATES

Sequential Intercept Model Mapping Report on Justice-Involved Persons with ICCoD

Kansas Department for Aging and Disability Services

Final Report

November 2022

ACKNOWLEDGEMENTS

This report was prepared by Regina Huerter of Policy Research Associates, Inc. (PRA) and Dr. Debra Pinals, Consultant. PRA wishes to thank Secretary Laura Howard of the Kansas Department for Aging and Disability Services (KDADS) and Kansas Department for Children and Families (DCF), Interim Commissioner Mandy Flowers of the KDADS, Representative Barbara Ballard of District 44, and Michael Stevens, CEO of Sunflower Health Plan for organizing this effort. PRA also wishes to thank all the local stakeholders that participated.

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INTRODUCTION

On November 9, 2022, Policy Research Associates (PRA) convened a cross-system group representing KDADS, County disability providers, disability advocates, individuals with living mental health, substance use, I/DD or other disability experience, criminal justice, and behavioral health system stakeholders from across Kansas for a special Sequential Intercept Model (SIM) Mapping Workshop. The workshop focused specifically on the involvement of persons with ICCoD (referring to persons with Intellectual and Developmental Disability (I/DD), Neurocognitive Disorders including Acquired Brain Injury (ABI), co-occurring behavioral health conditions and other disabilities) in the criminal legal system.

PRA delivered a presentation on the ICCoD SIM Framework and facilitated discussions focused on identifying available resources for responding to the needs of adults with complex co-occurring needs involved in the criminal legal system, as well as gaps in services. The discussions focused on all intercepts of the SIM however the major focus was I/DD organizational structure in Kansas, meeting the needs of individuals with co-occurring complex needs and crisis interventions. On November 10, 2022, PRA convened the same group of stakeholders to identify and prioritize areas of work and develop draft action plans.

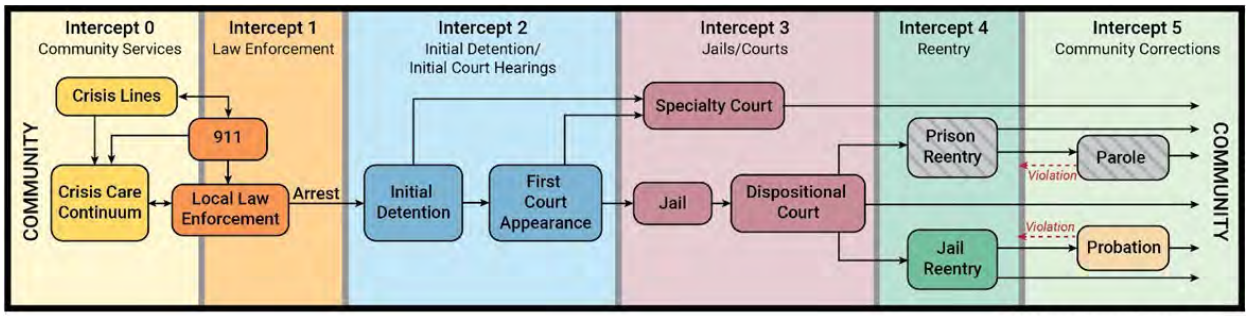
THE SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model (SIM), developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] provides a conceptual framework for jurisdictions interested in exploring the intersection of behavioral health and criminal legal system, assessing available resources, identifying gaps in services, and conducting strategic planning. These activities are best accomplished by a diverse cross-system group of stakeholders from the behavioral health and criminal legal systems including mental health and substance use treatment providers, law enforcement and other first responders, courts, jails, community corrections, social service agencies, housing providers, people with lived experience, family members, and many others.

SIM Mapping Workshops result in a snapshot of how people with mental and substance use disorders and other complex needs enter and move through the criminal legal system. Through the process, facilitators and participants identify opportunities for linkage to treatment and other support services, and for prevention of further penetration into the criminal legal system.

SIM Mapping Workshops have three primary objectives:

1. The development of a comprehensive picture of how people with mental and substance use disorders and complex needs enter and move through the criminal legal system along six distinct intercept points: (0) Community Services, (1) Law Enforcement (2) Initial Detention and Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections.
2. Identification of resources, gaps in services, and opportunities at each intercept for individuals in the target population.
3. The development of priorities for change and strategic action plans.



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

ICCoD and SIM Convergence Framework

ICCoD Background

We are using a concept of converge or convergence of the traditional sequential intercept model with system and services for intellectual disabilities, developmental disabilities, neurocognitive conditions including acute brain injury, and individuals with co-occurring mental health challenges or substance use disorders. To capture the complex nature of multiple conditions, we will be using the acronym, ICCoD (I/DD, Cognitive impairment, Co-Occurring conditions, and other disabilities). At times in this report, we will also refer to this population as having "complex needs." While we are using this acronym, we are talking about people first and just trying to keep our language clear and inclusive. The ICCoD framework was created by Regina Huerter in 2021. Dr. Deb Pinals, a SIM co-facilitator, contributed by providing a review of the framework and workshop presentation slides.

Funding Opportunities

Of note is the infusion of federal dollars, in particular the American Rescue Plan that can help plan for future sustainable and progressive supports for individuals with complex needs. Other funding sources are Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, both through the substance abuse prevention side of it as well as, the Center for Mental Health Services (CMHS; Center for Mental Health Services | SAMHSA). There are also several initiatives looking at Certified Community Behavioral Health Clinics (Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (samhsa.gov). There are provider relief funds for providers in rural areas and those serving rural communities. There are also opportunities for enhanced F-MAP for provider services, as well as pilot initiatives including those for individuals that might be under waiver services. Opportunities for more flexible new match dollars from Centers for Medicare and Medicaid Services (CMS) are also available, so it's a perfect time for planning and thinking cooperatively and collaboratively across systems to try and identify how funds are going to be used, and make sure that the needs of a population that might represent fewer numbers of people, are met (Regulations & Guidance | CMS)

Population Characteristics

There are overlapping issues of the criminal legal system or the juvenile legal system, and individuals with complex needs of co-occurring mental health, substance use and trauma with intellectual and developmental disabilities, and acquired brain injuries. In addition, it is important to note intersectionality with racial and ethnic disparities and inequities across individuals of color access to services, and treatment. There is a need for a targeted study to understand the needs of complex populations as they relate to the criminal legal system.

The ICCOD and SIM Convergence Framework

I=Intellectual and Developmental Disabilities, C=Cognitive Disabilities,
Co=Co-occurring Mental and Substance Use Disorders, D=Other Disabilities

A — ICCOD AND SIM CONVERGE A: Organizational Structure

Organizational Structure

Administration	Policy	Finance

- Data
- Cross-System Coordination
- Workforce Development

B — ICCOD AND SIM CONVERGE B: Cross-Cutting Considerations at the Population and Person Level

ICCoD Service Capacity: Identification of Needs

Eligibility	Access	Availability

- Enrollment
- Special Populations
- Coordinated Delivery of Treatment and Supports
- Accommodations & Support
- Continuity of Treatment and Supports
- Housing and Homeless Services and Supports
- Transitions, Stabilization and Recovery
- Skill-based, Culturally Responsive Cross-Training

The ICCoD and SIM Convergence Across Intercepts

C — ICCOD AND SIM CONVERGE C: Crisis Systems (Intercepts 0-1)

- Collaborative Policy and Process
- Early Contact Identification and Screening
- 9-1-1 and Crisis Lines, Warmlines

CRISIS INTERVENTIONS

First Responder Response and Options	Policy Considerations

- Acute Crisis Interventions and Services and Settings
- Transition Planning
- Civil Process and Resources

D — ICCOD AND SIM CONVERGE D: Criminal Justice (Intercepts 2-5)

- Identification and Screening
- Case Processing: Juvenile & Adult Accommodations and Supports
- Cross-Agency Coordination, Deflection and Diversion
- Jail/Prison/Forensic Services
- Specialized Caseloads and Services
- Community Supervision

Developed by: Regina Huerter and Debra Pinals, 2021, v2

AGENDA (DAY ONE)

Kansas Sequential Intercept Model Summit

November 9, 2022

Lawrence, Kansas

AGENDA

8:30 a.m. – 9:00 a.m.	**Registration and Networking**
9:00 a.m. – 9:15 a.m.	**Welcome and Opening Remarks** • ***Secretary Laura Howard***, Kansas Department for Aging and Disability Services • ***Mandy Flower***, Assistant Commissioner for Long Term Services and Supports, Kansas Department for Aging and Disability Services • ***Representative Barbara Ballard***, District 44 • ***Michael Stevens***, Chief Executive Officer, Sunflower Health Plan
9:15 a.m. – 10:15 a.m.	**PRA Introductions and Presentation** • ***Regina Huerter***, Senior Project Associate, Policy Research Associates, Inc. • ***Dr. Debra Pinals***, Senior Consultant, Policy Research Associates, Inc.
10:15 a.m. – 10:30 a.m.	**BREAK**
10:30 a.m. – 10:45 a.m.	**Case Study Panel Discussion** Moderator: ***Nanette Perrin***, Sunflower Health Plan • ***Paula Morgan***, IDD Program Manager, Kansas Department for Aging and Disability Services • ***Nick Wood***, Associate Director, InterHab • ***Dee Nighswonger***, Regional Director, Kansas Department for Children and Families • ***Tim DeWeese***, Director, Johnson County Mental Health • ***Scott Braun***, Sheriff, Ellis County
10:45 a.m. – 11:15 a.m.	**Case Study Breakout Groups**
11:15 a.m. – 12:15 p.m.	**Mapping Exercise**
12:15 p.m. – 1:00 p.m.	**LUNCH**
1:00 p.m. – 2:30 p.m.	**Mapping Exercise**
2:30 p.m. – 2:45 p.m.	**BREAK**
2:45 p.m. – 4:15 p.m.	**Mapping Exercise**
4:15 p.m. – 4:30 p.m.	**Closing Remarks and Preview of Day 2** • ***Deputy Secretary Scott Brunner***, Kansas Department for Aging and Disability Services • ***Regina Huerter***, Senior Project Associate, Policy Research Associates, Inc. • ***Dr. Debra Pinals***, Senior Consultant, Policy Research Associates, Inc.

AGENDA (DAY TWO)

Kansas Sequential Intercept Model Summit

November 10, 2022

Lawrence, Kansas

AGENDA

8:30 a.m. – 9:00 a.m.	**Registration and Networking**
9:00 a.m. – 9:15 a.m.	**Recap and Reflections from Day 1** • ***Stephanie Rasmussen,*** Vice President of Long-term Services and Supports, Sunflower Health Plan • ***Matt Fletcher***, Executive Director, Interhab • ***Regina Huerter***, Senior Project Associate, Policy Research Associates, Inc. • ***Dr. Debra Pinals***, Senior Consultant, Policy Research Associates, Inc.
9:15 a.m. – 10:00 a.m.	**Panel Discussion:** Moderator: ***Nanette Perrin***, Sunflower Health Plan • ***Dee Nighswonger***, Regional Director, Kansas Department for Children and Families • ***Tim DeWeese***, Director, Johnson County Mental Health
10:00 a.m. – 10:30 a.m.	**Identification of Priorities for Change**
10:30 a.m. – 10:45 a.m.	**BREAK**
10:45 a.m. – 11:30 a.m.	**Identification of Priorities for Change (continued)**
11:30 a.m. – 12:00 p.m.	**Voting Exercise**
12:00 p.m. – 12:45 p.m.	**LUNCH**
12:45 p.m. – 2:00 p.m.	**Facilitated Discussion**
2:00 p.m. – 2:15 p.m.	**BREAK**
2:15 p.m. – 3:15 p.m.	**Facilitated Discussion**
3:15 p.m. – 3:30 p.m.	**Closing Remarks and Next Steps** • ***Regina Huerter***, Senior Project Associate, Policy Research Associates, Inc. • ***Dr. Debra Pinals***, Senior Consultant, Policy Research Associates, Inc. • ***Stephanie Rasmussen,*** Vice President of Long-term Services and Supports, Sunflower Health Plan • ***Matt Fletcher***, Executive Director, Interhab

RESOURCES AND GAPS AT EACH INTERCEPT

The centerpiece of the SIM Mapping Workshop is the identification of resources, gaps, and opportunities for change. The information gathered is a snapshot in time and reflects the views and experiences of those in the workshop. Moreover, this report can be used by system planners over time to build on existing resources and address prevailing gaps in services and systems.

Case Studies and panels were used to gather perspectives and information from a variety of viewpoints. Four case studies, one involving a juvenile were discussed by a panel of experts. Participants were broken into 6 groups to discuss the remaining three case studies (two groups discussed and reported out on the same case study). Following is a combined summary of all four case studies and small group discussion points. Case studies covered 4 profiles, (1) youth, (2) 33-year-old female, (3) 30-year-old female, (4) 47-year-old male living in a rural community. The case studies can be found in the Appendix.

Summary of panel and case-study issues including areas of concern/discussion, needs and opportunities. Items in this section should be considered as resources and gaps along with other items found under Sections A, B, C and D:

Individual Level Challenges / Items to Address	Suggested Opportunities and Needs
• It takes time to build rapport with an individual. • Need to build support plans based on the individuals' strengths.	• Need for billable time to build rapport with client. Need ability to revisit supports and accommodations at specific intervals. • Ensure individual voice and supported decision

• Ensure individual voice and decision making. • Vulnerable population. Ensure trauma informed care and interventions. • Sexual health, appropriate boundaries, and relationship training. • Need for social connections and reduce isolation. • Environmental and cultural considerations ("home setting", community/resources, culture, gender, age) Diagnosis Accuracy: • Training for practitioners to diagnose individuals with complex needs. • Access to updated diagnosis • Interpretation of needs and interventions based on diagnosis.	making opportunities. • Need services at the level needed, not having to fail or receive minimal response. • Access to, and billable sexual health and boundary training • Need trained multidisciplinary response teams. • Proactive access to services. Define resources and roles – crisis, stabilization, and long-term services. Waitlist only reinforce a crisis cycle. Review supports and accommodations and adjust! • Create opportunities for day and social supports. • Create training standards for the identification and diagnosis of individuals with complex needs. NADD training. Ensure access to appropriately trained practitioners.
Support: System, Providers, Family Challenges / Items to Address	Suggested Opportunities and Needs
Parents/family and care providers need for: • Ongoing training • Intervals of revisiting needs especially after transitions • Respite and on-going support • Support managing their own challenges • Home safety and home repair resources Providers, Training and Coordination • Mental health crisis providers are not trained or equipped to support individuals with complex needs. • Lack of cross training and skill and confidence to provide care. Need to adopt "no wrong door" mindset. • Lack of data on how many ICCoD individuals across systems. • Need for policy and training to uniformly screen and assess needs. • Need for set appointments post crisis. • Need to improve coordination and acceptance of responsibility to provide care across systems	Need to "use what we know" to build individualized support plans: • Whole person – 8 dimensions of wellness: emotional, physical, occupational, social, spiritual, intellectual, environmental, and financial • Strengths, challenges of the individual • What type and level of support/intervention needed now, without having to fail at a lower level • What setting(s) are best • What is available (transportation, distance, ability) • Build on existing support system. • Cultural considerations • Build in support for the support system. • Individualized, dynamic, and proactive support plans Focus on change at the system(s) level – not the individual level. • Need leadership and strategies at the state and local level: "how to get to "yes" to break siloes", bridge efforts across systems,

Supports and Services

- Need for broader array of day program options
- Need for non-state hospital for dual diagnosis
- Limited I/DD youth Waiver
- Formal, individualized transitions, and transition standards are lacking or non-existent. '
- Lack of follow-up and stabilization focus post-crisis. Need more than just referral
- Lack of availability, access and consistency to and in services and supports (frequency, intensity, and duration).
- Need for and lack of funding for crisis intervention and stabilization resources.
- Lack of timely access to services

Justice Impacted

- Not all diversion options are not available for individuals with complex needs.
- I/DD/ABI education in CIT training is not universal
- Lack of CIT teams with I/DD professionals
- Lack of ICCoD training and policies at all levels.
- Lack of access to supports and accommodations.
- Law enforcement and criminal justice system stakeholders don't know about ICCoD community resources. Community resources reluctant to engage with justice involved stakeholders or individuals.
- Lack of comprehensive jail-based screening for ICCoD and appropriate response, access to supports and accommodations.
- Correctional staff not trained to ensure safety and access to supports and accommodations
- KDOC: Lack of resources, need providers, and family; promote ownership of roles and responsibilities.
- Need targeted funding, policy, training, and support to address complex care needs
- Need dedicated "boundary spanners/champions" with ability to address gaps and barriers.
- Need regular cross-system meetings
- Need to fund comprehensive, multidisciplinary, proactive support and crisis response model such as START model. Center for START Services |
- Create and fund standards to promote timely access to services.
- Need uniform cross-training between I/DD, Mental health, Substance Use treatment and other systems.
- Review and update KS Behavioral Sciences Regulatory Board (BSRB) regulations to promote cross-training. Kansas Behavioral Sciences Regulatory Board (KSBSRB) Home

Need for the State to set the stage

- Provide "backbone" support to build ongoing relationships between systems
- Need for training, policy, and coordination consistency across the state and disciplines.
- Create non-state hospital Dual Diagnosis facilities
    - Less intensive care facilities than state hospital
- Review and revise State regulations + conditions regarding crisis and stabilization
- Address waitlists for "crisis" services and follow-up for individuals with complex needs.
- Address Waiver eligibility and address Medicaid restrictions and improve "Network" adequacy.
- Identify gaps in care, especially at transition points from institutions to HCBS waiver.
- Fund crisis intervention, and stabilization services at the level needed by the individual
- Develop a less limited I/DD waiver for youth.

Interventions and Treatment

assessment for planning early in process • Lack of meaningful transitions to services post carceral setting	• Access to services outside of 9-5 M-F. • Need for Multidisciplinary Team Approach (MDT) to address individuals with complex needs. (Multidisciplinary teams working for integrated care | SCIE) • Need for Transitional Care Management (TCM) (Transitional Care Management - Care Management Medicare Reimbursement Strategies for Rural Providers (ruralhealthinfo.org)) • Need for post-crisis stabilization and ongoing services and support. Improve transitional services including *discharge record sharing.* • Need for childhood support guardian education • Need for mental health centers, SUD treatment, and I/DD providers to assertively reach out and coordinate care. • Need for model examples of a good comprehensive treatment plan to promote consistency in care and resources. • Improve connection to resources – employment • PRTF works with parents/discharge plan • Explore the role of Adult Protective Services • Create transportation options to services especially in frontier and rural communities. Housing and Homelessness • Create housing access rights and address barriers bias to housing "no eject, no reject" • Create a damage repair fund Information sharing and access to services • Work with 911, 988 and first responders to track and analyze data • Share discharge plans Justice Impacted • Improve LE access to complex care, no wrong door. Use the Johnson County Crisis Behavioral Health Team Proactive Response Plan and team model • Expand CIT funding to support complex care professionals, standardize training.

	• Create opportunities for pre-arrest and pre-plea diversion • Develop standards for jail medical to have trained staff and services to meet ICCoD needs: screening, responding, coordination with correctional staff to ensure safety and access to supports and accommodations • Develop proactive transition planning. Include jails in KDOC / MCO coordination.

Section A: ICCoD Fundamentals And Cross-Discipline Coordination

"Section A" of the ICCoD focuses on the State and County organizational structure of disability, mental health and substance services including policy, finance, and administration. It also includes data and information sharing, overarching cross-system coordination, and workforce development.

The ICCoD SIM incorporated discussions of Kansas disability, mental health and substance use organizational structure, policy, finance, and administration throughout the workshop.

Section A Resources

Organizational Level

- Kansas has 1915 (c) waivers for behavioral health support with services identified in the State Plan and overall coordination with an 1115 waiver. The renewal process for the 1115 waiver is currently underway. Committees within the State Legislature as well as the State Medicaid Agency (SMA) have stated Kansas will transition to a 'skinny' 1115 waiver that will operate alongside a 1915b/c concurrent managed care waiver. 1915c waivers will be managed under the 1915b waiver. This transition is planned to begin in 2024.

- The Developmental Disability Reform Act (DDRA) clarified definitions under Article 18 Developmental Disabilities Reform. 39-1803 https://kdads.ks.gov/docs/librariesprovider17/CSP/HCBS/I- DD/ddreformacttext.pdf?sfvrsn=0

- Medicaid Waivers are available through the Kansas State Plan; Community Development Disability Organizations (CDDOs) manage the service system at the local level. Following are Kansas Waivers active in 2021:
    - KS HCBS Autism Waiver (0476.R02.00)
      Provides respite care, family adjustment counseling, as well as parent support and training (peer-to-peer) for individuals with autism ages 0 – 5. This waiver has been available since 2008 and allows for state-planned clinical and habilitative services.
    - KS HCBS Brain Injury Waiver (4164.R06.00)
      Provides personal care, OT, PT, speech/language, financial management services, assistive services, behavior therapy, cognitive rehabilitation, enhanced care services, home-delivered meals, medication reminder services, personal emergency response system and installation, as well as transitional living skills for individuals with brain injury ages 0-64

- KS HCBS Frail Elderly Waiver (0303.R05.00)
  Provides financial management services, adult day care, assistive services, comprehensive support, enhanced care service, home telehealth, medication reminder service/installation, nursing evaluation visit, oral health services, personal care services, personal emergency response system and installation, as well as wellness monitoring for individuals aged 65 – no max age.
- KS HCBS I/DD Waiver (0224.R06.00)
  Provides day supports, overnight respite care, personal care service, residential supports, supported employment, financial management services, assistive services, enhanced care service, medical alert rental, specialized medical care, wellness monitoring for individual's w/autism, DD, IID ages 5 – no max age
- KS HCBS Physical Disability Waiver (0304.R05.00)
  Provides personal care services, financial management services, assistive services, enhanced care service, home-delivered meals services, medication reminder services, personal emergency response system and installation for individuals with physical disabilities ages 16-64.
- KS HCBS Serious Emotional Disturbance (SED) Waiver (0320.R04.00)
  Provides attendant care, independent living/skills building, short term respite care, parent support and training, professional resource family care, wraparound facilitation for individuals with SED ages 4-18
- KS HCBS Technology Assisted Waiver (4165.R06.00)
  Provides medical respite care, personal care services, financial management services, health maintenance monitoring, home modification, intermittent intensive medical care, specialized medical care for medically fragile and technology dependent individuals ages 0 – 21.

Source: "Kansas Waiver Factsheet." Medicaid. Accessed August 04, 2021. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/KS

- There are waitlists for I/DD and Physical Disability (PD) services.
- Certain facilities are tasked with brain injury rehabilitation for the brain injury waiver, (https://kdads.ks.gov/docs/librariesprovider17/ltss/hcbs/hcbs-policies/bi/e2019-154-brain-injury-eligibility-and-waitlist-management.pdf?sfvrsn=68ea05ee_4)
- The Applied Behavior Licensure Act allows funds for Applied Behavior Analysts (ABA). Behavior Analysis services are specific to autism services. There is an exception identified through the Medicaid waiver for individuals considered "autism specialists" who have completed training. They are also able to provide behavior analysis services without being Board Certified behavior analyst. Statute | Kansas State Legislature (kslegislature.org)

- In 2018, the Kansas Judicial Council reviewed the statutes governing competency to stand trial, specifically as they relate to defendants who are developmentally disabled

(DD), have a traumatic brain injury (TBI), or are otherwise deemed incompetent to stand trial and not likely to become competent, but who are not "mentally ill persons subject to involuntary commitment for care and treatment" under the Kansas Care and Treatment Act for Mentally Ill Persons ("Care and Treatment Act"), K.S.A. 59-2945 et seq.

During the Judicial Council's review and in subsequent testimony provided by state agencies to the Senate Judiciary Committee, it was estimated that the 'loophole' in Kansas' civil commitment statutes has resulted in 50 to 70 Kansans with DD or TBI court ordered to the State Hospital in Larned every year for 'competency restoration' for up to 180 days. During that time, if efforts at the hospital do not result in restoration of competency, under current law, the individuals can be ordered back to Larned for another 180 days. This process can cause an *indefinite incarceration* of Kansans with disabilities who are accused of a crime.

After Senate hearings were held in 2020, conferees were asked to determine what kind of services and programming would meet the needs of these individuals if the law were to change and they were no longer admitted to the State Hospital at Larned for 'competency restoration'. The conferees, including Kansas Department on Aging and Disability (KDADS), the Kansas Department of Corrections (DoC), as well as disability advocates and provider associations agreed that '*placing the defendant in a specialized, intensive community support and protection program with twenty-four-hour supervision, instruction, and support services as identified in the person's plan of care'* is a much better option for those who are caught in the civil commitment statute loophole in K.S.A. 59-2945 et seq.

- KanCare: Medicaid managed care.
  - Managed Care Organizations (MCOs) assess, approve, and coordinate medical, behavioral health and I/DD benefits for members. They also manage a statewide network of I/DD providers and manage the quality and qualifications of providers in their network. They offer choice options statewide for I/DD services.
  - The 27 Community Developmental Disability Organizations (CDDOs) manage the service system and provide some oversight at the local level. The CDDOs do not provide direct service but perform eligibility determination and provide options counseling.
  - Three MCOs are contracted to manage KanCare. https://www.kancare.ks.gov/providers/health-plan-information
    - Aetna, Sunflower, and United Health Care Community Plan
    - See "Network Adequacy Reporting" on the KanCare website: https://www.kancare.ks.gov/quality-measurement/network-adequacy

- State Institutions: there are very few private beds
  - Larned State Hospital serves the western two-thirds of the state and has the

capacity to serve over 450 individuals. It serves as the forensic competence restoration facility. The other state mental health institution is Osawatomie State Hospital.

- **Parsons State Hospital and Training Center** is one of two residential treatment, training, and care facilities to serve individuals with intellectual disabilities. According to the website, as of November 2018 there were 165 individual residents; of those approximately 90% were also dually diagnosed with a psychiatric impairment or behavioral disorder. **The Kansas Neurological Institute** located in Topeka is the other institution.
- **Parson State Hospital** does provide inpatient and outpatient care/treatment for individuals who have sexual offending history.
- Source https://kdads.ks.gov/state-hospitals-and-institutions

- Children who are on the autism waiver and exhaust the services/time limit do have the continuity of if eligible going directly on the I/DD waiver without the waitlist. A child in the autism waiver is eligible for 3 years plus one year extension (so 4 years once they are offered a spot). https://kancare.ks.gov/docs/default-source/kancare-ombudsman/volunteer- program/ongoing-education-modules/8-what-is-au-waiver.pdf?sfvrsn=e8084a1b_6

Cross-Agency Coordination

- Cross-agency I/DD coordination is occurring at the local level in Johnson County. In Johnson County the Crisis Intervention Team (CIT) program has an I/DD focused interest group who is helping to inform practices. As a result, CIT training includes I/DD, and officers and I/DD providers coordinate services as needed. Johnson County is happy to share their training, coordination model and materials.
- InterHab has a task group within their workforce regarding complex needs populations https://interhab.org/

Section A Gaps

Statewide related gaps from the Sedgwick ICCoD SIM are included in the following information:

Structural Level

Capacity of care provision and process to access care: Waivers

a) To be eligible for an Institutional Transition to an HCBS waiver, a person must meet the following criteria:
    - Must be a current resident in a qualified institutional setting
    - Must have been in a qualified institutional setting for a minimum of ninety (90) consecutive days for waivers that currently have a waiting list
    - Indicate an interest in moving back into the community through the "Nursing Facility Survey" or verbal communication to family/hospital/Managed Care Organization (MCO)/ Community Developmental Disabilities Organization (CDDO; cddo-map9acd5ea0172e66d690a7ff00009edf98.pdf (ks.gov)), or an Aging

and Disability Resource Center (ADRC; adrc-map-2018.pdf (ks.gov).

- Meet the HCBS waiver eligibility criteria for the FE, PD, BI or I/DD waivers
- Be financially eligible for Medicaid.

b) The state has defined "Institutional Setting" (excluding jail and prison) as the following:

- Nursing facility
- State hospital (KNI, Osawatomie, Larned and Parsons)
- Intermediate Care Facility (ICF-IID) as the institutional equivalent for ID/DD.*
- Traumatic Brain Injury Rehabilitation Facility (TBIRF) is the institutional equivalent for the Brain Injury Waiver. The state has defined these facilities. There is only one in Kansas and four in use out of state. All are privately operated.
- Psychiatric Residential Treatment Facility (PRTF).

*There are two state-operated intermediate care facilities (ICFs) which have a census of less than 400 total; currently there are fewer than 150 remaining private ICF beds.

Discussion at the Sedgwick County ICCoD SIM included questions as to whether a jail or prison is an "institutional setting." Jails/prisons are not considered institutional settings in the context of being able to discharge from these settings with funding access guaranteed. Individuals accessing I/DD program services from these settings must meet the "crisis" definition as articulated in State's I/DD Program Functional Eligibility Assessments and Waitlist Management policy.

- People receiving waivers lose coverage while incarcerated, but CDDO's have advocated for individuals who received services prior to arrest to be able to retain access to those services at release. Current KDADS/CDDO contract language allows for an individual detained in jail or prison for less than 12 months to have Medicaid reinstated without a new review. CDDO's are required to notify KDADS of the discharge/release within 5 days of exit to ensure the individual is able to access the "exception". The practice is currently in contract only and not through State policy.
- The cut off is 30 days of incarceration after which people lose all of the supports, waivers, case management, and other services which results in further traumatization and less resources.

c) Statewide, there is a waiting list of over 4600 and growing adults and children for I/DD HCBS services. Approximately 960 (21%) of the waiting list being Sedgwick County individuals. Those currently waiting have been on the list for nearly 10 years on average.

- Currently, children who are on the autism waiver and exhaust the services or allowed time (3 years plus one year extension once they are offered a slot) do have eligibility continuity allowing them to go directly on the I/DD waiver. However, others are not directly placed on the waitlist. The Autism Waiver is not currently a part of the I/DD Service System and is separately managed within KDADS.
- Aging and Disability Resource Center (ADRC) reported challenges regarding youth population access to waivers.
- For the Physical Disability (PD) waiver, individuals in an institutional setting are only

eligible to transfer directly to the PD waiver after a 90 day stay or longer in the institutional setting. For a crisis exception, anyone living in a residential facility such as an assisted living, Homeplus, etc. are typically NOT found eligible for a crisis exception for the PD waiver.

d) Currently, homelessness is not considered a condition for an *exception* to the HCBS I/DD Waiver waiting list; however, imminent risk of abuse, neglect, or exploitation could be therefore, it is important to consider how being homeless would lead to imminent risk. It was noted that the state does reserve capacity for individuals who have exhausted the service limits of a current waiver and for foster care and military.

e) Specific to the I/DD Waiver, KDADS policy and CDDO Contracts with the State allow for access to services for those determined to be in crisis and/or a member of a priority population:
   - Crisis/Imminent risk of crisis defined as persons whose needs can only be met through services available through the HCBS I/DD Waiver, require protection from confirmed/substantiated abuse, neglect, or exploitation or at imminent risk of serious harm to self or others. Homelessness is not necessarily a situation that would meet crisis criteria for access to I/DD waiver funding unless the case could be made that being homeless put someone at imminent risk of ANE.
     - Priority populations eligible for exception access to the I/DD Waiver include:
       - Transitioning from TA, Autism or Brain injury waiver and have been assessed eligible for the HCBS I/DD Waiver.
       - Transitioning from an institutional setting as noted previously.
     - It is unclear how the level of severity of intellectual disability (mid-tier group) or other complex needs impacts eligibility and access to services.

f) Clarification regarding where persons living with co-occurring mental health, I/DD and forensic involvement are treated is needed.
   - The screening process is different for the state hospitals, ICF-II/DD and PRTF.

g) Impact of Medicaid expansion was discussed the Sedgwick ICCoD SIM. Medicaid expansion would not necessarily expand services for individuals with I/DD, however, it was noted that Medicaid expansion would positively impact human service care delivery systems through increased health care access and coverage of the professionals who perform direct care work.
   - Targeted Case Management (TCM) is a Medicaid service. Medicaid expansion would benefit those on the I/DD Waiver waiting list as those who are waiting that may be eligible for Medicaid would then have access to TCM.
   - It was noted that there are a couple of Medicaid-Buy-In programs that can help with access.

h) Services and care delivery are siloed:
   - The mental health, substance use disorder and I/DD services and systems are separated

organizationally, in funding and access to services.

- Little cross-system coordination even though many clients have co-occurring needs as often apparent in the number of folks in the criminal legal system who are not able to access full services to meet their needs.
- Lack of coordination between provider systems, courts, and probation services.
- Persons with co-occurring needs, I/DD, SUD and MH, face many "wrong doors" due to lack, or unwillingness to coordinate services or, internally develop expertise to serve individuals through a person-centered care approach that embraces self-determination with a focus on strengths and capabilities and level of adaptive functioning.
- Lack of funding flexibility to serve individuals with complex needs and co-occurring services.
- Lack of services for individuals with co-occurring sensory deficits, hearing and visual impairments and co-occurring mental health, substance use and I/DD disabilities.

- Continued efforts are needed to integrate services at the State and local level. Key stakeholders include the Kansas Department for Aging and Disability Services (KDADS), the Behavioral Health Services, LTSS, and Certification and Credentialing commissions.
  - Need to improve coordination between Managed Care Organizations (MCO), Community Mental Health Centers (CMHC) and I/DD providers.

i) Individuals can be stuck in the process of restoring competence for trial, in facilities long-term.

j) The structure of Kansas waivers does not allow for a prospective payment system based on a diagnosis. Current waivers are set up to meet a threshold such as risk of institutionalization.

- The waiting list is a tremendous issue.
- Proactive, preventative services and support are a large gap.
  - Many individuals living with I/DD never meet the "crisis exception" but would greatly benefit from services.
  - Individuals who have met the "crisis exception" probably needed services before they met that threshold.

There is a waitlist for Permanent Supportive Housing and Dual Diagnosis Team (DDT) at Parson's State Hospital.

k) As previously noted, there is approximately a 10-year waitlist for Home and Community Based Services.

Cross-Agency Coordination and Access to Services

- Lack of an established oversight group at the provider, county, state, and impacted person level that is tasked and authorized to improve coordination, and the development of shared commitment to manage gaps and barriers.
  - Many individuals with I/DD will self-report that they only have a "learning disability" to other people. Opportunity to ask about "learning disability" and then to ask more

questions or as a cue to inquire further.

- Under Medicaid rules, states can target services to people who need LTSS through certain waivers. These waivers are called home- and community-based services (HCBS) 1915 waivers. The State Medicaid Agency is the Division of Health Care Finance at the Kansas Department of Health and Environment. HCBS program and most Mental Health services in Kansas are managed under the State Operating Agency, which is the Kansas Department on Aging and Disability Services (KDADS).
- For LTSS, the process for determining Eligibility and Service Development activities is found in each of the federally approved 1915c waivers. For Community Mental Health Services found in the Rehab section of the State Medicaid Plan, eligibility and service development is done according to Medicaid rules, state Mental Health Reform statutes, and state regulations.

- In Kansas, most Community Mental Health Services are found in the Rehabilitation Section of the Medicaid State Plan. Kansas also operates a children's mental health program as a 1915c waiver. Mental health and substance use disorder (SUD) services are overseen by KDADS' Commission on Behavioral Health Services.
- For the I/DD waiver in Kansas, all applicants for program services must be determined to meet the I/DD System Eligibility requirements as defined in the Developmental Disability Reform Act (DDRA) and undergo a functional eligibility assessment for the I/DD waiver. The DDP is utilized to determine the level of care (LOC) eligibility for the I/DD waiver. The CDDO conducts an assessment of the individual and performs Options Counseling according to state law found in K.S.A 39-1803 and KAR 30-60-1 et al. Options Counseling includes assisting I/DD wavier participants to choose a Targeted Case Manager (TCM), if eligible for Medicaid Title XIX.
  - The participant's TCM is responsible for and assisting the participant in his/her effort to meet with waiver providers to discuss how the provider can meet the participants' needs. In addition, the case manager is responsible for informing the participant of training opportunities that are available to assist the participant in becoming more active in his/her role in the planning process to the extent that he/she chooses.
  - The Support Plan is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions, and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them.
- There is a lack of coordination and collection and analysis of common data points to que up the gaps and needs at the affected individual level, provider level, and the county level to inform the state regarding limitations under current 1915 and 1115 waivers, and necessary amendments to waivers that would improve outcomes.

- The current state definition and eligibility of “Health Home” is limiting and problematic and not in the spirit of how the “Health Home” funding model can be used. There have been two attempts to implement Health Homes in Kansas and neither has been effective in meeting the needs of the I/DD population or to including providers in our service system to engage in productive and meaningful ways to enhance supports to this population.
- Noted that there are efforts to seek more collaboration with Kansas Department on Aging and Disability (KDADS)

- Applications for services are complex, often vary broadly in terms of requested documentation, and need to be streamlined to reduce the administrative burden on providers and participants.

Workforce Development

- Gap in workforce for ABA supervision. Wichita State University currently has a certificate program. This affects implementation of the State Plan and is specific to autism.
- Major gaps remain in the workforce and coverage to meet complex needs of individuals, especially those returning from the state hospital.
- No recommended training standards or training happening consistently across agencies even though training is available.
- Individuals who work in the justice system generally do not have specific I/DD related training. Noted in the Sedgwick ICCoD SIM that DSP Basic Certificate through WSU includes two badge courses: DSP Basic Part 1 and DSP Basic Part 2 could be appropriate. Noted that basic badges would be very good for jail personnel who are basically functioning in the role of a direct support professional.

Section B: Early Identification, Crisis Response, Interventions, Acute Care, And Resources

Section B focuses on cross cutting consideration at the population and person level. The focus is on eligibility, access and availability of services and interventions including co-occurring treatment, transitions, and housing.

Section B Resources

Identification, Intake and Services

- State statue, the Developmental Disability Reform Act (DDRA) and associated regulation (Article 64) the I/DD Waiver and KDADS Policies all direct the process for eligibility, functional assessment, and information/referral for individuals with I/DD in Kansas. The ADRCs utilize the FAI (Functional Assessment Instrument) for Physical Disability (PD) and Frail elderly (FE) waivers and use the Medicaid Functional Eligible Instrument (MFEI) This tool is specific to Kansas and is the state's adaptation to the InterRAI. KU has worked to adapt the InterRAI through a contract with KDADS to create a tool that can be used for all (or many) of the State's waivers. There is an assessment tool for brain injury waiver.
  - Financial eligibility is another step in the process for accessing the HCBS I/DD Waiver. Individuals must meet Medicaid Title XIX income thresholds. If the applicant is a minor child, the parent income is waived.
    - KDHE has a specific team with specialized knowledge that processes these applications for review.
  - Functional Assessment is used to determine Waiver eligibility. I/DD Program Services and Waiver eligibility are initiated by CDDOs but approved by KDADs.
    - Eligibility for I/DD system is outlined in the Developmental Disability Reform Act (DDRA) and is further defined by KDADS eligibility policy.
    - The Functional Assessment Score is converted to a "Tiered" Score of "zero - to- five" to sort population needs.
    - There is a "Tier 0" status for individuals that don't meet functional eligibility requirements.
    - Eligibility determination timeframes are based on CDDOs process, resulting in varied timeframes.
    - Some individuals will not be determined to be functionally eligible for the waiver which limits access to care. Access to services children aged 5 years and younger or Tier 0 adults cannot access HCBS waiver services. Additionally, services to those on the HCBS waiver waiting list have limited access to services/supports while they wait for waiver funding.
    - The state continues to work on implementation of the MFEI (adapted

InterRAI) for additional waiver populations including for I/DD waiver eligible. This may affect the current tier system.

- Currently the tier system drives reimbursement.

Section B Gaps

Perspectives Provided

- Children and adolescents with co-occurring mental health and educational need additional supports.
- Once an adult, if an individual has not already been receiving services there are almost no services available to enroll in.
- Society seems to exclude people with disabilities rather than include people with disabilities. If subject-matter about people with I/DDs was taught in schools, it would help people meet others with disabilities without preconceived notions.
- Being inclusive of people with I/DDs is not solely about behavior but understanding the ways people communicate.
- Healthcare and mental health providers should be familiar with the Americans with Disabilities Act (ADA).
- Participants commented that mental health and substance use disorder treatment providers do not feel individuals with co-occurring I/DD is their population to serve. Need a "no wrong door" approach.
- Sentiments were expressed that there is no urgency from I/DD providers to respond to someone in crisis.
- Need to bridge the gap between frontier, rural and urban resources.
- Kansas Legislature is currently developing recommendations for a community support waiver, with the goal of eliminating the I/DD waitlist.
- There is a lack of "ownership" of the issues and siloed response.
- Bias regarding race and ethnicity further compound the challenges and gaps.

Lack of services and continuity of care

- There are too many "wrong doors" for persons with I/DD. There is a culture that indicates a lack of agency responsibility to create services that respond to the whole person.
- Mental health, SUD and I/DD providers are not "comfortable" or confident in their ability to work with someone with complex, co-occurring needs.
- Individuals are treated "like a hot potato". Providers are reluctant to be responsive because they don't want to get "stuck" with someone resulting in unnecessary emergency department boarding and jail boarding. There is a lack of care options across the state and within Counties.
- Medicaid and waivers and billing processes are part of the challenge in providing care. Medicaid funds have defined benefits and structure – value-based funding.
    - Need to push for change to Medicaid 1115 Waiver so Medicaid funding and enrollment can begin earlier (other states have make such requests of CMS).

    - Need to support services that sustain care and retention in services.
    - KS is a Medicaid termination state. Need for suspension state.
    - There is a lack of formal process to reinstate Medicaid. Staff shortage is often used as the reason for the delay.
    - Most KS jails do not allow access to computers so individuals cannot initiate the enrollment or reinstatement process.
- There is a lack of training and access and readily available resources. There are misunderstandings and a need for training in different systems, roles, responsibilities. Need for training across systems when providing a direct response.
- Need for improved support of parents and care givers. Need for transparency of resources and education to parents about how to access resources and advocate for family members.
- Need to educate the community on services, disabilities, ADA, and how to support fellow community members and families. Increase understanding of how individuals are trying to communicate needs.
- Need for improved training for schools.
- Need for data analysis and information sharing between CCBHCs and CDDOs. There are waiting lists for services between CCBHCs and CDDOs.
- Need for increased peer supports across settings.
- Need for medical provider training to know more about I/DD and other disabilities.
- Tools such as Wellness Recovery Action Plans (Mental Wellness and PWI/DD) are not used but can be a positive way to ensure a person's voice is included throughout their daily routines and during crisis.
- The crisis exceptions found in Olmstead are not being utilized.
- Lack of stabilization services.
- "Quality Assurance" is written into contracts with KDAD, however not universally implemented.

<u>Cross-system Workforce Training and Service Gaps</u>

- Behavioral health (mental health and substance use disorder) providers need additional training to be equipped and comfortable working with co-occurring I/DD and behavioral health needs.
    - There are personal and systemic biases that exclude people with co-occurring I/DD and behavioral health (mental health and substance use disorder) needs from co-occurring behavioral health treatment services and supports.
    - Medicaid reimbursement limitations and regulations impose a significant barrier to mental health providers' willingness to provide services to the co-occurring population.
- Staff need cross-disciplinary and cross-system training before being able to serve populations with complex needs
- Mental health professionals repeatedly report that they are not trained, nor are they comfortable working with I/DD individuals.
- Cross-training is needed for Mental Health, I/DD, brain injury and Substance use

professionals. Filling that gap would provide a base level of service that will support them throughout their career.

- There are access gaps related to support and education. Once a person reaches adulthood it is difficult to retrain their mind. Kids fare the best when kept out of foster care or PRTF.
- The National Association for the Dually Diagnosed (NADD) provides training on assessing and treating individuals with co-occurring diagnosis. As previously noted, Sedgewick County has worked with Wichita State University and NADD to create training cross-training courses.

Section C: Crisis Systems (Intercepts 0-1)

Section C focuses on deflection strategies, crisis response and related services.

Resources

Perspectives Provided

- Once law enforcement is involved in a call, it is difficult to defer a person to other options.
- Some police departments are using CIT teams to be inclusive of I/DD specialists.
- I/DD waiver daily reimbursement rate is more than direct care (nursing) reimbursement rate; it is also more flexible than direct care reimbursement.
- Need focus on children and family wellbeing

988

- KDADS implemented 988 on July 16, 2022.
    - The line answers over 90% of calls and texts that originate in state.
    - They are in the process of developing the I/DD response.
    - KDADS is working with CCBHCs, and using the increased Federal Medical Assistance Percentage (F-MAP) reimbursement for Mobile Crisis reimbursements.
        - Across the state there is a need to identify 988 training needs in general and specific to I/DD. Training is/will be developed.

Crisis Response

- Crisis Intervention Team training for law enforcement is statewide although not all departments use the full model and only use the training.
- Crisis Intervention is a service in the state plan that is allowable and can be provided to any person. Access to individuals with I/DD is limited.
- Crisis Prevention Institute (CPI) Training is used as training by many providers delivering 'waivered' services. Crisis Prevention Institute (CPI Training)
    - Johnson County has worked to formalize CPI training throughout their provider system. The model is funded locally.
        - Partnerships have been developed between the Health Department, Johnson County CDDO, Emergency services, and corrections. There is an MOU with Johnson County Mental Health.
        - Using a true Crisis Intervention Team (CIT) response model to create a coordinated cross-system team response. Model includes I/DD training, I/DD trained professionals, and trained mental health clinicians, fire and police.
        - Proactive communication and coordination between officers and co-responders; fire is also involved. Currently serving 40 individuals; 20 people

are waitlisted. Clients' Behavioral Intervention Plans are tied in at various points to prevent crisis needs from escalating to emergency rooms or courts.
    - Everyone is relying on the initial plan that has been set up at the front end with modifications made as necessary.
- Olathe is providing training to I/DD providers on "how to work with law enforcement."

Services and Coordination

- KS Stepping Up TA Center is seen as a resource. KDADS supports Stepping Up implementation. The majority of Stepping UP work is with mental health issues.
- Legislation was passed to support statewide implementation of Certified Community Behavioral Health Centers (CCBHCs).
- Federal grant was received for opioid response and first responders. The focus was to support frontier and rural counties.
- Statewide CIT Council has I/DD representation.

GAPS

Crisis Response Gaps

- There is not a statewide crisis policy, program, or process.
- System is set up to push people into crisis services through Medicaid. People have to fail at lower levels of services. Providers are forced to deal with crisis when they could have dealt with less crisis earlier on.
- Need to develop common definition of crisis, emergency, long-term/ ongoing support, case management, transition, transition plan, etc.

Mobile Crisis and Co-Responder

- Partnerships between law enforcement and providers vary across the state.
- Lack of funding to replicate Johnson County crisis response model. Funding is needed to expand the model and serve the other 20 or more individuals on the waitlist.
    - Challenges include limited crisis options due to staff expertise, skills, and experience; settings are not always equipped to support individuals with complex needs.
- ICT1, is a mobile crisis response co-responder unit in Sedgwick County but lacks I/DD training and resources.
- Shawnee County law enforcement has a mobile crisis unit but needs more capacity and lacks coordination with service agencies. The county reported needing to change the how the use of jail was viewed, and that jail isn't the answer.
    - Need for access to services without criminal justice involvement. 57% of the jail population are living with mental illness; 100% of the women are living with mental illness.

- CPI is not integrated across the state. There is a lack of universal CPI training across providers. Staff working for some departments under Human Services are likely to have CPI training, but many staff have not received CPI or any crisis training.
    - Their needs to be a framework other than "emergency or crisis". Need for meaningful plans that stabilize and support individuals rather than short-term interventions.
- Reportedly, some staff find it easier to call law enforcement than to address client's communication processes proactively and patiently.
    - In some situations, a person may be trying to communicate needs, but due to display of emotion, physical movements may be interpreted as crisis behaviors warranting a response greater than the available staff can provide.
- Evidence that some I/DD professionals do not conduct post-acute crisis follow-up.
    - Crisis triggers go unaddressed in MCO service plans.
    - Behavior Support plan and the Person-Centered Support Plans are developed by the TCM and incorporated into the Person Centered Service Plan and Backup Plan by the MCO.
- Lack of statewide crisis response resources or protocols for the I/DD population.
    - There are no I/DD specific crisis response resources or training across systems and the state.
- Dearth of proactive policies, practices, and coordination with hospitals.
    - Even with CPI training, police are often called, individuals are generally taken to hospital emergency departments where they may be admitted but are most likely not admitted and returned home.
- Need for non-hospital stabilization response setting, staffing patterns, and better training to enable staff to assist clients.
    - Emergency departments are often the default response setting, but most do not have mental health specific training or resources specifically for supporting someone with co-occurring I/DD and behavioral health needs.
    - Most require law enforcement to stay with the individual, pulling the officer out of service for hours.
    - Law enforcement is the likely agency called to manage situations and transport individuals to a different setting.
    - Law enforcement, especially in rural communities, do not have the time or resources to transport and stay with individuals.
- Emergency Departments, crisis stabilization centers, CCBHC's and Federally Qualified Health Centers (FQHC) lack training on I/DD. There is a lack of cross-provider coordination and collaboration.
- Need for specialized workforce across the Intercepts.
- Lack of utilization of persons with living experience and supports they can provide.
- State statues often only cover or refer to mental health.
- The I/DD Waiver is limited. It doesn't sufficiently cover psych needs.

- Psych facilities do not have staff trained to provide services to individuals living with co-occurring and complex needs.

Crisis Centers

- Heavy reliance on law enforcement to manage "crisis." I/DD providers are not equipped to "keep people safe".
- Need for a continuum of services and levels of care and support: START or complex care response team, respite, short-term crisis, step-up and step-down care, true discharge planning and transitions to ongoing services.
- Without viable crisis options equipped with trained staff and resources, hospital emergency departments and jails are the default crisis response units.
- It is very difficult to get someone admitted to a state mental health hospital, especially for those with complex needs.
- There is a shortage of crisis centers across the state.
- Existing crisis centers are not trained or equipped to intervene with and support individuals with co-occurring behavioral health and I/DD needs.

Schools

- Schools can conduct early Individual Education Plans (IEP), however the process is not uniform.

Transition Age Youth (TAY)

- Resources are needed for 18 -25-year-old population.

Section D: Criminal Justice (Intercepts 2-5)

Section D focuses on the criminal justice system starting with jail, courts, case processing and community supervision and how criminal justice systems and community providers work together.

Resources

Perspectives Provided

- The cultural shift necessary to move away from viewing incarceration as the answer. We cannot continue to criminalize the mentally ill or perpetuate the cycle that requires defendants to plead guilty as a predecessor for treatment.
- System stakeholders need to be more familiar with the ADA.
- Time spent incarcerated can make people worse.

Resources

- Most large jails have release coordination.
- State corrections KDOC:
    - Discharge planning begins at intake, and resumed 120 days before release
    - SOAR application specialist on staff.
    - Benefit reinstatement at release for Medicaid and SSI.
    - Dedicated discharge planners and discharge planning for those with medical needs and for Level 5 Classification – serious mental illness (SMI).
    - KDOC is working to secure apartments and working with landlords.
- Alternative Sentencing, SB 123 SB 123 (ks.gov) provides for certified substance abuse treatment. Cognitive behavioral training is included and provided by 140 certified providers.
- MCOs are working with KDOC to coordinate with community-based organizations, and other providers.
    - Referrals are made to MCOs for I/DD/waivered individuals; and for those with SMI through a *unified referral system*.
    - There is an automatic trigger for the MCO to start reentry process and resources.
    - Possible value-added funds or money follows the person (MFP) opportunity. MFP grant begins rollout in December 2022.
- Several State level initiatives were mentioned:
    - Stepping Up
    - CIT Council
    - CCBHC roll out
    - 988 roll out
    - I/DD Modernization TF

    - Statewide Court Group. Recent statewide court-based mental health conference
    - Justice Involved Mental Health Council
- Courts
    - A statewide mental health court summit was held in 2021.
    - Courts are becoming more versed in the complex needs of those involved.

Gaps

Reimbursement and funding

- Dis-incentive to work across systems due to state reimbursement policy.
- There is a not a differential pay-rate for providing services to someone with complex needs.
- No difference in compensation for certified programs.
- Need for flexible funds. Funding is member specific which precludes a provider to maximize staff and resources.
- There is $3 million earmarked in State funding for behavioral health, primarily for substance use disorders and mental health, but it can be flexible. Support for peer services can also be included.

Cross-system coordination

- There is not a "collective impact" approach to addressing cross-system issues.
- Lack of focus on meeting individuals needs in their home community. Individuals are often sent to larger communities because of the lack of services in the community of origin. This puts an undue burden on the resources of the new community and creates gaps in natural supports for the individual.
    - Individuals are often sent to a place for services by un-informed judges and judicial systems. Need judicial training on resources, services, and expectations.
    - State needs to resource communities to provide more comprehensive services in more rural and frontier areas.
    - Need a greater focus on stabilizing individuals for longer periods of time. More intensity and duration of services and supports especially during transitions.
    - Lack of supports and infrastructure for systems providing ongoing care.
    - Rural communities do not have access to all the resources necessary to support individuals with complex needs.
    - Lack of supports for aging population.
- Transition and community-based support
    - Need for transition planning across the lifespan.
    - No reliable forensic release team or process.
    - Case management is based on programs resulting in a lack of continuous case management support.
- Training, common language and understanding
    - Gaps in community conversations between judges, correctional facilities, hospitals. Need for common language across systems and services.

    - Treatment providers, probation, parole, and other community providers all need training on how to support individuals who have come out of institutions.
- Duplication of services between hospital, residential and jail.
- SACK provides education on "sex health" however it is underutilized by justice system stakeholders. The current I/DD waiver does not cover sexual health/relationship education services such as screening, consultation, education about appropriate boundaries and other supports. Access to "Sex education" is provider specific.
- The roll of the I/DD system with probation and parole is unclear. Need for policy, training, and practices. Parole does have specialized supervision units.
    - Being successful on probation or parole requires executive function skills. There is a need for supports and accommodations to help individuals living with I/DD and brain injury to be successful.
    - Discussions across and within criminal justice stakeholders are not taking place regarding identification of clients' needs and related supports and accommodations.
    - There is a template for an "Individualized Justice Planning (IJP)", however, how much they are utilized is not clear. Individual Justice Planning — Disability Rights Center of Kansas (drckansas.org).
        - IJPs could be adopted for pre-plea diversion opportunities.

Correction Setting

- Individuals with complex needs are not proactively identified for jails, KDOC, Courts or Probation. Need to have flexibility and individualized approach across justice system stakeholders and systems.
- Detained/jailed individuals living with I/DD, brain injury or other disabilities may be placed/kept in "isolation".
- Identification of detained individuals' needs is not consistent. Apart from some larger jails, most jails, and jail medical staff do not have the staff or knowledge to conduct comprehensive assessments of complex needs.
    - Medical, custody staff, judicial offers, defense, prosecutors, probation, and parole need training on I/DD, ABI, disabilities, ADA. Olmstead; supports and accommodations.
    - Need for coordination between jail medical staff and defense attorneys or court regarding individuals with complex needs.
    - The Chief Justice requested a legislative audit of jail mental health services.
- When individuals are detained for longer periods of time, they may lose their services and support plan.
- There is a process to request a crisis exception, however the impacted individual or family members may not know how to advocate for an exception. (Nick – Im not sure what this refers to 'crisis exception through Olmstead')

Courts

- Unknown if any treatment courts accept individuals with co-occurring mental health, substance use and I/DD or ABI conditions.
- Training is needed for defense, prosecutors and judicial officers regarding I/DD, ABI and other

disabilities. Efforts need to include how to work with defendants, witnesses, and victims.

Competency

- Work is taking place regarding competency and to address process if someone cannot be restored. Unfortunately, that could include trying to sentence to I/DD State Hospital. There is an immediate need to train judges on I/DD and related services.
    - Community-based restoration is permitted, however, providers nor the process is tailored to work for individuals living with I/DD or ABI.
    - Competence evaluators may not have any training in disabilities.
    - Lack of policy regarding non-restorable due to disabilities. Many may languish in institutions. If found incompetent and released there are no policies on how to transition and support in community.
    - There is not a statewide forensic director.
    - Need to develop policies regarding competency and persons with complex needs.

Reentry

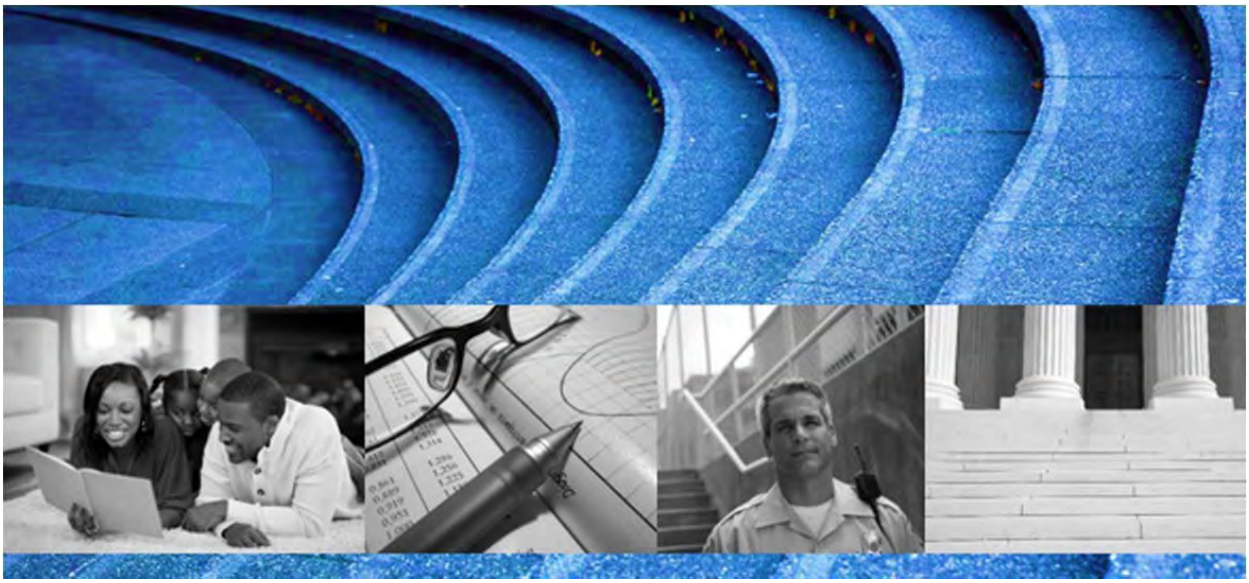
- Lack of uniform reentry from jails, including large jails and across levels of need. Mid and small jails do not have staff or time to coordinate release or provide release planning.
- No standardized comprehensive needs assessment.

KDOC

- KDOC medical and mental health transition planning is only available for highest needs and Level 5 classification meaning many with mental health, brain injury, and other needs are not released with services, supports and resources.
    - MCO has to be assigned first before engagement with providers can begin. Funding, (3160)
    - Release data is needed sooner than 60 days to put resources into place.
    - SUNFLOWER reported they are willing to look at the release process.
- KDOC needs to have the “right person” to provide coordination between DOC and I/DD at the state and local level.

Data

- There is no cross-system data being tracked and analyzed even though there is existing KDOC and MCOs unified reentry data that could be used to understand benefits of coordinated reentry, and trajectory of individuals who end up in prison including demographic information, community settings, access to services over a life span.
- Lack data analysis regarding competency (currently around 160 individuals) with Sunflower, other MCOs, KDADS database.
- Need for person-centered historical data review to understand decision points, access to services, service match to needs and justice involvement.



PRIORITIES FOR CHANGE

The priorities for change were determined by SIM Mapping Workshop participants. SIM Mapping Workshop participants were asked to identify a set of priorities followed by a vote to identify top priorities for change for strategic action planning.

<u>Seven themes seemed to rise from the discussion across the ICCoD:</u>

1) Continuum of care and level of response: level of independence, choice, assessments, ensure emergency staffing

2) Staff and supports: peer, advocates, and training

3) Policy: targeted case manager and funding, targeted behavioral plan with probation and parole, voice of person with lived experience, state level navigation team, increase wages and training requirements

4) Financial: level of compensation (differential support, needs population, special skills, direct service professionals), different funding mechanism needed for training and staff, eligibility for access to services

5) Cross-system: common language, collaborative work and collaborations, collective impact approach, persons with less voice

6) Leadership: bring in education and medical leaders

7) Data and information sharing

Identification of priorities largely followed the seven themes identified above. A total of 24 priority areas were identified presented here in rank order by the number of votes:

Rank	# Votes	Priority (Rank T = tie votes)
1.	23	Expand mobile behavioral intervention te4ams and follow-up with targeted case managers equipped for broad responses (family, staffed homes, etc.)
2.	19	Expand cross-training – family, DSPs, healthcare, crisis line/988, first responders, payors, corrections, municipal, state, and juvenile courts. Include training on alternative communication.
3.	16	Improve timely access to care including crisis beds not excluded for people with I/DD
4.	14	Build a statewide leadership team for MH/I/DD
5. T	11	Workforce development (cultivation, Recruitment, etc.)
5. T	11	Expand funding options to expand access to BCBA and expand staffing for BCBAs
6.	10	Track, measure success! Use claims, and other data crosswalk for state and county levels (such as DOC data). Outcomes assessments and improvements and develop prevention strategies (e.g., prevention of criminal justice involvement)
7. T	9	Develop policies /practices to include people with all levels of experience and communication styles.
7. T	9	Timely information sharing with EMS, law enforcement, etc., for better responses and bi-directional information sharing
8.	7	Ensure crisis Olmstead exceptions applied fairly and similarly across regions/communities
9.	6	Develop process improvement with experts such as criminal justice coordinators, boundary spanners, etc., including training needs
10.	5	Create culture shift for bringing services together and reducing barrios and siloes
11. T	3	Develop diversion and alternative opportunities across Intercepts. Create training for court related stakeholders: judges, prosecutors and defense attorneys
11. T	3	Add MH staffing to I/DD services
11. T	3	Expand/modify funding structures for DSPS – maximize their aces to benefits
12. T	2	Consider a medical home for people with I/DD/MI across the lifespan
12. T	2	Identify more safe settings to provide people with breaks (without institutionalizing people)
12. T	2	Provide/develop emergency staffing pools

12. T	2	Lift up rights and protections and self-direction across systems
12. T	2	Expand prevention with more partners (education/medical/etc.)
13. T	1	Pay increases for services and expand billing mechanisms for blended and braided funding
13. T	1	Expand vocation options and supports
14. T	0	Develop a dedicated county leader to loot at data (DEI, etc.) and drive change
14. T	0	Create systems where there can be dually trained staff and find ways to dual fund when needed for two staff

For the benefit of tracking the work taking place in Kansas regarding I/DD, Sedgwick ICCoD SIM Priorities were as a follow:

1. Enhancing screening for ICCoD to promote early identification.
2. Enhancing tools used to determine waiver eligibility. Also, increasing uniformity statewide as some counties have smaller networks and capacity issues when determining waiver eligibility.
3. Expanding ICCoD direct care/service workforce. Also, providing additional specialized/cross-training and increasing National Association for Dually Diagnosed Clinical Certifications.
4. Decreasing wait times for accessing ICCoD home and community-based services. Revisiting home and community-based setting regulations and identifying barriers to accessing services.
5. Expanding access to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and Brain Injury Rehab Facilities (BIRF).
6. More inclusive education systems for individuals with ICCoD. Development of training and skill building programs. Access to sex education/sexuality services.
7. Access to services for justice-involved youth with ICCoD and required documentation.
8. Establishment of multi-agency cross-system group to focus on ICCoD, behavioral health, and criminal justice issues. Convene meetings with Managed Care Organizations, Community Mental Health Centers, and ICCoD providers.
9. Increase collaboration with Kansas Department on Aging and Disability (KDADS). Also, integration of KDADS' Behavioral Health Services and Home and Community Based Services commissions.
10. Improving civil commitment laws (in progress?).
11. Ensuring individuals are released from facilities/custody to designated guardians when appropriate.
12. Individuals who are involved in the competency evaluation/restoration process can remain

in facilities for long periods of time.

13. People in Crisis turn to the CDDO for support, but CDDO is not a provider of service- Need for a gap program to meet this need.
14. Need for work with state hospitals around admission criteria inclusion and exclusion factors to gain a shared understanding.
15. Developing data sharing to track individuals and share information needed. Develop information sharing pathway so no wrong door and any part of the system knows who to call.
16. Access to housing and assistance with maintaining housing. Housing supports for children in IEP system in crisis and across systems when respite and in-home services are inadequate (limited availability of PRTF if the youth does not meet the criteria for those services).
17. Expand ABA network of providers for youth with ASD. Currently available as an EPSDT benefit.
18. Expand START or confer with ACT team like interventions that could be appropriate for ICCoD populations.
19. Family engagement and support services.

Priority Area 1: Expand mobile behavioral intervention team and follow up equipped for broad responses (incorporating family, staffed homes, etc.)				
Objective		Action Steps	Who	When
1.	Identify effective model to replicate that includes rural responses	Research states to model	Nick Wood Shinta Gray	January 2023
2.	Determine provider criteria	Establish review team to identify standards and definition Draft criteria	KDADS	January 2023 January 2023
3.	Capacity Analysis	Crisis Now Regional look Hospital utilization data to obtain baseline for diversion	Andy Brown Monika Keez KDHE- Monica	March 2023 March 2023
4.	Early intervention, referrals, and offsite support	Research partnerships and collaborations Facilitate conversations between partners to choose a CIE	Ali Wilbert Stephanie Luther	Start January 2023
5.	Training for direct service providers	Research training options Facilitate training Develop T4T	KDADS Nick Woods	March 2023 Begin Spring 2023

Priority Area 2: Expand cross-training				
Objective		Action Steps	Who	When

1.	Elevate voices of people with Lived Experiences
	• Build rapport and trust
	• Diversity
		• Have people with lived experience teach applied training
		• Identify training needs
		  o Knowledge sharing
		• Disability 101
		  o History- Rights
		  o Responsibility (series)
		• Utilize leadership
		• Accessibility for those training and being trained
		• Plain language
		• Training development
		  o Include direct support staff
		• Consider existing models
		• Trainers model values to audience
		• Look at IEP data
		  o Opportunities to address
			Stephanie (SACK) will contact Jamie Wong to identify those with lived experiences who are willing to participate in cross training with adequate compensation	by November 18, 2022

2.	Identify what existing I/DD training is available and taking place across the state	Identify stakeholders • Courts • DCF • MCO's • CMHC's • SIL • Self-Advocacy	Team will divide the state	

		• KCAL • Education • Families • Foster Care • TX		
3.	SACK will look at existing training and determine their accessibility.	Identify existing training • Who is it for? • What does it teach? • Accessibility?	Team will divide the state	
4.	SACK will also review developed trainings on I/DD	Identify gaps in training • Transition from school to "adulting" • Education system knowing about services for I/DD early on o Waitlist can happen earlier • Education expectations of I/DD students	SACK	
5.		Present to Leaders • Cross train committee		

Priority Area 3: Improve timely access to care Participants: Jonathan Pendergrass, Sherry Arbuckle, Nan Perrin, Jamie Yannacito, Peggy Shear Martin, Jason Hinkle				
Objective		Action Steps	Who	When
1.	Crisis response and diversion through the creation of Crisis Stabilization Centers A) Goal to interrupt before crisis • KDADS to bring "no wrong door discussion to peer respite - Jamie Wallen • Ensure CCBHC case management available and timely for members with co-occurring DD - Drew Adkins	Sec. convene stakeholders (ADV, CMHC, CDDO) to operationalize req. for funding Blend hospital, state, county, and federal funds to fund 2017 legislation (Crisis Intervention Act) State - finalize policies for implementation to ensure inclusive of I/DD population Reporting and accountability Look at other state models (AZ, TX) KDADS encourage DDO/ CMHC/ CCBHC alignment Connect to ongoing IC health navigation	Andy Brown Laura Blake	
2.	24/7 therapeutic services that accept everyone ("no wrong door")			
3.	Connect to ongoing supports and ensure family/ res provider have supports in place			

4.	Precursor/ Interrupt before crisis	KDADs to Bring no wrong door discussion to peer respite home Ensure CCBHC case management available in a timely way for members with co-occurring developmental disorders	KDADS Jamie Wallen Drew Adkins	

Priority Area 4: Build a statewide leadership team for the MH/I/DD population				
Objective		Action Steps	Who	When
1.	To accomplish 23 goals starting with the first 6 weighted by votes cast during the November 2022 SIM			
2.	Composition of team with recc. to Secretary once PRA report received			
3.	Statewide leadership team determine resources needed to accomplish goals			

Priority Area 5: Workforce Development				
Objective		Action Steps	Who	When
1.	Training	Badge program Career Ladder Education incentives Lived experience	Kris Macy Ian Kuenzi Robert McKeiman Megan Shepard	
2.	Recruitment	Streamline hiring process Ableist policies		
3.	Increase Pay due to cost of living	Provide salaries		
4.	Benefits	Person on waiver, MCO Pay for insurance		
5.	Incentivize work	Childcare Transportation Housing		
6.	Untapped workforce	Previous incarceration		
7.	H.S. and University programs	Internships Certifications Personalized training		
8.	Oversight for accountability			
9.	Immigration status changes			
10.	Collaboration	Incentivizing improvement Policies, RFP's Increase employer incentives Recognition		
11.		Review licensing standards	KDADs MCO's	

		Review and revise “the floor” Mitigate the conflict of interest (perceived profit) RFP Non-profit MCO Incentivize credentials w/m RFP’s Partnerships with orgs with successful workforce growth	Advocates	

Priority Area 6: Use claims and other data to measure outcomes assessments and improvements, develop prevention strategies, and track success				
Objective		Action Steps	Who	When
1.	Develop SIM plan for Kansas KDHE, KDAPS, KDOC (leadership)	Executive leadership meeting between KDADS/ DCF/ KDHE/ KDOC/ OJA (Office of Judicial Admin)		
2.	Require CDO's to DCF collect data on those in criminal justice system	KDHE/ KDADs look at incarceration rates for HBCS I/DD recipients		
3.	Identify who can collect the data and take point	Data sharing agreements across state agencies		
4.	Funding / Budget allocation	Meta analysis/ RFP (KDADS)		

Team:
Sean Swindler, Marie McNeal, Shelly May, Erica Peres, Seth Kilber, Madison Elliot

Other Notes
- Meta analysis of all state data across multiple agencies and systems
- Data analysis / science
- Interagency agreements/ MOU/ Privacy concerns
- Governor Executive Order
- Retro review of past data
- Require CDDOs to share/ trade with corrections
- How many people on I/DD waiver have interacted with Corrections system within the last year through law enforcement involvement, incarceration, or probation

RECOMMENDATIONS

1) Require competence evaluators to be dually credentialed or specifically trained in I/DD, ABI in addition to mental health and substance use disorder; or involve a psychiatrist review for complex cases.
2) Offer regular training opportunities for evaluations of individuals with IDD/CoD/ABI
3) Identify basic screening questions so that individuals coming into institutions (mental health and carceral) know to identify individuals who have received IDD/ABI services and waivers or may need to be screened for eligibility for these services
4) Create a standardized discharge and transition planning process from state institutions, local hospitals, prison, and where possible, jails.
    - Use of a standardized, comprehensive needs identification and transition checklist.
    - Develop proactive, seamless. and coordinated "bridge" resources for individuals between hospitals, jail or prison that includes benefit and benefit enrollment, housing, treatment, case management and other supports.
    - Track data regarding gaps, wait times, current setting, types of supports needed, etc. Provide data to the state (KDADs) for planning purposes and to build flexibility to current policies or innovate and demonstrate new ways to do business.
    - Improve coordination between I/DD, ABI, and Mental health system.
5) Increase workforce confidence to support, treat, and care for individuals living with complex and co-occurring needs through training, training standards and outcome measures across behavioral health, disability, and criminal justice workforce.
6) Create a funding mechanism to allow for I/DD, ABI, mental health and substance use disorder treatment professionals and peers to co-support and co-treat individuals living with co-occurring behavioral health needs and support their habilitative needs.

7) Create and coordinate data tracking and analysis across-systems through agreed upon common fields to identify individuals across settings and collectively demonstrate provider and client needs, type, and level of supports, wait times to access to services and supports; types of supports needed, etc., to use for local planning and inform the state of local needs so they can address state budget and legislative priorities.
    - Specifically track use of state hospitals, emergency departments, homeless shelters, and jail by needs and benefits including unnecessary "boarding" issues and length of stay for individuals with complex needs.
    - Develop and apply cost metrics to data.
8) Work with a cross-sector group of state administrators, local providers and coordinating entities to review and update laws and policy for definitions especially relating to institutions, jail, prison, eligibility, crisis, homelessness or imminent risk of abuse, neglect or exploitation, and exceptions for ICCoD. Consider if the level of severity of I/DD, ABI or Mental Illness or co- occurring disorders is a factor.
9) Consider expanding capacity to meet the needs of individuals with complex needs including creating a multi-agency and multi-disciplinary team to help problem solve and identify proper resources for individuals
    - Develop a funding mechanism to support complex case CIT teams such as the ones serving Johnson County.

ICCoD Resources

ICCoD Resources: I/DD and General Disability

Agencies:

- Aging and Disability Resource Centers, Administration for Community Living: https://acl.gov/programs
- Alzheimer National: https://www.alz.org
- American Association on Intellectual and Developmental Disabilities (AAI/DD), https://www.aaI/DD.org
- Diagnostic Adaptive Behavioral Scale (DABS); https://www.aaI/DD.org/publications/bookstore-home/product-listing/diagnostic-adaptive-behavior-scale-(dabs)-user's-manual-and-25-interview-forms
- The ARC, National Center on Criminal Justice and Disability.

  http://www.thearc.org/NCCJD

  PATHWAYS to Justice https://thearc.org/resource/pathways-to-justice-get-the-facts-interacting-with-your-states-protection-and-advocacy-organization-pa/

  State and local Chapters of The ARC https://thearc.org/find-a-chapter/

  People with Intellectual disabilities in the Criminal Justice Systems:

  Victims and Suspects, https://thearc.org/wp-content/uploads/forchapters/Criminal%20Justice%20System.pdf
- National Association for Dual Diagnosis (NADD): www.thenadd.org
- National Association of State Directors of Developmental Disabilities Services (NASDDDS) www.nasdds.org
- National Association of State Mental Health Program Directors (NASMHPD) www.nasmhpd.org
- Protection and Advocacy Organizations https://www.ndrn.org/about/ndrn-member-agencies/
- State Departments and Agencies for Developmental Disabilities

Housing Resources

- Housing Equity Framework: https://housingequityframework.org/webinars#webinar1
- Urban Institute's ERA Prioritization Tool : https://www.urban.org/features/where-prioritize- emergency-rental-assistance-keep-renters-their-homes
- Available Homeless Funding Sources: https://endhomelessness.org/wp- content/uploads/2021/06/06-24-2021 Advancing-Equity-and-Impact-.pdf
- Targeting Emergency Rental Assistance: https://endhomelessness.org/wp-content/uploads/2021/02/7-16-21 UpdatedTargetingEmergencyRentalAssistance.pdf

Articles, Journals and Presentations

- Bertelli, M.O., Rossi, M., Varrucciu, N., Bianco, A., Scuticchio, D., Del Furia, C., Buono, S. and Tanzarella, M. (2016), "Relationship between psychiatric disorders and adaptive functioning in adults with intellectual disabilities",

  Advances in Mental Health and Intellectual Disabilities, Vol. 10 No. 1, pp. 92-101. https://doi.org/10.1108/AMHID-08- 2015-0038
- Bhatt, Nita V, Gentile, Julie P. Co-occurring intellectual disability and substance use disorders[J]. AIMS Public Health, 2021, 8(3): 479-484. doi: 10.3934/publichealth.2021037
- Chapman SL, Wu L (2012) Substance abuse among individuals with intellectual disabilities. Res Dev Disabil 33: 1147–1156
- Center for Medicare and Medicaid Services, Glossary of health coverage and medical terms, OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146, https://www.cms.gov/cciio/resources/files/downloads/uniform-glossary-final.pdf.
- CSG and The ARC, Diverting people with I/DD from the criminal justice system, PowerPoint (10/29/2020). For more information please contact DEIRDRA ASSEY at DASSEY@CSG.ORG
- Hinton, Jill, Blanco, Roberto, Mental Health Diagnosis in I/DD: Bio-psycho-social Approach; https://www.aucd.org/docs/webinars/Mental%20Health%20Diagnosis%20in%20I/DD%20-%20AUCD.pdf,
- Journal of Mental Health Research in Intellectual Disabilities https://www.tandfonline.com/toc/umid20/current
- Pinals, Debra, Hovermale, Lisa, Mauch, Danna, Anacker, Lisa (2017). The vital role of specialized approaches: Persons with intellectual and developmental disabilities in the mental health system, NASMHPD, Assessment #3

- Substance Abuse and Mental Health Services Administration (2019), Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities. https://www.ncbi.nlm.nih.gov/books/NBK64881.
- Supporting Individuals with Co-Occurring Mental Health Support Needs and Intellectual/Developmental Disabilities: Themes, Trends, and a Synthesis of Promising Activities, 2018. Roundtable, NASDDDS, NADD, and NASMHP. https://www.nasmhpd.org/content/findings-joint-nasmhpdnaddnasddds-roundtables-supporting-individuals-co-occurring-mental-0
- Resource modules on health of people with intellectual disabilities: https://I/DDhealthtraining.org/module-2/scenario-1/resources/online-training/

Environmental Build, HMIS and Biopsychosocial Approach

- 7 Principles of Universal Design https://dac.berkeley.edu/committees/ccrab-home/universal-design-principles
- Empathy in Architecture: Using Trauma-informed Design to Promote Healing. https://e4harchitecture.com/empathy-in-architecture-using-trauma-informed-design-to-promote-healing/
- Using Trauma-informed design buildings to become tools for recovery, Colorado Trust https://www.coloradotrust.org/content/story/using-trauma-informed-design-buildings-become-tools-recovery
- Census 6 Questions: https://www.census.gov/topics/health/disability/guidance/data-collection-acs.html
- HUD HMIS Data Dictionary, https://files.hudexchange.info/resources/documents/FY-2022-HMIS-Data-Dictionary.pdf
- VISPDAT https://cchealth.org/h3/coc/pdf/2014-0521-packet-2.pdf
- Biopsychosocial Approach*: NADD: http://thenadd.org/I/DD-mi-diagnosis*

TRAUMA, VICTIMS AND CRIMINAL JUSTICE

Victims: Sight and Hearing Impaired and Accommodations

- Anti-Ableist Glossary of Disability Terms, Sara Acevedo, The National Resource Center for Reaching Victims, https://reachingvictims.org/wp-content/uploads/2020/07/Anti-Ableist-Glossary-of-Disability-Terms.pdf
- National Child Traumatic Stress Network, Children with intellectual and developmental disabilities who have experienced trauma, https://www.nctsn.org/resources/tailoring-trauma-focused-cognitive-behavior-therapy-for-children-with-I/DD
- Talent, Brian, Adapting trauma focused CBT for individuals with intellectual and developmental disabilities, 2016, http://reachacrossla.org/wp-content/uploads/2016/09/Adapted-Trauma-Treatment-for-Individuals-With-I/DD-1.pdf
- Vera Institute of Justice, May 7, 2020 https://reachingvictims.org/resource/just-ask/

National Resource Center for Reaching Victims (NRC and Vera:
Deaf/Hard of Hearing (HoH), https://reachingvictims.org/
Limited English Proficiency Palm Cards
https://reachingvictims.org/resource/language-access-tip-sheets-and- palm-cards/

- Victim hearing and sight impaired resource; Vera Institute of Justice, May 7, 2020 https://reachingvictims.org/resource/just-ask/

Criminal Justice

- BJA Police Mental Health Collaboration Toolkit: https://bja.ojp.gov/program/pmhc
- Bronson J. & Maruschak L., Disabilities among Prison and Jail Inmates, 2011–12, U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics Special Report, RTI International (December 2015). https://bjs.ojp.gov/content/pub/pdf/dpji1112.pdf
- Criminal Justice System: Joint Position Statement of AAI/DD and The Arc, https://aaI/DD.org/news-policy/policy/position statements/criminal- justice#.WWBcrYjyuUk.
- Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act https://www.ada.gov/cjta.html
- IACP's Policy on I/DD: https://www.theiacp.org/resources/policy-center- resource/intellectual-and-developmental-disabilities
- Individuals with intellectual and developmental disabilities who become involved in the criminal justice system: A guide for attorneys (2014). The Criminal Justice Advocacy Program, The ARC of New Jersey. https://frdat.niagara.edu/assets/THE- FINAL-ATTORNEY-GUIDE-1.pdf
- Criminal and juvenile justice best practice guide for state brain injury programs, (2020), NASHIA, https://www.nashia.org/cj-best-practice-guide-attachments-resources-copy,https://www.nashia.org/resources-list/ultvlaoicnk14l0k1f0prgqvhlt04f-8wllr
- People with Intellectual Disabilities in the Criminal Justice Systems: Victims and Suspects, Leigh Ann Davis, The Arc, https://thearc.org/wp-content/uploads/forchapters/Criminal%20Justice%20System.pdf
- The ARC Pathways to Justice: https://thearc.org/our-initiatives/criminal-justice/pathway-justice/

BRAIN INJURY

CDC TBI resource for incarcerated persons

- https://www.cdc.gov/traumaticbraininjury/pdf/Prisoner_TBI_Prof-a.pdf

MINDSOURCE

- developed the Achieving Healing through Education, Awareness, and Determination (AHEAD) psychoeducational group facilitator guide: https://mindsourcecolorado.org/ahead/

Model Systems Knowledge Transition Center (MSKTC)

- https://msktc.org/tbi/model-system-centers

National Association of State Head Injury Administrators (NASHIA)

- https://www.nashia.org/
- https://www.nashia.org/resources-list?category=Criminal%20and%20Juvenile%20Justice
- webinar training that relates to criminal justice: https://www.resourcefacilitationrtc.com/webcast-seminar-information
- Drew Nagele, Monica Vaccaro, MJ Schmidt & Daniel Keating (2019): Brain injury in an offender population: Implications for reentry and community transition, Journal of Offender Rehabilitation, DOI: 10.1080/10509674.2018.1549178 To link to this article: https://doi.org/10.1080/10509674.2018.1549178

PA Brain Injury Wallet Card:

- https://www.health.pa.gov/topics/Documents/Programs/Brain%20Injury%20Wallet%20Card.%20v%204.pdf.

TBIMS National Data and Statistical Center https://www.tbindsc.org/

- TBIMS Annual Presentation: Traumatic Brain Injury Model Systems National Data and Statistical Center, 2020 Traumatic Brain Injury Model Systems Annual Presentation, DOI 10.17605/OSF.IO/A4XZB [PDF File]. Retrieved from https://www.tbindsc.org; https://www.tbindsc.org/StaticFiles/Documents/2021%20TBIMS%20Slide%20Presentation.pdf

TBI Screening Tools

- OSU TBI-ID https://wexnermedical.osu.edu/neurological-institute/departments-and-centers/research-centers/ohio-valley-center-for-brain-injury-prevention-and-rehabilitation/osu-tbi-id
- BISQ https://icahn.mssm.edu/research/brain-injury/resources/screening
- HELPS https://abitoolkit.ca/assets/images/HELPS-tool.pdf
- Brain Check Survey – BCS https://www.chhs.colostate.edu/ot/research/life-outcomes-after-brain-injury-research-program/

Training Institute on Strangulation Prevention

https://www.strangulationtraininginstitute.com/health-issues-result-from-strangulation/

Competency and Training

Competency

- The ARC and NCCJD
    - https://thearc.org/resource/competency-of-individuals-with-intellectual-and-developmental-disabilities-in-the-criminal-justice-system-a-call-to-action-for-the-criminal-justice-community-2/
    - http://thearc.org/wp-content/uploads/2019/07/16-089-NCCJD-Competency-White-Paper-v5.pdf
- Pinals D.A., Where Two Roads Meet: Competence to Stand Trial Restoration from a Clinical Perspective, *New England Journal of Civil and Criminal Confinement* 31, pp. 81-108 (2005).
- Linhorst DM, Loux TM, Dirks-Linhorst PA, Riley SE. Characteristics and Outcomes of People With Intellectual and Developmental Disabilities Participating in a Mental Health Court. Am J Intellect Dev Disabil. 2018 Jul;123(4):359-370. doi: 10.1352/1944-7558-123.4.359. PMID: 29949424.
- Linhorst, D.M, Dirks-Linhorst, P.A., & Sy, J. (2018). Criminal Justice responses to offenders with intellectual and developmental disabilities. In W.R. Lindsay & J.L. Tylor (Eds.), The Wiley handbook on offenders with intellectual and developmental disabilities: Research , training and practice (pp86-104). Wiley-Blackwell. https://doi.org/10.1002/9781118752982.ch5

Training

- Association of University Centers on Disabilities (AUCD), *About LEND* (2011), https://www.aucd.org/template/page.cfm?id=473.
- Board-Certified Behavior Analysis, https://bacb.com/bcba/.
- Center for START Services: https://centerforstartservices.org/START-Training
- Direct Support Professional Framework; Sedgwick, KS, University of Wichita
- NADD: http://thenadd.org/products/accreditation-and-certification-programs/.
- National Alliance for Direct Support Professionals https://nadsp.org/resources/the-nadsp-competency-areas/
- University Centers for Excellence in Developmental Disabilities (UCEDDs), interdisciplinary training. Developmental Disabilities Assistance and Bill of Rights Act of 2000 https://www.aucd.org/template/admin_resource_list.cfm
- Center for START Services: https://centerforstartservices.org/START-Training

Direct Support Professional Framework; Sedgwick, KS, University of Wichita

FINANCINGCONSIDERATIONS

CMS – Medicaid

- Home and community-based services under § 1915(c) Medicaid waiver and the § 1915(i) state plan option (which allows wide array of community-based treatments and residential supports).
- How and When Medicaid Covers People Under Correctional Supervision, https://www.pewtrusts.org/-/media/assets/2016/08/how_and_when_medicaid_covers_people_under_correctional_supervision.pdf
- Self-directed person care through § 1915(j) state plan services or the § 1915(k) Community First Choice personal care option can support people who live in their homes – but provisions do not automatically incorporate access to acute psychiatric care benefits.
- LTSS in context of developing accountable care organizations (ACO) § 1115 Medicaid waivers with provisions for ACOs and LTTS management
- Money Follows the Person (MFP) and Balancing Incentive Payment (BIP) programs which, while providing increased Federal financing for home and community-based services do not align with psychiatric care benefits.

Affordable Care Act

- Coordination and integration of care for populations with complex needs.
- Health Homes are an optional state plan service designed to improve care coordination across primary, acute, behavioral health, and long-term services and supports for individuals with two or more chronic conditions.

Social Security Act

- § 1903(m) of the Social Security Act – need strong state oversight of MCO - many going to ACO and LTTS provider networks; others ACO and Behavioral Health provider networks … impact on integration of care for co-occurring conditions.

LEGISLATION

- A Guide to Disability Rights Laws, U.S. Department of Justice, Civil Rights Division, Disability Rights Section (July 2009), https://www.ada.gov/cguide.htm#anchor63409
- ABLE Act – created tax advantaged savings accounts for individuals with disabilities which are exempt form means-testing in federal programs
- Americans with Disabilities Act (ADA), (1990) 42 U.S.C. § 12132, to ensure that people with disabilities can access care without being institutionalized. https://www.justice.gov/crt/rights-persons-disabilities
- Title II of ADA government requires agencies make all services available to people with disabilities. Includes providing and paying for auxiliary aids and services. Making reasonable modifications to policies, procedures, and practices.
- Article 12, United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2006), http://www.un.org.proxy.lib.umich.edu/disabilities/convention/conventionfull.shtml.

- Civil Rights Act and Executive Order 13166, Section 504 of the Rehabilitation Act
- Title VI of the 1964 Civil Rights Act and Executive Order 13166, Section 504 of the Rehabilitation Act, and The Americans with Disabilities Act (ADA) – language access must be timely, accurate and effective
- Developmental Disabilities Assistance and Bill of Rights Act, (2000) creation of University Centers for Excellence in Developmental Disabilities (UCEDDs) https://acl.gov/sites/default/files/about-acl/2016-12/dd_act_2000.pdf
- Endrew F. v. Douglas County School District, 580 U.S. (2017) https://www.supremecourt.gov/opinions/16pdf/15-827_0pm1.pdf; further clarified IEP standards
- Civil Rights of Institutionalized Persons Act (CRIPA), (1980) 42 U.S.C. § 1997a, allows the Attorney General to review conditions and practices within these institutions. https://www.justice.gov/crt/rights-persons-confined-jails-and-prisons
- Juveniles: Uses both of the above https://www.justice.gov/crt/rights-juveniles
- Developmental Disabilities Services and Facilities Construction Amendments of 1970 and subsequent amendments, and P.L. 94-142 (precursor to IDEA) which guarantees a free and appropriate public education for all children with disabilities
- Fair Housing Amendments Act (1988). Pub. L:. No. 100-430
- Higher Education Act, (2004): help students move from public schooling to higher education, employment, and adult life.
- Individuals with Disabilities Education Act, (1975), https://sites.ed.gov/idea/
- Mental Retardation and Community Mental Health Centers Construction Act of 1963, Mental Retardation Facilities Construction Act. Pub L. No. 88-164 (1963), https://history.nih.gov/research/downloads/pl88-164.pdf
- Olmstead v. L.C. (98-536) 527 U.S. 581 (1999) https://www.supremecourt.gov/ held that persons with mental disabilities have the right to live in community settings, rather than institutions, If States treatment professionals determine community placement is appropriate, and transfer to a less restrictive setting is not opposed by the individual, and the placement can be reasonably accommodated.
- Rosa's Law, changed the reference to mentally retarded individual to an individual with an intellectual disability, 2010. https://www.govinfo.gov/content/pkg/CRPT-111srpt244/html/CRPT-111srpt244.htm
- Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 (re-codified at 34 U.S.C. § 12601), allows us to review the practices of law enforcement agencies that may be violating people's federal rights. https://www.justice.gov/crt/conduct-law-enforcement-agencies
- Olmstead v. L.C., 527 U.S. 581 (1999)

Alternative Health Response and Co-Responder

- Alternatives to Arrest and Police Responses to Homelessness, Urban Institute. https://www.urban.org/sites/default/files/publication/103158/alternatives-to-arrests-and- police-responses-to-homelessness.pdf
- Behavioral Health Crisis Alternatives https://www.vera.org/behavioral-health-crisis-alternatives, Vera Institute
- Blair L. Bigham, Sioban M. Kennedy, Ian Drennan & Laurie J. Morrison (2013) Expanding Paramedic Scope of Practice in the Community: A Systematic Review of the Literature, Prehospital Emergency Care, 17:3, 361-372, DOI: 10.3109/10903127.2013.792890
- From Harm to Health Microsoft Word - From Harm to Health 2021.docx (fountainhouse.org),Fountain House.org
- Kevin E. Mackey & Chichen Qiu (2019) Can Mobile Integrated Health Care Paramedics Safely Conduct Medical Clearance of Behavioral Health Patients in a Pilot Project? A Report of the First 1000 Consecutive Encounters, Prehospital Emergency Care, 23:1, 22-31, DOI: 10.1080/10903127.2018.1482390
- Renee Roggenkamp, Emily Andrew, Ziad Nehme, Shelley Cox & Karen Smith (2018) Descriptive Analysis Of Mental Health-Related Presentations To Emergency Medical Services, Prehospital Emergency Care, 22:4, 399-405, DOI: 10.1080/10903127.2017.1399181
- Kate Emond, Peter O'Meara & Melanie Bish (2019) Paramedic management of mental health related presentations: a scoping review, Journal of Mental Health, 28:1, 89-96, DOI: 10.1080/09638237.2018.1487534

Acute Crisis Response

- Alternative Health Response Models
  - Alternatives to Arrest and Police Responses to Homelessness, Urban Institute https://www.urban.org/sites/default/files/publication/103158/alternatives-to-arrests-and-police-responses-to-homelessness.pdf
  - CAHOOTS (Eugene, OR) https://whitebirdclinic.org/cahoots/
  - STAR (Denver, CO) VICE https://www.youtube.com/watch?v=vCmTcS5YvOQ&ab_channel=VICENews
- Crisis Now
  - https://theactionalliance.org/resource/crisis-now-transforming-services-within-our-reach
- Crisis Residential Best Practices Handbook: Practical Guidenlines and Resources, 2018, tbdSolutions. http://www.tbdsolutions.com
- Crisis Services Meeting Needs, Saving Lives
  - https://www.nasmhpd.org/sites/default/files/2020paper1.pdf
- Integrated Treatment EBP Tool Kit
  - https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-

10112019_0.pdf

- Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models
  - https://www.prainc.com/resource-library/coresponder-models/
- SAMHSA Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies:
  - https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848
- Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities: PEP 19
  - https://store.samhsa.gov/product/Tailoring-Crisis-Response-and-Pre-Arrest-Diversion-Models-for-Rural-Communities/PEP19-CRISIS-RURAL?referer=from_search_result
  - The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness, 1st Ed. Oxford University Press; 1st edition (February 24, 2015)

Intercept 0-1 Resources

- Transition Specialist Program (TSP) Colorado
  - https://www.rmhumanservices.org/single-post/2019/05/20/rocky-mountain-human-services-launches-program-to-help-coloradans-with-substance-use-and
  - https://drive.google.com/file/d/1q8qSX6XmRwOmYjgvi9ltgaTtQ-Ijf1Iw/view
- Momentum (Colorado)
  - https://drive.google.com/file/d/1d7d7XXrn2byosGzuht2RwIGyHAEOPJ31/view
- SAMSHA Bringing Recovery Supports to Scale:
  - https://www.samhsa.gov/brss-tacs
- Philadelphia Peer Support Tool Kit:
  - https://dbhids.org/peer-support-toolkit/
- SPOTLIGHT: Building Resilient and Trauma Informed Communalities
  - https://store.samhsa.gov/product/Spotlight-Building-Resilient-and-Trauma-Informed-Communities-Introduction/SMA17-5014?referer=from_search_result
- Dimensions: Peer Support Program Toolkit. Anschutz Medical Campus School of Medicine
  - https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf
- Peer Support in Rural Communities
  - https://www.ruralhealthinfo.org/toolkits/substance-abuse/2/peer-based-recovery-support/peer-specialist
- What Are Peer Recovery Support Services?
  - https://store.samhsa.gov/product/What-Are-Peer-Recovery-Support-Services-/SMA09-4454
- Bringing Resource Supports to Scale BRSS-TACS
  - https://www.samhsa.gov/brss-tacs
- Peer respites
  - https://power2u.org/directory-of-peer-respites/

- Copeland Center for Wellness and Recovery
  - https://copelandcenter.com/sites/default/files/attachments/WRAP%20for%20Everyday%20Lives_0.pdf
- Advanced Psychiatric Directives
  - https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf
- Promotores de Salud/Community Health Worker, Center for Disease Control and Prevention
  - https://www.cdc.gov/minorityhealth/promotores/index.html
- Integrating the Promotores Model to Strengthen Community Partnerships Center for the Study of Social Policy: Ideas in Action
  - https://cssp.org/wp-content/uploads/2019/02/CSSP-Toolkit-4-RBA-Integrating-Promotores.pdf
- CIT International

- https://www.citinternational.org/
- Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions
  - https://nicic.gov/improving-responses-people-mental-illnesses-tailoring-law-enforcement-initiatives-individual
- Law Enforcement Assisted Diversion (LEAD)
  - http://www.leadbureau.org/
- Police Assisted Addiction and Recovery Initiative
  - https://paariusa.org/
- TIP 61: Behavioral Health Services for American Indians and Alaska Natives
  - https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070
- TIP 29: Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities:
  - https://store.samhsa.gov/product/TIP-29-Substance-Use-Disorder-Treatment-for-People-With-Physical-and-Cognitive-Disabilities/SMA12-4078
- Rural Health Information Hub (RHI) Telehealth Models
  - https://www.ruralhealthinfo.org/toolkits/substance-abuse/2/treatment/care-delivery/telehealth
  - https://hsc.unm.edu/echo/institute-programs/bha/
- In Brief: Rural Behavioral Health: Telehealth Challenges and Opportunities:
  - https://store.samhsa.gov/product/In-Brief-Rural-Behavioral-Health-Telehealth-Challenges-and-Opportunities/SMA16-4989
- Permanent Supportive Housing EBP
  - https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509
- TIP 55: Behavioral Health Services for People Who Are Homeless
  - https://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA15-4734
- Denver Supportive Housing Social Impact Bond Initiative, Urban Institute
  - https://www.urban.org/policy-centers/metropolitan-housing-and-communities-policy-center/projects/denver-supportive-housing-social-impact-bond-initiative

Intercept 2-3 Resources

- Stepping Up:
  - For more information, download the project overview (PDF).
- Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court
  - https://csgjusticecenter.org/publications/improving-responses-to-people-with-mental-illnesses-the-essential-elements-of-a-mental-health-court/
- Organizational Toolkit on Medication Adherence

- https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Medication_Adherence_Toolkit_Final.pdf?daf=375ateTbd56
- American Bar Association Standards: Treatment of Prisoners, 3rd Ed.
  - https://www.americanbar.org/groups/criminal_justice/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners/

➢ Jails: The Inadvertent Health Care Providers, PEW Trusts
  - https://www.pewtrusts.org/-/media/assets/2018/01/sfh_jails_inadvertent_health_care_providers.pdf
- After Prison: Roadblocks to Reentry, A Report on State Legal Barriers Facing People with Criminal Records, 2004
  - https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=205269
- NM Competence Rule
  - http://jec.unm.edu/materials/2019conclave/1-30-2-30-breakout-sessions-thursday-june-6/criminal-competency-new-rules-reports-and-resources

Intercept 4-5 Resources

➢ Understanding Health Reform as Jail Reform: Medicaid, Care Coordination and Community Supervision, The Square One Project
  - https://squareonejustice.org/wp-content/uploads/2020/11/Final-Understanding-Health-reform-WEB-201103.pdf

➢ SAMHSA TIP 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community, Treatment Improvement Protocol
  - https://store.samhsa.gov/sites/default/files/product_thumbnails/SMA08-3920%20thumbnail_0.PNG
- SSI/SSDI Outreach, Access, and Recovery (SOAR)
  - https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/soar
- Behavior Management of Justice-Involved Individuals: Contemporary Research and State-of-the-Art Policy and Practice
  - https://nicic.gov/behavior-management-justice-involved-individuals-contemporary-research-and-state-art-policy-and
- Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation
  - https://csgjusticecenter.org/publications/improving-responses-to-people-with-mental-illnesses-the-essential-elements-of-specialized-probation-initiatives/
- Supported Employment Tool Kit
  - https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-se_0.pdf
- Corrections and Mental Health NIC, an update of the National Institute of Corrections
  - https://community.nicic.gov/blogs/mentalhealth/archive/2012/07/16/suicide-risk-factors-among-recently-released-prisoners.aspx

➢ Leveraging Medicaid to Establish Meaningful Health Care Connections for Justice-Involved Populations

        - https://www.shvs.org/wp-content/uploads/2019/09/Justice-Involved-Populations-QA-Updated-9-12.pdf
    - Leveraging Medicaid to Address the Social Determinants of Health
        - https://www.milbank.org/wp-content/uploads/2017/01/SODH-Bachrach.pdf
    - ASAM: American Society of Addiction Medicine
        - https://www.asam.org/asam-criteria/level-of-care-certification; https://www.asamcontinuum.org/about/
    - SAMSHA and HRSA Integrated Solutions
        - http://www.samhsa.gov/medication-assisted-treatment
    - Rural Information Hub: Rural Prevention and Treatment of Substance Use Disorders Tool Kit:
        - https://www.ruralhealthinfo.org/toolkits/substance-abuse
- Contingency Management, A Complete Guide 2020 Ed, 5STARCooks (February 2,2020)
        - https://www.amazon.com/Contingency-Management-Complete-Guide-2020/dp/1867322161
    - Police Harm Reduction
        - https://www.opensocietyfoundations.org/uploads/0f556722-830d-48ca-8cc5-d76ac2247580/police-harm-reduction-20180720.pdf

POLICY RESEARCH ASSOCIATES

APPENDICES

Appendix 1

SIM Case Study Form

1) **Present information:**

Case Study: Juvenile Male (IDD/MH)	**Age**: 13	**Gender:** Male
Diagnosis: Mild Intellectual Disability, Autism, Post-traumatic Stress Disorder, ADHD Combined Type, Disruptive Mood Dysregulation Disorder	**Waiver Status:** IDD	**Location**: Suburban/Urban

Current Living Situation	Currently at PRTF Resided with adoptive mom at home prior to admission- several acute hospitalizations prior to that and recent move from another community
Employment/Day Activities	Currently at PRTF Enrolled in school prior to admission- inconsistent attendance due to acute hospitalizations and stay at juvenile detention
Description of support system (family/friends/paid)	Adoptive parents are divorced. Lived with adoptive dad for some time, receiving waiver services. Dad is no longer involved. Adoptive mom is now primary caregiver- became paid caregiver through the IDD Waiver when no workers were identified
Social/Medical History (Diagnosis, major medical support needs, history of support needs, etc.)	History of trauma from early childhood- removed from biological home at age 2 due to abuse and neglect. Placed in approximately 7 foster homes. Reports of sexual abuse by biological grandfather while placed in their home. One of the foster families became his legal guardians, refers to them as “mom” and “dad” History and ongoing law enforcement involvement: - Stole dad’s ATV and wrecked it, then involved in a foot chase with law enforcement - Threatening parent and workers with knife - Elopement/running away from home - Stealing from grocery store - Acquired firearm from the home and carrying openly out in public Ongoing challenging behaviors include resisting supervision, elopement, physical aggression, defiance/argues, stealing
Current barriers	Co-occurring mental health with IDD needs

SIM Case Study Form

	- Autism services available, but no expertise in high mental health need - Mental health supports available, but no expertise in autism/IDD Availability of appropriate supports to meet his needs- and ability for those supports to collaborate with one another Personnel shortage- no additional paid caregivers but mom, so no respite Planning for what is actually available for wraparound supports following discharge from the PRTF
Things tried in the past	Living with dad with supports Living with mom with supports Alternative educational placement Acute hospitalizations YRC-II placements (Youth Residential Center) PRTF stays (Psychiatric Residential Treatment Facility) SED Waiver, state-plan CMHC supports IDD Waiver- personal care services Parsons Dual Diagnosis Outreach DCF Involvement- Foster Care, Family Preservation Attempted to access state-plan autism services Criminal Justice System- Juvenile Detention, House Arrest Exploration of out-of-state placement
Other system stakeholders	Law enforcement Department of Children and Family PRTF Emergency Services CMHC

Problem statement (Main reason for brainstorm) ICCOD and SIM Converge • B: Cross-Cutting Considerations at the Population and Person Level • C: Crisis Systems • D: Criminal Justice	B: Cross-Cutting Considerations at the Population and Person Level • Special Populations • Coordinated Delivery of Treatment & Supports • Accommodations & Support • Continuity of Treatment and Supports • Transitions, Stabilization and Recovery • Skill-based, Culturally Responsive Cross-Training C: Crisis Systems • Acute Crisis Interventions and Services and Settings • Transition Planning

SIM Case Study Form

	D: Criminal Justice • Cross-Agency Coordination, Deflection and Diversion

2) Ask for questions
3) Team provides suggestions:

Appendix 2

SIM Case Study Form

1) **Present information:**

Case Study:	**Age**: 33	**Gender:** Female
Diagnosis: Borderline Personality Disorder, Borderline Intellectual Functioning, Oppositional Defiant Disorder, Bi-Polar Disorder, Intermittent Explosive Disorder, seizure disorder and as a child was diagnosed with Serious Emotional Disturbance. Her mother reports that she has a diagnosis of Frontal Lobe Syndrome, unknown origin.	**Waiver Status:** none	**Location**: Urban

Current Living Situation	Incarceration for battery on a law enforcement officer
Employment/Day Activities	No history of employment
Description of support system (family/friends/paid)	Sibling is her guardian, parents and other siblings limit interactions with the member due to past aggression. Guardian also acts are her payee. When she is not in jail her family does her grocery shopping and delivers them to her.
Medical History (Diagnosis, major medical support needs)	Adopted as an infant. Had mental health supports from early childhood on. Counseling last 10-15 years. State hospitalization, crisis supports. During a recent state hospital stay the member assaulted a staff and was sent to a correctional facility. Has a history of seizure disorder. Has a history of several pregnancies but the children were removed from her care. She indicates plans to become pregnant again.
Current barriers	24/7 support needs due to history of fire starting, not able to safely cook. Supported housing in her own apartment was tried but due to her hallucinations, impulsive & aggressive behavior. After release, she was readmitted to state hospital due to her inability to maintain herself in a living arrangement that is not extremely structured to provide safety for her and safety for those around her.
Things tried in the past	SED waiver – aged out. Ongoing counseling with limited improvement. Housing support Behavioral Health Case Management

SIM Case Study Form

Other stakeholder systems	911 988 CMHC Police Department

Problem statement (Main reason for brainstorm) **ICCOD and SIM Converge** • **B: Cross-Cutting Considerations at the Population and Person Level** • **C: Crisis Systems** • **D: Criminal Justice**	B – Transitions, Stabilization and Recovery Housing and Homeless Services and Supports Coordinated Delivery of Services C – Acute Crisis, Transition Planning D – Jail

2) Ask for questions
3) Team provides suggestions:

Appendix 3

SIM Case Study Form

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1) **Present information:**

Case Study: Adult Female (MH possible IDD/BI)	**Age**: 30	**Gender:** Female
Diagnosis: Bipolar Disorder, Unspecified Psychosis, Anxiety, Depression, Attention Deficit Hyperactivity Disorder, History of Substance Use, Type 2 Diabetes	**Waiver Status:** none	**Location**: Urban
Other Impacted Systems: Adult Protective Services, Judicial System, Mental Health, LTC/NFMH		

Current Living Situation	Hospitalized at acute hospital for behavioral health - Transferred from NFMH
Employment/Day Activities	No employment Day activities at NFMH
Description of support system (family/friends/paid)	Has a court-appointed guardian and APS involvement Past residential placements had been established with supports, however, continued challenges included: - Reports of having men over who she engaged in sexual activities in exchange for access to drugs - Leaving her home for periods of time and be found in areas where people experiencing homeless congregated- this is reportedly where she would have access to drugs Family is involved and has contact but cannot support her needs. Mom has been known to provide access to substances Admit to NFMH due to concerns for her safety
Social/Medical History (Diagnosis, major medical support needs, history of support needs, etc.)	Lived with mother and mother's family, removed and placed in custody at age 11 due to mother's ongoing substance abuse. Placed in foster homes, then with a kinship placement until adulthood. History of neglect as well as emotional, physical and sexual abuse. Mother used drugs and alcohol during pregnancy. She was exposed to alcohol and drugs while in mother's care. Reports indicated she experienced blows to the head, which led to loss of consciousness as a child. She was described to have

SIM Case Study Form

	hyperactive sexual activity as a child, believed to be associated with history of sexual abuse. History of cannabis and methamphetamine use, as well as experimentation with cocaine. Reports of engaging in indiscriminate sexual activity with partners to gain access to substances- possibility of trafficking. Reported to have been supported with an IEP through school. Reported to have had behavioral problems since early adolescence. History of multiple inpatient and residential psychiatric stays, as well as state hospital stay. History of property destruction and aggression towards others, unstable moods and trouble with coping skills and managing intense emotions. Was charged in the past with assault and battery, as well as resisting arrest. Questions regarding cognitive impairment due to past TBI or fetal alcohol syndrome.
Current barriers	Inconsistent housing Community providers report unwillingness to engage- would do well for a little bit, then go back to seeking drugs and sexual partners Questions regarding other support needs due to presence of cognitive limitations (however, most recent psych eval has FSIQ of 79) NFMH has discharged due to assault towards a staff member- no other NFMH indicating ability to support her Reached out to Supported Housing programs- cannot support needs due to aggression, past charges Inpatient Rehabilitation had been explored- but clinicians would bring up that she would not be a good fit due to suspected cognitive limitations
Things tried in the past	Foster placement PRTF Acute hospitalizations Community-based services through the CMHC Residential supports

SIM Case Study Form

	NFMH

Problem statement (Main reason for brainstorm) ICCOD and SIM Converge • B: Cross-Cutting Considerations at the Population and Person Level • C: Crisis Systems • D: Criminal Justice	B: Cross-Cutting Considerations at the Populations and Person Level • Special Populations • Coordinated Delivery of Treatment and Supports • Accommodations & Support • Continuity of Treatment & Supports • Skill-based, Culturally Responsive Cross-Training • Housing and Homeless Services and Supports • Transitions, Stabilization and Recovery C: Crisis Systems • Early Contact Identification and Screening • Acute Crisis Interventions and Services and Settings D: ICCOD an SIM Converge • Specialized Caseloads and Services • Community Supervision

2) Ask for questions
3) Team provides suggestions:

Appendix 4

SIM Case Study Form

1) **Present information:**

Case Study: Adult Male (IDD)	**Age**: 47	**Gender:** Male
Diagnosis: Mild Intellectual Disability, Major Depressions, Schizoaffective Disorder, Hypothyroidism, Seborrheic Dermatitis, Sleep Apnea, GERD, Constipation, Asthma, Obesity, History of Alcohol Dependence (sober 11 years per Support Plan)	**Waiver Status:** IDD	**Location**: Rural

Current Living Situation	Lives in own home with no roommates • Authorized for 31 days/mo. of Residential Services through the IDD Waiver- per PCSP, he requires extensive supports
Employment/Day Activities	Chooses not to attend Day Services Not employed Reports that member wanders the streets Disassembled things in the home (fan, plumbing) due to boredom, per self-report
Description of support system (family/friends/paid)	Reports indicate staff supports are only to drop off medications, grocers and to assist with laundry at times Residential provider lost medical coordinator for the area in May, new personnel who oversees care lives pretty far away
Social/Medical History (Diagnosis, major medical support needs, history of support needs, etc.)	Diabetes- requires medication, blood sugar checks, diabetic diet Behavioral Health diagnoses requiring ongoing medication management, including regular lab checks
Current barriers	Living alone without adequate staffing/supports to meet his need- puts him at increased risk for law enforcement involvement

SIM Case Study Form

	Several encounters with Law Enforcement- has been found wandering the streets at all hours of the night, including in people's yards and near schools, making vulgar comments Not seeing specialists for medication management and diabetes management • Verified with CMHC that intake was completed in May, but has not been back since Several safety concerns identified during 9/13 home visit some examples: • Disheveled appearance- hair and beard overgrown, toenails severely overgrown • Central air was broken, had window a/c unit that was not doing much • Crumbs/debris scattered on the flood • Broken window with shards of glass on the floor • Ceiling fan hung disassembled • Sink full of dirty dishes • Mattress on the floor with no box springs, frame or sheets
Things tried in the past	Risk Assessments put in place APS Report for Self-Neglect- unsubstantiated, as it was member's choice to live in these conditions
Other system stakeholders	Law enforcement Adult Protective Services Emergency Services Medical providers

Problem statement (Main reason for brainstorm) ICCOD and SIM Converge • B: Cross-Cutting Considerations at the Population and Person Level • C: Crisis Systems • D: Criminal Justice	B: Cross-Cutting Considerations at the Populations and Person Level • Special Populations • Coordinated Delivery of Treatment and Supports • Accommodations & Support • Continuity of Treatment & Supports • Skill-based, Culturally Responsive Cross-Training C: Crisis Systems • Early Contact Identification and Screening

SIM Case Study Form

2) Ask for questions
3) Team provides suggestions:
