North Dakota Behavioral Health Vision 20/20

Strategic Goals	
1	Prevention & Early Intervention
1.1	Select and implement evidence-based and culturally-relevant mental health promotion strategies
1.2	Expand the work of the State Epidemiological Outcomes Workgroup (SEOW) to encompass social and emotional wellness promotion/mental health and social determinants of health alongside substance use prevention
1.3	Expand school-based prevention activities using evidence-based curriculums
1.4	Expand school-based early intervention activities using evidence-based curriculums
1.5	Secure adequate funding for the Parents Lead program, which provides information for parents to support the behavioral health of their children and encompasses mental health and substance use issues
1.6	Implement Zero Suicide statewide
1.7	Expand the implementation of activities focused on decreasing risk factors and increasing protective factors to prevent suicide, with a focus on groups and individuals identified as high risk, including American Indian populations, LGBTQ/GNC individuals, older adults, and military service members, veterans, family members, and survivors
1.8	Establish and integrate treatment and recovery services for individuals and families impacted by suicide
1.9	Collect and organize data concerning the nature and extent of Neonatal Abstinence Syndrome (NAS) from substance use in the state
1.10	Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from substance use
1.11	Identify federal, state, and local programs that provide services to mothers who use drugs or alcohol and to newborns who have NAS, and evaluate those programs to determine if gaps in programs or ineffective policies exist
1.12	Evaluate methods to increase public awareness of the dangers associated with substance use, particularly to women, expectant mothers, and newborns
1.13	Implement sustainable, effective interventions that raise public awareness of NAS, reduce its negative impacts, and prevent future occurrences
1.14	Expand evidence-based services for first-episode psychosis
2	Access to Appropriate Behavioral Health Services
2.1	Coordinate and streamline information sources for BH resources, particularly mental health services and related social services
2.2	Ensure reimbursement for SBIRT and expand statewide, with a priority focus on pregnant women
2.3	Identify universal age-appropriate, culturally-sensitive behavioral health screening instruments (including trauma, brain injury) for children and adults
2.4	Implement universal behavioral health screenings in primary care and social service settings
2.5	Ensure Qualified Service Providers and HCBS Case managers who work with older adults and people with physical disabilities receive basic and ongoing trainings in behavioral health, including confronting misperceptions about the population
2.6	Expand telebehavioral health crisis services statewide, including services for children and youth
2.7	Expand intoxication and withdrawal management services that focus on treatment engagement and connection to services
2.8	Expand mobile crisis teams for adults in urban areas statewide
2.9	Establish statewide mobile crisis teams for children and youth in urban areas
2.10	Expand the implementation of activities to prevent the attempt and completion of suicide, including crisis services
2.11	Develop crisis alternatives, including peer respite/living room and peer crisis line (Recovery Centers may be expanded for this purpose)
2.12	Ensure people with brain injury and people with psychiatric disability are aware of eligibility for services through all avenues, including Medicaid waiver services
2.13	Review current HSC policies, practices, capacity, and specialization/competencies that may act as barriers to access for persons with brain injury at HSCs, and determine service gaps in the larger system that contribute to these issues

2.14	Require and deliver training on brain injury to all HSCs, social services agencies, and behavioral health treatment providers
2.15	Enhance behavioral health support capacity through the ND Brain Injury network and CILs throughout the state
2.16	Review current HSC policies and practices that may act as barriers to serving veterans and military service members and their families
2.17	Ensure syringe service programs statewide
3	Outpatient and Community-Based Services
3.1	Provide case management services on a continuum of duration and intensity based on assessed need, with a focus on enhancing self-sufficiency and connecting to natural supports
3.2	Conduct review of behavioral health services to identify "legacy" services that are not sufficiently evidence-based
3.3	Expand evidence-based team-based services such as Assertive Community Treatment (ACT)
3.4	Expand medication-assisted treatment (MAT) statewide, including within prisons and jails.
3.5	Expand the continuum of evidence-based SUD treatment services for children and youth.
3.6	Expand school-based mental health and SUD treatment services for children and youth.
3.7	Expand options for parents to access substance use disorder treatment by providing options for bringing children into residential treatment and other supports for providing child care while the parent participates in treatment
3.8	Develop a state behavioral/physical health integration framework that: defines levels of integration; includes essential care coordination functions and delineation of roles; considers national models (e.g. CCBHCs, Collaborative Care);and outlines the administration, regulatory, and funding impact of integration
3.9	Standardize physical/behavioral health system navigation protocols, including referral pathways, cross-sector provider communication, and follow-up practices to ensure greater integration across the state
3.10	Ensure the primary care workforce receives basic and ongoing trainings in behavioral health, including confronting misperceptions about the population
3.11	Scale up behavioral health service capacity in FQHCs statewide based on local best practice
3.12	Explore the use of peer support specialists trained as whole health navigators and community health workers located in primary care to assist with navigation and integration across health care access points
3.13	Expand evidence-based supported housing
3.14	Establish a statewide strategy for identifying and pursuing resources to address capital shortages and coordinate behavioral health housing. This strategy may include creating a state-level behavioral health housing coordinator and/or a centralized housing registry and coordinated entry program
3.15	Expand evidence-based supported education and employment
3.16	Diversify funding for Recovery Centers, including ensuring Recovery Centers pursue Medicaid reimbursement for peer services if they are added to the Medicaid state plan
3.17	Create Peer Bridger programs for individuals transitioning to the community from institutional settings, including residential treatment settings
3.18	Ensure sober living environments contracted through the state meet basic requirements for health and safety and participant rights and responsibilities
3.19	Convene emergency and inpatient service providers and community-based providers to create a universal protocol for supporting referral and connection to community-based services after crisis that includes "in-reach" practices and ongoing communication to address bottlenecks and troubleshoot emergent issues
3.20	Establish and track measures of connection to community-based services following an emergency department or inpatient visit
3.21	Conduct a review of BH services in long-term care facilities to explore options for community-based alternatives
3.22	Implement a standardized process for determining level of need for residential mental health treatment, prioritizing placement based on need
3.23	Implement a standardized process for determining level of need for residential substance use disorder treatment, prioritizing placement based on need
4	System of Care for Children and Youth with Complex Needs
4.1	Establish and ratify a shared vision of a community system of care for children and youth

4.2	Explore options to adjust the $15,000 Medicaid service spending threshold for family support services
4.3	Expand culturally-responsive, evidence-based, multi-systemic therapy services for children and families involved in multiple systems
4.4	Expand culturally-responsive, evidence-based wraparound services for children and families involved in multiple systems
4.5	Expand DJS Community Day Treatment
4.6	Expand in-home community supports for children, youth, and families, including family skills training and family peers
4.7	Target SUD screening, outreach, engagement, and services to parents/caregivers of children and youth involved in the foster care and juvenile justice systems
4.8	Partner with tribal nations to review TFC licensing requirements for cultural responsiveness and create a joint strategy to expand availability of American Indian foster care providers
4.9	Identify TFC providers who are accepting of and responsive to the needs of LGBTQ/GNC youth and prioritize the placement of youth in those homes
4.10	Monitor the demographics and competencies of TFC providers on an ongoing basis with a goal of having a foster care network that matches the racial and ethnic make-up of the population served
4.11	Develop strategy for enhancing TFC capacity statewide and placing children and youth in TFC based on assessed need
4.12	Implement a standardized process for determining level of need for residential treatment (including treatment foster care, PRTFs, and QRTPs) for children and youth and prioritizing placement based on need
4.13	Review staffing and training in intensive residential settings to ensure the workforce's capacity to work with children and youth with extreme behaviors, and implement a training program to fill gaps in clinical competency
5	Criminal Justice System Strategy
5.1	Implement Dual Status Youth Initiative recommendations
5.2	Engage in coordinated efforts to reduce the involvement of girls and LGBT/GNC youth in the juvenile justice system through addressing behavioral health-related needs
5.3	Ensure sustainability and statewide adoption and expansion of successful Free through Recovery diversion efforts
5.4	Implement Crisis Intervention Team training for all law enforcement officers and emergency medical responders statewide, with e-learning options for those in rural areas
5.5	Implement training on trauma-informed approaches - including vicarious trauma and self-care - for all criminal justice staff
5.6	Review BH treatment capacity in jails and create a plan to fill gaps
6	Behavioral Health Workforce
6.1	Establish a single entity responsible for supporting BH workforce implementation. The entity will: oversee workforce-related efforts; provide central leadership and support in coordinating the various behavioral health workforce incentive programs, including identifying and responding to behavioral health workforce related funding opportunities; foster partnerships with education entities to increase education pathways; collaborate with licensing boards and local employers to support collaboration and alignment of strategic goals
6.2	Develop a single electronic database of available statewide vacancies for BH professionals, available student placements, available incentive programs, and competency requirements
6.3	Develop a program for providing recruitment and retention support to assist with attracting providers to fill needed positions and retain skilled workforce
6.4	Expand loan repayment programs for BH students working in areas of need
6.5	Ensure providers and students are aware of student internships and rotations
6.6	Conduct a spatial analysis of state licensures to determine maldistribution and shortages
6.7	Create a comprehensive database of behavioral health licensure to identify trends over time
6.8	Conduct a comprehensive review of state licensure requirements to establish inter-state compacts with bordering states and tribal nations
6.9	Establish a formalized training and certification process for peer support specialists
6.10	Implement credentialing programs for early childhood mental health professionals (for example, the Endorsement available through https://www.allianceaimh.org/)

6.11	Implement credentialing programs for prevention specialists
6.12	Implement credentialing programs for Certified Psychiatric Rehabilitation Professionals (CPRP)
6.13	Create a centralized organization to provide training, continuing education, and support for peer support specialists; additionally, create mechanisms for supporting employers, organizations, and agencies with issues regarding adoption and integration of peer services
7	Telebehavioral Health Interventions
7.1	Develop mechanism for training of behavioral health professionals in telehealth techniques and development familiarity with technology to combat provider resistance to adoption
7.2	Explore the utilization of paraprofessional staff to assist with the time constraints of providing telebehavioral health services
7.3	Expand the reach of telebehavioral health services for substance use disorders
7.4	Expand the reach of telebehavioral health services for children and youth
7.5	Expand the reach of telebehavioral health services for American Indian populations
7.6	Increase the types of services available through telebehavioral health
7.7	Develop clear, standardized procedural and regulatory guidelines for telebehavioral health
7.8	Identify and facilitate resolution of any regulatory or funding barriers to adoption telebehavioral health services
8	Person-Centered, Trauma-Informed, and Culturally/Linguistically Competent Approaches
8.1	Pilot shared decision-making strategies in one HSC with an aim to scale up successful strategies
8.2	Apply for technical assistance to support person-centered systems change
8.3	Promote establishment of mental health advance directives in HSCs and Recovery Centers
8.4	Develop a statewide plan to enhance overall commitment to cultural and linguistic competence based on CLAS standards in partnership with tribal nations and local communities
8.5	Develop and maintain an epidemiological profile of all BH service users that includes race, ethnicity, preferred language, sexual orientation, gender and gender identity, and country of origin
8.6	Develop and maintain a database that includes information on linguistic competencies of the behavioral health workforce, and use the data to inform workforce development initiatives
8.7	Ensure adequate translation services are available throughout the state, particularly in areas with higher concentration of New Americans
8.8	In partnership with tribal nations and local communities, create an ongoing training program for all behavioral health professionals that includes modules on American Indian history and culture, health equity, and other areas identified in the statewide cultural and linguistic competence plan
8.9	Create an ongoing training program for all behavioral health professionals on best practice in working with veterans and military service members and their families
8.10	Update and expand registries of LGBTQ/GNC-friendly providers
8.11	Develop and implement a policy and practice to reduce the use of seclusion and restraint in schools
8.12	Apply for technical assistance through National Center on Trauma-Informed Care (NCTIC) to develop a strategy for ensuring a trauma-informed system that includes system-wide training for all behavioral health staff
8.13	Establish a process for organizational self-assessments of person-centeredness, cultural and linguistic competence, and trauma-informed care in each HSC, social services agency, and other behavioral health entities in the state
8.14	Initiate a first round of organizational self-assessments to establish benchmark data and inform future planning
9	Communities to Promote High-Quality Behavioral Health Services
9.1	Establish a state-level leadership position that represents the perspective of persons with lived experience
9.2	Foster the development of community coalitions to advocate for wellness promotion and prevention in their communities
9.3	Review existing behavioral health-related advisory boards and committees to explore opportunities to increase the membership of people with lived experience

9.4	Establish training and mentorship opportunities for emerging advocates
9.5	Establish a scholarship program to support emerging advocates to attend the state Behavioral Health Conference and other events
9.6	Include dedicated trainings and sessions at the State Behavioral Health Conference related to advocacy skills and partnerships with advocacy communities
9.7	Foster connections to national advocacy movements by supporting travel and attendance at national conferences and at virtual advocacy networks
9.8	Include dedicated trainings and sessions at the State Behavioral Health Conference related to peer-run organizations
9.9	Apply for technical assistance through the Recovery Café to increase the number and reach of peer-run organizations in the State
9.10	Convene local communities to identify and share best practice about community-driven initiatives that reduce discrimination and marginalization of people with psychiatric disabilities
9.11	Identify and apply for additional resources (e.g. grant opportunities, partnerships with public and private entities in the state) to support enhancement of community mental health education efforts
10	Increase Health Equity for American Indian Populations
10.1	Re-convene state and tribal leaders to review July 2017 recommendations and explore an aligned strategic planning process
10.2	Redouble efforts to establish partnerships between tribal nations and state behavioral health stakeholders through in-person meetings between state and tribal leadership
10.3	Integrate traditional medicine as part of the behavioral health care continuum and explore options for sustainable financing of traditional approaches
10.4	Engage in ongoing education with tribal leaders, specific to each tribal nation, about what services they can bill and be reimbursed for
10.5	Invest monies recouped from the 100% FMAP back into tribal communities
11	Funding for Behavioral Health
11.1	Develop an organized system for identifying and responding to funding opportunities
11.2	Establish 1915(i) Medicaid state plan amendments to expand community-based services for key populations
11.3	Establish peer services as a reimbursed service in the Medicaid state plan
11.4	Expand the financing of Community Health Workers (CHWs) through the Medicaid state plan
11.5	Increase the sustainability of the SUD voucher program, and expand the SUD voucher program to include mental health population
11.6	Change Medicaid eligibility requirements so that benefits are suspended rather than terminated when an individual is incarcerated
11.7	Engage in targeted efforts to enroll eligible service users in Medicaid to maximize federal contribution to publicly funded BH services
11.8	Partner with local health systems to conduct a review of implementation of federal parity laws
12	Data Systems
12.1	Draft a ten-year plan for aligning DHS and other state and local data systems to support system goals and increase readiness for implementing value-based payment models
12.2	Identify a standard set of data elements to collect from contracted providers that aligns with state data systems and goals for the behavioral health system
12.3	Work with contracted providers to collect and report standard data elements
12.4	Identify priority system metrics to benchmark progress on key goals
12.5	Expand the function and utilization of the SEOW to provide and/or analyze data to guide programmatic decisions across behavioral health systems
12.6	Develop a system for identifying high utilizers and analyzing trends in service utilization

Acronyms

BH	Behavioral health
BHD	Behavioral Health Division
CIL	Center for Independent Living
CCBHC	Certified Community Behavioral Health Center
CFS	Children and Family Services Division
CBHTF	Childrens Behavioral Health Task Force
CHW	Community health worker
CLAS	Culturally and linguistically appropriate services
DOCR	Department of Corrections and Rehabilitation
DHS	Department of Human Services
DJS	Department of Juvenile Services
DPI	Department of Public Instruction
DVR	Division of Vocational Rehabilitation
EPSDT	Early and Periodic Screening, Diagnosis,and Treatment
FQHC	Federally Qualified Health Center
FS	Field Services Division
FTR	Free though Recovery
HCBS	Home and Community-Based Services
HSC	Human Service Center
IAC	Indian Affairs Commission
IHS	Indian Health Service
LGBTQ	Lesbian, gay, bisexual, transgender, queer/questioning
MA	Medicaid Division
MAT	Medication-assisted treatment
MST	Multisystemic therapy
NCTIC	National Center on Trauma-Informed Care
DoH	ND Department of Health
NAS	Neonatal Abstinence Syndrome
NDHFA	North Dakota Housing Finance Agency
PRMC	Prevention Resource and Media Center
P&A	Protection and Advocacy
REA	Regional Education Association
SBIRT	Screening Brief Intervention and Referral to Treatment
SEOW	State Epidemiological Outcomes Workgroup
SUD	substance use disorder
TGNC	Transgender/gender non-conforming
TFC	Treatment foster care