North Dakota

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

(generated on 8-28-2008 2.45.20 PM)

Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

Table of Contents

State:
North Dakota

Face Page	pg. 4
Executive Summary	pg. 5
Certifications	pg. 8
Public Comments on State Plan	pg. 19
Set-Aside For Children Report	pg. 21
MOE Report	pg. 22
Council List	pg. 24
Council Composition	pg. 33
Planning Council Charge, Role and Activities	pg. 35
Adult - Overview of State's Mental Health System	pg. 79
Adult - Summary of Areas Previously Identified by State as Needing Attention	pg. 82
Adult - New Developments and Issues	pg. 84
Adult - Legislative Initiatives and Changes	pg. 87
Adult - Description of Regional Resources	pg. 89
Adult - Description of State Agency's Leadership	pg. 91
Child - Overview of State's Mental Health System	pg. 94
Child - Summary of Areas Previously Identified by State as Needing Attention	pg. 97
Child - New Developments and Issues	pg. 99
Child - Legislative Initiatives and Changes	pg. 102
Child - Description of Regional Resources	pg. 106
Child - Description of State Agency's Leadership	pg. 109
Adult - Service System's Strengths and Weaknesses	pg. 112
Adult - Unmet Service Needs	pg. 118
Adult - Plans to Address Unmet Needs	pg. 121
Adult - Recent Significant Achievements	pg. 129
Adult - State's Vision for the Future	pg. 134
Child - Service System's Strengths and Weaknesses	pg. 136
Child - Unmet Service Needs	pg. 142
Child - Plans to Address Unmet Needs	pg. 145
Child - Recent Significant Achievements	pg. 148
Child - State's Vision for the Future	pg. 153

Adult - Establishment of System of Care	pg. 155
Adult - Available Services	pg. 166
Adult - Estimate of Prevalence	pg. 176
Adult - Quantitative Targets	pg. 178
Adult - Outreach to Homeless	pg. 182
Adult - Rural Area Services	pg. 186
Adult - Older Adults	pg. 188
Adult - Resources for Providers	pg. 192
Adult - Emergency Service Provider Training	pg. 195
Adult - Grant Expenditure Manner	pg. 197
Table C - MHBG Transformation Expenditures Reporting Form	pg. 199
Table C - Description of Transformation	pg. 200
Adult - Goals Targets and Action Plans	pg. 211
Child - Establishment of System of Care	pg. 210
Child - Available Services	pg. 218
Child - Estimate of Prevalence	pg. 231
Child - Quantitative Targets	pg. 233
Child - System of Integrated Services	pg. 237
Child - Geographic Area Definition	pg. 245
Child - Outreach to Homeless	pg. 248
Child - Rural Area Services	pg. 252
Child - Resources for Providers	pg. 254
Child - Emergency Service Provider Training	pg. 257
Child - Grant Expenditure Manner	pg. 259
Child - Goals Targets and Action Plans	pg. 261
Planning Council Letter for the Plan	pg. 260
Appendix A (Optional)	pg. 264

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_FY2009 ___FY 2009-2010 ___FY 2009-2011

STATE NAME: North Dakota

DUNS #: 802-742-534

I. AGENCY TO RECEIVE GRANT

AGENCY: North Dakota Department of Human Services

ORGANIZATIONAL UNIT: Div. of Mental Health and Substance Abuse Services

STREET ADDRESS: 1237 W. Divide Avenue, Suite 1C

CITY: Bismarck STATE: ND ZIP: 58501

TELEPHONE: 701-328-8920 FAX: 701-328-8969

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: JoAnne Hoesel TITLE: Director

AGENCY: North Dakota Department of Human Services

ORGANIZATIONAL UNIT: Div. of Mental Health and Substance Abuse Services

STREET ADDRESS: 1237 W. Divide Avenue, Suite 1C

CITY: Bismarck STATE: ND ZIP CODE: 58501

TELEPHONE: (701) 328-8924 FAX: (701) 328-8969

III. STATE FISCAL YEAR

FROM: 07/01/2008 TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: JoAnne Hoesel TITLE: Director

AGENCY: North Dakota Department of Human Services

ORGANIZATIONAL UNIT: Div. of Mental Health and Substance Abuse Services

STREET ADDRESS: 1237 W. Divide Avenue, Suite 1C

CITY: Bismarck STATE: ND ZIP: 58501

TELEPHONE: 701-328-8924 FAX: 701-328-8969 EMAIL: jhoesel@nd.gov

North Dakota

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

EXECUTIVE SUMMARY

1. North Dakota's Current Public Mental Health System

The North Dakota Department of Human Services provides and administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. Two components coordinate the development and actual provision of public community-based mental health services: Program and Policy and the Human Service Centers.

Located within Program and Policy, the Division of Mental Health and Substance Abuse Services performs many functions in the planning, development, and implementation of the community-based mental health care delivery system including: planning and research, grant writing, licensing of residential facilities, and education.

The regional human service centers serve consumers in the community through a linked spectrum of services including: crisis stabilization and resolution; inpatient services; psychiatric/medical management; social services; residential services and supports; vocational and educational services and supported employment; and social and leisure activities.

In addition to these, the North Dakota State Hospital provides total care to individuals with mental illness and/or substance abuse issues consisting of physical, medical, psychological, rehabilitative, social, recreational, and spiritual services. The only such facility in North Dakota, it is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified.

North Dakota has promoted a regional interagency structure to deal with the complexities in the delivery of services for youth with serious emotional disturbances. This consists of an interagency service team comprised of the parents and family and representative of special education, social services, the Department of Human Services, and the Division of Juvenile Services. This helps to ensure that all available resources are brought to the table when developing a service plan for families.

2. State Plan on Mental Health

Through the collaborative efforts of the Department, the Planning Council, consumers and family members, private providers, consumer advocate groups, tribal representatives, and many other mental health stakeholders, the community-based mental health delivery system continues to grow and thrive. Some of the plans for the upcoming year include:

- Consensus building, training, and/or pilot programs concerning evidence-based practices
- Continuation of the Children's Mental Health System of Care
- Continuation of the project to implement education targeted to the community-based mental health clinicians concerning aging and mental health issues.
- Continuation of the Mental Health Consumer and Family Network

NORTH DAKOTA PUBLIC MENTAL HEALTH CARE DELIVERY SYSTEM

Program and Policy

Located within Program and Policy is the Division of Mental Health & Substance Abuse Services

Includes functions in the planning, development and implementation of the community-based mental health care delivery system including; planning and research, grant writing, licensing of Psychiatric Residential Treatment Facilities and education.

8 Regional Human Service Centers

Serves individuals and families in the community through a linked spectrum of services including; crisis stabilization and resolution; inpatient services; psychiatric/medical management; social services; residential services and supports; vocational and educational services and supportive employment and social and leisure activities.

North Dakota State Hospital

Provides total care to individuals with mental illness and/or substance abuse issues consisting of physical, medical, psychological, rehabilitative, social, recreational, and spiritual services. The only such facility in North Dakota, it is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified.

State Review Team

The state review team is a problem solving, creative options think tank that addresses not only individual cases but also explores systemic issues. It is not a forum to resolve disputes or appeal system decisions or replace local team responsibilities.

The agencies represented on the State Review Team are: Division of Juvenile Services, Adult Corrections, Department of Public Instruction/Special Education, Children & Family Services Division-DHS, Medical Services-DHS, Mental Health and Substance Abuse Services-DHS, Developmental Disabilities/Vocational Rehabilitation-DHS, Aging Services Division – DHS, Institutions – State Hospital and Developmental Center and the Regional Human Service Centers.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that North Dakota agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

---

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
Carol K. Olson, Executive Director

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
   (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Carol K. Olson, Executive Director
APPLICANT ORGANIZATION North Dakota Department of Human Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: ☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	**2. Status of Federal Action** ☐ a. bid/offer/application b. initial award c. post-award	**3. Report Type:** ☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:** **Congressional District,** *if known:*	
6. Federal Department/Agency:	**7. Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____	
8. Federal Action Number, *if known:*	**9. Award Amount,** *if known:* **$**	
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Carol K. Olson, Executive Director
APPLICANT ORGANIZATION North Dakota Department of Human Services	DATE SUBMITTED

SF-424B (Rev. 7-97) Back

North Dakota

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

PUBLIC COMMENTS ON THE STATE PLAN

The Division of Mental Health & Substance Abuse Services accepts public comments on the proposed activities described in the Community Mental Health Services Block Grant Application through the following initiatives:

- Copies of the application are made available to members of the North Dakota Mental Health Planning Council for their review and comments. The Council provides feedback about the application to the Division during their July quarterly meeting.
- The draft application is placed on the Department's website. The website can be accessed at http://www.nd.gov/humanservices/.
- A press release is drafted by the Department's Public Information Officer announcing release of the draft application for comments.
- A public notice is submitted to the 53 official county newspapers in North Dakota announcing the availability of the draft application for review and comment. The public can either view the document online through BGAS or receive a hardcopy from the Division. The public is encouraged to attend the Planning Council meeting to provide verbal comments or mail comments directly to the Division.

No comments from the general public were received for this application.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
$561,619	$762,702	$1,118,651

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
$12,998,486	**$14,063,017**	**$16,172,507**

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Anderson, Maggie	State Employees	Medicaid	600 E Boulevard Ave, Dept. 325 Bismarck,ND 58505 PH:701-328-1603 FAX:701-328-1544	manderson@nd.gov
Anderson, Michael	State Employees	Housing	1500 East Capitol Avenue PO Box 1535 Bismarck,ND 58502-1535 PH:701-328-8050 FAX:701-328-8090	maanders@ndhfa.org
Barnes, Vincen	Others(not state employees or providers)		10 North River Road Fort Yates,ND 58538 PH:701-854-8276 FAX:	Vincen.barnes@ihs.gov
Brown, Richard	Others(not state employees or providers)	General Public	5418 11th St. S. Fargo,ND 58104-6452 PH: FAX:	brown.richard.1.n@att.net
Fischer, Tom	Others(not state employees or providers)	ND Legislature	1524 Sundance Square, South Fargo,ND 58104 PH:701-235-8396 FAX:	tfischer@nd.gov
			200 2nd	30gerk@nd.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Gerhardt, Ken	State Employees	Social Services	Avenue NW Mandan,ND 58554 PH:701-667-3395 FAX:701-667-3384	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Haugen-Hoffart, Sheri	Others(not state employees or providers)		9200 33rd Street, SE Bismarck,ND 58504 PH:701-224-5403 FAX:	sherihaugenhoffart@mail.und.nodak.edu
Helgeland, Susan	Others(not state employees or providers)	Mental Health America of North Dakota	PO Box 4106 Bismarck,ND 58502-4106 PH:701-255-3692 FAX:	mharrv@juno.com
Highum, Sara	Consumers/Survivors/Ex-patients(C/S/X)		812 Tenth Street, NW Minot,ND 58703 PH:701-839-8335 FAX:	shighum@srt.com
Hoekstra, Rick	State Employees	Criminal Justice	PO Box 5521 Bismarck,ND 58506-5521 PH:701-328-6699 FAX:701-328-6186	rhoekstr@nd.gov
Hoesel, JoAnne	State Employees	Mental Health	1237 W. Divide Avenue Suite 1C Bismarck,ND 58501 PH:701-328-8924 FAX:701-328-8969	jhoesel@nd.gov
Jendro, Deb	Consumers/Survivors/Ex-patients(C/S/X)		2709 Elm Street Fargo,ND 58102 PH:701-235-9923 FAX:701-	dcbjfederation@i29.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
			235-9923	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Johnson, Debra	Family Members of adults with SMI		930 N. 3rd Street Grand Forks,ND 58203 PH:701-795-9143 FAX:701-795-5560	djohnsonphf@yahoo.com
Kleven, Diane M.	Family Members of Children with SED		1043 2nd Street W. West Fargo,ND 58078 PH:701-282-4853 FAX:	datachsr51@far.midco.net
Larsen, Tereasa	Others(not state employees or providers)	Protection and Advocacy Project	400 E. Broadway Suite 409 Bismarck,ND 58501 PH:701-328-2950 FAX:701-328-3934	tlarsen@nd.gov
McCleary, Carlotta	Others(not state employees or providers)	ND Federation of Families for Children's Mental Health	PO Box 3061 Bismarck,ND 58502 PH:701-222-3310 FAX:701-222-3310	carlottamccleary@bis.midco.net
McKenzie, Nancy	State Employees	Vocational Rehabilitation	1237 W. Divide Avenue Suite 1A Bismarck,ND 58501 PH:701-328-4060 FAX:701-	nmckenzie@nd.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
			328-8969	
McMahon, Sheri	Family Members of Children with SED		717 Seventh Avenue North Fargo,ND 58102 PH:701-293-6511 FAX:	dfmcmahon1@msn.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Olsen, Drinda	State Employees	Education	600 E Boulevard Ave, Bismarck,ND 58505-0440 PH:701-328-2269 FAX:701-328-7880	dolsen@nd.gov
Quick, Karen	State Employees	Social Services	316 2nd Ave. W. Box 1266 Williston,ND 58802 PH:701-774-4685 FAX:701-774-4620	kquick@nd.gov
Quintain, Cathy	Family Members of Children with SED		1358 Sims Street Dickinson,ND 58601 PH: FAX:	
Rauschenberger, Laurie	Family Members of adults with SMI		609 East Capitol Avenue Bismarck,ND 58501 PH: FAX:	
Sevart, Becky	Family Members of Children with SED		Bismarck,ND PH:701-258-1628 FAX:701-258-1628	bmsevart@hotmail.com
Solem, Randy	Consumers/Survivors/Ex-patients(C/S/X)		655 1st Street East Dickinson,ND 58601 PH:701-483-0264 FAX:	irving@pop.ctctel.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Zimmerman, Minerva	Others(not state employees or providers)	NAMI SWND	9289 Highway 10 Taylor,ND 58656 PH:701-974-3336 FAX:	

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	25	
Consumers/Survivors/Ex-patients(C/S/X)	3	
Family Members of Children with SED	4	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	2	
Others(not state employees or providers)	8	
TOTAL C/S/X, Family Members and Others	17	68.00%
State Employees	8	
Providers	0	
Vacancies	0	
TOTAL State Employees and Providers	8	32.00%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

The Council has submitted to the Governor's Office the names of a family member of a child with SED and an adult consumer and are awaiting the Governor's appointment. This will bring the Council to the full membership of 27 and increase the total ratio of C/S/X, Family Members and Others to 70%,

North Dakota

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

Under the mandate outlined in Public Law 102-321 (42 U.S.C 300X-4), a twenty-seven member board -- the North Dakota Mental Health Planning Council -- was created with members appointed by the Governor of North Dakota. The Council's objective is to receive federal funds designated for mental health services and to monitor, review, and evaluate the allocation and adequacy of mental health services in the state. Each board member is appointed to a three-year term and at least 51% of the board is composed of individuals other than state employees and providers of mental health services. Recently the Council engaged in strategic planning, using the New Freedom Commission's goals as guidance.

NORTH DAKOTA MENTAL HEALTH PLANNING COUNCIL

BYLAWS

ARTICLE I: NAME

The name of the council shall be the North Dakota Mental Health Planning Council.

ARTICLE II AUTHORITY

Public Law 102-321

ARTICLE III PURPOSE

To provide advice and consultation to the Governor of the State of North Dakota regarding the overall administration and service delivery of mental health services.

ARTICLE IV: MEMBERSHIP

Section 1: The North Dakota Mental Health Planning Council shall consist of twenty-seven (27) members, who shall be appointed by the Governor. Members of the council shall be represented in the following manner:

Residents of the State, including representatives of the principle State agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; public and private entities concerned with the need,

planning, operation, funding, and use of mental health services and related support services; adults with serious mental illnesses who are receiving (or have received) mental health services; and the families of such adults or families of children with emotional disturbances.

The ratio of parents of children with a serious emotional disturbance to other members of the Council shall be sufficient to provide adequate representation of such children in the deliberations of the Council; and not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 2: Duties

1. Review and evaluate services and programs provided by the State of North Dakota and make periodic reports to the Department of Human Services and the Governor's office, including any recommendations for improvements in services, programs, or facilities.

2. Review the status of the mental health block grant, staff resources, expenditure of funds and available case management information at least semi-annually. Review the State Plan on Mental Health at least annually.

3. Work with legislators in members' respective regions to familiarize lawmakers with the need for appropriate mental health issues.

4. Recommend the initiation of surveys of regional human service needs and review the results of such surveys for the purpose of recommending to the Department of Human Services ways in which identified needs can be met by the Department of Human Services.

5. Serve as the State forum for meetings with governing boards of other public and private human service agencies that are brought to the council by the Department of Human Services for the purpose of promoting greater understanding, efficiency and effectiveness in the working relationships among local and regional service providers.

6. Review the progress in the development and monitoring of the goals and objectives of the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services, Mental Health Unit.

7. Promote clear lines of communication between the Department of Human Services, the Governor's office, and the Mental Health Planning Council.

8. Review and recommend policies and procedures of the Department of Human Services to the Department of Human Services and Governor.

9. Review the various certifications and licensing standards and assist in evaluating the Department of Human Services compliance.

10. Serve as an advocate for adults with serious mental illnesses, children with severe emotional disturbances, and other individuals with mental illnesses or emotional problems.

Section 3. Terms of council members and vacancies

The term of offices shall be three (3) years. Vacancies occurring on the Council for other than an expiration of a term shall be filled by an appointment from the Governor. The term of each council member shall commence on July 1 of a given year and terminate on June 30 three years thereafter, with the exception that an appointment to fill a vacancy shall be only for the unexpired term. Members may be reappointed by the Governor. Terms shall be staggered. There will be no term limits.

Section 4: Absences

If a council member has two (2) consecutive absences in any one (1) year, the Chairperson will report to the Governor for recommendations as to the continuance of the individual to be a member of the North Dakota Mental Health Planning Council.

Section 5: Compensation

Members of the Council shall be compensated for per diem and travel, at the rate of state employees, for Council and committee meetings as approved by the Chairperson. Members of the Council who are consumers or family members shall be provided an honorarium of $100.00 for Council meetings as approved by the Chairperson and shall be reimbursed for childcare expenses.

Section 6: Meetings

The Council shall have at least two (2) meetings in any one (1) year. The exact day, time, and place shall be set by the Chairperson in consultation with the liaison staff at the Division of Mental Health and Substance Abuse Services. Special meetings may be called by the Chairperson of the Council or upon request of the majority of the Council. Written notice of a Council meeting, whether regular or special, must be mailed to all Council Members and other appropriate State departments and agencies at least

thirty (30) days before the meeting date. The annual meeting of the council shall be held during the month of October each year, the exact date, time, and place to be set by the Chairperson, for the purpose of electing the Council Chair, reading of annual reports, and transacting such other business as may come before the Council. Notice to the public of all meetings will be made one (1) month prior to the scheduled meeting time. Special meetings may be held via teleconference or video conference.

Section 7: Quorum

A simple majority of the duly appointed members of the Council shall constitute a quorum for the transaction of business.

Meetings for discussion and reporting may be held without a quorum present, at the discretion of the Council Chairperson. A vote may follow via telephone, mail, or e-mail so long as a detailed description of the matter at issue is provided to all Council members prior to voting.

Section 8: Alternates; Abstention

There shall be no proxies for meetings of the Council. However, state employees and members of advocacy organizations who are designated as members by virtue of their office or advocacy organization representation may appoint a designated alternate to attend meetings in their stead, and such alternate may cast a vote. No Council member may abstain in any matter not involving a conflict of interest for that member, and all non-voting members who do not declare a conflict shall be counted as affirmative votes.

Section 9: Parliamentary Authority

Robert's Rules of Order Newly Revised shall be the parliamentary authority for all matters of procedure not specifically covered by the Bylaws of the North Dakota Mental Health Planning Council.

ARTICLE V: OFFICERS

Section 1: Number

The officers of the Council shall be Chairperson, Vice-Chairperson, each of whom shall be selected by the Council from its own membership. The Chairperson shall serve no more than two (2) consecutive one (1) year terms. No two (2) offices may be held by the same person concurrently. The Secretary of the Division of Mental Health and Substance Abuse Services, Mental Health Unit, shall take minutes and submit to the Vice-Chairperson for approval before submitting to the full Council membership for approval.

Section 2: Election and term of office

The officers of the Council shall be elected annually at the annual meeting. If the election of officers is not held at that meeting, the election shall be held as soon thereafter as is convenient. Each officer shall hold office until his/her successor has been duly elected and qualified, or until his/her death, resignation, or removal as hereafter provided.

Section 3: Removal

Any officer or agent elected or appointed by the Council may be removed by the Governor of the State of North Dakota whenever, in his/her judgement, the best interests of the Council would be served thereby.

Section 4: Vacancies

A vacancy in office, because of death, resignation, removal, disqualification, or otherwise, shall be filled by the Governor for the unexpired portion of the term.

Section 5: Powers and terms

The powers and duties of the officers shall be as provided from time to time by resolution or other directive of the Council. The Chairperson shall serve as advisor to the Department of Human Services and the Governor and will represent the North Dakota Mental Health Planning Council as requested by the members. The Vice-Chairperson shall take over position of Chairperson in the event of an absence. Chairperson's duties shall include chairing the meetings, and preparing the agenda for the meetings.

ARTICLE VI: COMMITTEES

Section 1: Executive Committee: Shall be made up of not more than five (5) members which must include the Chairperson, Vice Chairperson, immediate past Chairperson, a consumer of mental health services, and a member at large. This committee shall be charged with reviewing the bylaws and making recommendations to the Council. This committee has the authority to act on behalf of the Council during interim periods.

Section 2: Committees shall be appointed by the Chairperson as the Council deems necessary to carry on its work. The Chairperson shall be an ex-officio member of all other committees.

ARTICLE VII: These bylaws may be amended at any meeting of the Council, provided that thirty (30) days written notice of such meetings be given to all members of the Council and that the notice contain the text of any suggested amendments.

Goal	Action Steps	Responsible Party	Due	Date Completed
GOAL ONE: North Dakotans understand that mental health is essential to overall health	1. The Council will develop a protocol to be used to challenge situations when they arise. 2. The Council will recommend avenues for public education. 3. Identify Council members interested in performing public speaking concerning mental health topics.	1. Goal Committee 2. Goal Committee 3. Goal Committee	1. January 2005 meeting of the North Dakota Mental Health Planning Council 2. January 2005 meeting of the North Dakota Mental Health Planning Council 3. Following October 2004 meeting of the North Dakota Mental Health Planning Council	1-05 1-05 10-04
Committee Members: Randy Solem, Diane Kleven, Drinda Olsen, Ken Gerhardt, Carlotta McCleary (Chair)				
GOAL TWO: Mental healthcare is consumer and family driven.	1. Draft white paper or position statement. 2. Receive report from Division.	1. Goal Committee 2. Goal Committee	1. October 2005 meeting of the North Dakota Mental Health Planning Council 2. Ongoing	4-06
Committee Members : Randy Solem, Teresa Larsen, Diane Kleven, Deb Johnson, Carlotta McCleary				
GOAL THREE: Disparities in mental health services are eliminated.	1. Invite representative of Blue Cross/Blue Shield to meet with the Council to discuss current mandates and the need for parity of coverage for mental health 2. Form a task force of Council members and Blue Cross staff to determine possible legislation or policy change to address insurance coverage gaps 3. The Council will review the New York model of	1. Goal Committee 2. Goal Committee 3. Goal Committee	1. January 2005 meeting of the North Dakota Mental Health Planning Council 2. January 2008 meeting of the North Dakota Mental Health Planning Council 3. October 2006	1-05 4-05

	prevention/early intervention 4. Dr. Dwelle, NDDOH and Mary Wakefield will be invited to help identify federal initiatives and successful models of recruitment and retention of mental health professionals 5. Invite speaker to present to the Council on "Info.org" related to transportation issues 6. Council will review transportation surveys to determine barriers to and needs of consumers/ families regarding transportation. 7. The Council will communicate the results of the survey to the DHS Executive Office, Governor, and Legislative leadership	4. Goal Committee 5. Goal Committee 6. Goal Committee 7. Goal Committee	4. January 2008 5. April 2005 6. October 2009 7. January 2009	4-05
Committee Members: Michael Anderson, Minnerva Zimmerman, Drinda Olson, Ken Gerhardt, Carlotta McCleary, JoAnne Hoesel (Chair)				
GOAL FOUR: Early mental health screening, assessment, and referral to services are common practice	1. Draft white paper or position statement. 2. Receive report from Division.	1. Goal Committee 2. Goal Committee	1. October 2005 meeting of the North Dakota Mental Health Planning Council 2. Ongoing	8-05
Committee Members: Michael Anderson, Minnerva Zimmerman, Rick Hoestra, Diane Kleven, Vincent Barnes, Ken Gerhardt,, Carlotta McCleary, Becky Sevart, Tim Sauter (Chair)				

GOAL FIVE: Excellent mental health care is delivered and research is accelerated	1. Draft white paper or position statement. 2. Receive report from Division.	1. Goal Committee 2. Goal Committee	1. October 2005 meeting of the North Dakota Mental Health Planning Council 2. Ongoing	7-06
Committee Members: Maggie Anderson, Rick Hoekstra, Karen Quick, Deb Johnson (Chair)				
GOAL SIX: Technology used to access mental health care and information	1. Council education on HIPAA 2. Council education on FERPA 3. Draft white paper or position statement to identify needs and associated costs 4. Draft white paper or position statement concerning better utilization of services already available.	1. Goal Committee 2. Goal Committee 3. Goal Committee 4. Goal Committee	1. April 2006 2. April 2008 3. January 2008 4. January 2008	4-06
Committee Members: Maggie Anderson, Rick Hoekstra, Karen Quick (Chair)				

Consumer And Family Driven Mental Health Care

A White Paper by the North Dakota Mental Health Planning Council

April 21, 2006

Preface

A mental health planning and advisory council exists in every State and U.S. Territory as a result of federal law first enacted in 1986. The law requires States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds. Stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership on the council.

States are required to submit yearly applications to receive federal block grant funds. The Mental Health Block Grant program is administered by the Center for Mental Health Services (CMHS), which is an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of block grant planning, in general, is to support the State creation and expansion of comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance. The goal of the Mental Health Block Grant program is to help individuals with serious mental illnesses lead independent and productive lives. The block grant program has served as an impetus in promoting and encouraging States to reduce the number of people receiving care in State psychiatric hospitals and to develop community-based systems of care.

In North Dakota, this group is called the Mental Health Planning Council (The Council). The Council consists of 27 members who are appointed by the Governor along with two ex officio members. Membership includes: representatives of the principle State agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services; adults with serious mental illnesses who are receiving (or have received) mental health services (consumers); and the families of such adults or families of children with emotional disturbances.

A diverse membership brings vast strengths and varying perspectives to The Council. There is a shared knowledge of individual and general consumer situations, Medicaid, service delivery systems, reimbursement issues, housing and community development, legal issues, and community resources. Points of

view are presented from consumers of mental health services, family members, advocates, referral sources, schools, institutional and community-based service providers, the general disability community, and the criminal justice system. A majority of the membership has direct experience with issues concerning recovery, peer mentoring, service delivery, children's issues, and/or advocacy for mental health.

Introduction

The Council's current strategic plan is based on a federal report published in July 2003. Titled *Achieving the Promise: Transforming Mental Health Care in America*, the publication was written by the President's New Freedom Commission on Mental Health. The Commission was charged with studying the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

The Commission's study resulted in six goals: 1) Americans understand that mental health is essential to overall health; 2) mental health care is consumer and family driven; 3) disparities in mental health services are eliminated; 4) early mental health screening, assessment, and referral to services are common practice; 5) excellent mental health care is delivered and research is accelerated; 6) technology is used to access mental health care and information.

Goal two of the Commission's report, also a goal of The Council's strategic plan, is that mental health care is consumer and family driven. The Council decided to write a white paper on this topic in order to provide its perspective on the existing service delivery system, related problems and concerns, as well as to offer solutions for policymakers and other stakeholders.

Perspectives on North Dakota's System for Mental Health Care

The "mental health care system" is a collective term referring to an array of programs for adults with mental illnesses and children with emotional disturbance. These programs are embedded in the Department of Human Services, schools, the juvenile and criminal justice systems, agencies that serve the homeless, disability services, and many others. They are in the public and the private sectors. Programs may provide treatment, services, and other supports directly or they may purchase these on behalf of the individual and/or family.

The mental health delivery system in North Dakota has a number of strengths. The state is relatively small in population and its provider population is small as well. North Dakota's mental health professionals know one another; they are collegial and supportive. People care about each other and want to help. Still, North Dakota is large geographically and needed services are not readily

available in some areas. There are children who are sent out of state, or hundreds of miles away within the state, to receive services.

The Department of Human Services provides mental health services directly through the eight regional human service centers and the North Dakota State Hospital. The regional human service centers serve consumers in the community through an array of services including: crisis stabilization and resolution; inpatient services; psychiatric/medical management; partial care/day treatment; social services; residential services and supports; vocational and educational services and supported employment; and social and leisure activities. The North Dakota State Hospital provides care to individuals with mental illness and/or substance abuse issues consisting of physical, medical, psychological, rehabilitative, social, recreational, and spiritual services.

The human service centers are licensed by the Department of Human Services. Administrative code mandates that the licensing team include a consumer or family member. Current licensing teams include both a consumer of mental health services and a family member of a consumer. The Council sees this as positive.

State rules prescribe standards for care plans for adults with serious mental illnesses who are served by a human service center (N.D.A.C. 75-05-04-03). The rules require that each individual have a plan, the overall development and implementation of which “are the responsibility of the professional staff member assigned the client”. A plan “must contain the client’s name, problems, service strategies to resolve problems, goals, names of staff members responsible for service strategies, and the signature of the case manager”. “The professional staff member assigned the client shall review the individual plan with the client and shall document the review in the client’s record”. For “clinical services, the case manager and the case manager’s supervisor shall review individual plans at least every six months, except for chronic cases, which must be reviewed at least every twelve months”. (N.D.A.C. 75-05-04-05)

Anecdotal conversations with consumers of mental health services reveal that many adults with a serious mental illness: 1) are NOT involved in the development of their plan of care; 2) have NOT seen their plan; 3) are NOT aware that they have a plan. In contrast, many adults with a serious mental illness have more than one plan, one through a residential provider and one developed by a case manager, which were not developed in concert with each other or with the participation (or even knowledge of) the consumer.

With changes to State law in the 2005 Legislative Session, it is now feasible for consumers to develop advanced directives for mental health care. Previously advanced directives were intended more generally for medical or physical care. Advanced directives allow individuals to make their own choices about treatment or care in advance of the need, when they are still capable of doing so.

As documented in North Dakota's Block Grant application, the wraparound process, which uses a strength-based approach to service delivery, is a method used that has "shown to improve the functioning of children who have complex needs. The process is used to help communities develop individualized plans of care. Working with the family, formal and natural supports (the child and family team) are wrapped around the family to provide them with the services/supports required to meet their needs. The wraparound process includes a set of core elements: 1) individualized plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting."

The Council believes that families involved in the *Partnerships Program for Children's Mental Health* have opportunities to collaborate on service plan development in conjunction with case management and service providers – it is a family driven process. It is not clear however, that families with children who receive case management but who are *not* in Partnerships have an opportunity for involvement in plan development. Many of these children have more than one plan, one through the school (an Individualized Education Plan or IEP) and one developed by or with a case manager, which were not developed in concert with each other.

As stated in the Block Grant application, the Division of Mental Health and Substance Abuse Services meets quarterly with each Human Service Center's program staff to plan and implement community-based mental health services statewide. It is further noted that the Human Service Centers regularly meet with regional stakeholders in addition to region-specific planning meetings that are held in every region throughout the year.[1] Discussion amongst consumers and family members indicate that there needs to be more focus on increasing the involvement of more consumers and family members in such activities.

Each of the eight human service centers provides for the operation of a psychosocial rehabilitation center that serves individuals with mental illnesses. The centers provide a minimum of forty hours of programming, including evening and weekend activities, seven days a week. Consumers who participate in center activities report that the programs are supportive, inclusive, and recovery-oriented. There are no such centers in the more rural communities.

The Council believes that the mental health consumer network in North Dakota needs strengthening. Over the years, the effectiveness and productivity of the consumer movement has fluctuated for a variety of reasons. A consistent, adequate funding source is needed to sustain its leadership and viability.

---

[1] ND FFY 2006 CMHS MH Block Grant Application

A Consumer and Family Driven Mental Health Care System

> *Consumers of mental health services must stand at the **center** of the system of care. Consumers' needs must drive the care and services that are provided.*
>
> *Achieving the Promise: Transforming Mental Health Care in America*

The Council believes that a consumer and family driven mental health care system, with their involvement in planning, decision-making, implementation and review at all levels, will result in greater positive outcomes for individuals with mental illnesses and children with emotional disturbance. There will be a stronger "buy-in" by those who use the services as well as a higher rate of satisfaction with the services. More partnerships and collaboration will ensue, facilitating more meaningful communication and a higher level of trust between consumers and providers. The result is a better chance, for adult and child consumers, of recovery and resiliency.

In a consumer and family driven system, individuals' and families' needs drive the policies and service delivery system. Choice leads to greater participation and higher consumer satisfaction with services.

In *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health states that providers should develop customized plans in full partnership with consumers and families of children. "The plans should form the basis for care that is both consumer-centered and coordinated across different programs and agencies."

> *Nothing about us without us…*
>
> Family member of The Council

The plan of care should not only describe the services and supports needed to achieve recovery, but the funding for the plan should follow the individual as identified in the plan. This takes a flexible funding mechanism. An example may be a young adult receiving inpatient acute care who, then for a short time, lives in a basic care facility. The consumer and his team develop a goal for independent living with community services and supports.

Recommendations

The following areas have been identified as current priorities under The Council's goal for mental health care to be consumer and family driven, along with a series of recommendations:

1. <u>Human service center licensure</u>
   a. Involvement of consumers <u>and</u> families on human service center licensure review teams should be mandated through State rules.

2. Individualized plans of care for adults with a serious mental illness
   a. State rules should recognize the consumer's right to participate in the development of the individual's plan of care, directly and through his/her legal decision-maker.
   b. After consulting consumers and their families, the Department should establish a protocol for development and implementation of single plans of care for adults receiving services from more than one provider.
   c. After consulting consumers and their families, the Department should develop standards for individual plan development, content, implementation and review that include consumer involvement at all levels.
   d. The Department should educate consumers and their families, including those on the Mental Health Planning Council, on the process for plan development, service options and the mental health delivery system generally.
   e. The Department should educate consumers on advanced directives and support them in the development of such plans.

3. Individualized plans of care for children with a serious emotional disturbance
   a. State rules should provide for the right of all families to participate in the development of the child's plan of care.
   b. With family input, the Department should establish a protocol for development and implementation of single plans of care for children receiving services from more than one provider.
   c. With family input, the Department should establish standards for plan development, content, implementation and review.

4. Involvement of consumers and families in orienting the mental health system toward recovery
   a. The Division and the Human Service Centers should broaden their approach, through psychosocial rehabilitation centers, service providers and the human service centers themselves, to informing consumers and families about stakeholder meetings and encourage their participation.
   b. The Council should hold periodic forums throughout the State with consumers and families to receive input on the mental health care service system.

5. Mental health services
   a. The Council should collaborate with the Department of Human Services regarding the viability of mental health services and, if the need warrants, potential expansion of support services into more rural communities in the State.

6. Mental health consumer network
   a. The Council's forums (recommendation 4.b.) should include discussion with consumers about their vision for a mental health consumer network (self advocacy movement) in North Dakota.

North Dakota Mental Health Planning Council Members

JoAnne Hoesel	Mental Health	DHS, Division of MH and SA
Yvonne Smith	Vocational Rehabilitation	DHS, Disability Services Division
Ken Sorenson	Criminal Justice	Attorney's Genera's Office
Drinda Olsen	Education	Dept. of Public Instruction
VACANT	Housing	Div. of Community Services
Ken Gerhardt	Social Services	Morton County Social Services
Maggie Anderson	Medicaid	DHS, Medical Services Division
Cheryl Kulas	Minority	Indian Affairs Commission
Karen Quick	Aging Services	DHS, Aging Services Division
Susan Helgeland	Advocate	Mental Health Association in ND
Teresa Larsen	Advocate	Protection & Advocacy Project
Carlotta McCleary	Advocate	Federation of Families
Minerva Zimmerman	Advocate	Dickinson Alliance for the Mentally Ill
Jennifer Bitz	Consumer	
Petra Clemens	Consumer	
Debra Sederquest	Consumer	
Randy Solem	Consumer	
Debra Johnson	Family Member	
Diane M. Kleven	Family Member	
Becky Sevart	Family Member	
Sheri McMahon	Family Member	
Cathy Quintaine	Family Member	
Sen. Richard Brown	Legislator	
Carl Rodlund	General Public	
VACANT	General Public	

Non-voting, ex officio members

Alex Schweitzer	Institutions	DHS, State Hospital/Developmental Cntr
Marilyn Rudolph	Human Service Centers	DHS, NWHSC

Staff

Lauren J. Sauer	Administrator Adult MH	DHS, Division of MH/SA
Carla Kessel	Administrator Children's MH	DHS, Division of MH/SA
Mariah Tenamoc	MH Services Researcher	DHS, Division of MH/SA

Consumer and Family Driven Mental Health Care

- The Mental Health Planning Council's (The Council) current strategic plan is based on the federal report, *Achieving the Promise: Transforming Mental Health Care in America,* published in July 2003. This publication was written by the President's New Freedom Commission on Mental Health (The Commission).

- The Commission was appointed to study the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

- Goal two of The Commission's report, also a goal of The Council's strategic plan, is "Mental Health is Care is Consumer and Family Driven."

What is consumer and family driven mental health care?

- The needs of individuals and families drive the policies and service delivery system.
- *Consumers of mental health services must stand at the* ***center*** *of the system of care.*

Why do we need consumer and family driven mental health care?

- Increase awareness and involvement in the development of the plan of care for adults with serious mental illness, and families with children who receive case management services.
    - Anecdotal conversations regarding the plan of care reveal:
        - Individuals or families may not be involved in the development of their plan.
        - Many may not be aware of a plan or may not have seen it.
        - More than one plan may be developed. Potentially, the plans were not developed in concert with each

other or with the participation or knowledge of the consumer.
    - Children also have a plan developed through the school, an Individualized Education Plan, more commonly known as an IEP.

- Increase the focus to include the participation of consumers and family members in quarterly meetings between the Division of Mental Health and Substance Abuse Services and the Human Service Center's program staff when they meet to plan and improve community-based mental health services statewide.
- Place psychosocial rehabilitation centers that serve individuals with mental illness, which are operated by each of the eight human service centers, in outlying communities.
- Strengthen the mental health consumer network in North Dakota. Over the years, effectiveness and productivity of the consumer movement fluctuated for a variety of reasons.
    - A consistent, adequate funding source is needed to sustain its leadership and viability.
- Increase consumer and family involvement in the mental health care system, with planning, decision-making, and implementation. Review at all levels will result in increased functioning for individuals with mental illnesses and children with emotional disturbances.
    - There will be a stronger "buy-in" by those who use the services as well as a higher rate of satisfaction with the services.
    - More partnerships and collaboration will occur, facilitating more meaningful communication and a higher level of trust between consumers and providers,
    - The result of consumer involvement is a better chance of recovery and resiliency.
- Give consumers and families a choice, which will lead to greater participation and higher consumer satisfaction with services.

What can be done to increase consumer and family driven mental health care?

- Partner with consumers and family members at all levels of planning, evaluation, and policymaking.
- Consumers and family members, along with service providers, can actively participate in designing and developing the systems of care in which they are involved.
- Integrate service plans by ensuring that a single plan of care addresses all needed services regardless of funding streams and providers.
- Policy makers, consumers, and families lead the mental health system to a recovery approach.

North Dakota Mental Health Planning Council
Mr. Lauren Sauer
Division of Mental Health & Substance Abuse Services
1237 W. Divide Avenue, Suite 1C
Bismarck, ND 58501-1208
Tel: 701-328-8920

Early Mental Health Screening, Assessment, and Referral to Services are Common Practice

A White Paper by the North Dakota Mental Health Planning Council

October 20, 2006

Preface

A mental health planning and advisory council exists in every State and U.S. Territory as a result of federal law first enacted in 1986. The law requires States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds. Stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership on the council.

States are required to submit yearly applications to receive federal block grant funds. The Mental Health Block Grant program is administered by the Center for Mental Health Services (CMHS), which is an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of block grant planning, in general, is to support the State creation and expansion of comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance. The goal of the Mental Health Block Grant program is to help individuals with serious mental illnesses lead independent and productive lives. The block grant program has served as an impetus in promoting and encouraging States to reduce the number of people receiving care in State psychiatric hospitals and to develop community-based systems of care.

In North Dakota, this group is called the Mental Health Planning Council (The Council). The Council consists of 27 members who are appointed by the Governor along with two ex officio members. Membership includes: representatives of the principle State agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services; adults with serious mental illnesses who are receiving (or have received) mental health services (consumers); and the families of such adults or families of children with emotional disturbances.

A diverse membership brings vast strengths and varying perspectives to The Council. There is a shared knowledge of individual and general consumer situations, Medicaid, service delivery systems, reimbursement issues, housing and community development, legal issues, and community resources. Points of

view are presented from consumers of mental health services, family members, advocates, referral sources, schools, institutional and community-based service providers, the general disability community, and the criminal justice system. A majority of the membership has direct experience with issues concerning recovery, peer mentoring, service delivery, children's issues, and/or advocacy for mental health.

Introduction

The Council's current strategic plan is based on a federal report published in July 2003. Titled *Achieving the Promise: Transforming Mental Health Care in America*, the publication was written by the President's New Freedom Commission on Mental Health. The Commission was charged with studying the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

The Commission's study resulted in six goals: 1) Americans understand that mental health is essential to overall health; 2) mental health care is consumer and family driven; 3) disparities in mental health services are eliminated; 4) early mental health screening, assessment, and referral to services are common practice; 5) excellent mental health care is delivered and research is accelerated; 6) technology is used to access mental health care and information.

Goal four of the Commission's report, also a goal of The Council's strategic plan, is that "Early mental health screening, assessment and referral to services are common practice". The Council decided to write a white paper on this topic in order to provide its perspective on the existing service delivery system, related problems and concerns, as well as to offer solutions for policymakers and other stakeholders.

Perspectives on North Dakota's System for Mental Health Care

"Addressing the emotional and behavioral needs of children and youth is a shared responsibility between public agencies, private providers, and families. While the mission of families is generally consistent across families, it is generally not consistent across public and private agencies/providers, even when the bottom line is the emotional and behavioral health and well being of children and youth. The varying missions tend to produce different terms and meanings, eligibility criteria and procedures, and program focus. Given the growing complexity of needs and the realization that these needs cannot be met by any one group in isolation from others, it is imperative that providers and families begin to build a shared understanding and common language". (Source: Draft of the Emotional Disorders Guidance Manual- Introduction Section)

Definition of Mental Health Screening- Screening is a relatively brief process designed to identify children and adolescents who are at risk of having disorders that warrant immediate attention, intervention or more comprehensive review. Identifying the need for further assessment is the primary purpose of screening. Mental health screening instruments are never used to diagnose a child, but instead, to inform parents and those working with families of concerns needing further assessment.

The Health Care System is a primary gateway for identification, screening, referral and access to services for young children- Thus, access to health care and the practices of pediatricians are extremely important elements in determining whether a child receives services. It is indicated that nearly 2/3 of all mental health problems are undetected by primary care physicians. It was pointed out there is a need for further research regarding screening and identification and to include preschoolers who have been nearly omitted from previous research.

The American Academy of Pediatrics has developed a policy on Developmental Surveillance and Screening of Infants and Young Children. Virtually all preschool children could be contacted by screening and identification practices contained in the health care system. However, fewer than 1/3 of the eligible children receive a full Early Periodic Screening and Diagnostic Testing (Health Tracks) screen and even fewer a screen that includes behavioral health.

This policy discusses the role of pediatricians in the early identification of developmental delays and referral of families to services. The statement notes that under the Individuals with Disabilities Education Act (IDEA), physicians are required to refer children with suspected developmental delays in a timely manner to the local early intervention system. The policy cites a definition of developmental surveillance as " a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children during the provision of health care. The components include; eliciting and attending to parental concerns, obtaining a relevant developmental history and making accurate and informative observations of children and sharing opinions and concerns with other relevant professionals" (p. 192). American Academy of Pediatrics Committee on Children with Disabilities (2001). Developmental Surveillance and Screening of Infants and Young Children (RE0062). *Pediatrics, 108*, 10, 192-196.

Head Start Performance Standards (ACF, 2002b)- Provides directives that encompass developmental and behavioral screening and the provision of disability and mental health services to children in Head Start and Early Head Start. The Child Health and Developmental Services sections of the Performance Standards cover screening, follow-up and treatment. Screening standards specify that within 45 days of enrollment, a screening must be obtained or performed "to identify concerns regarding a child's developmental, sensory

(visual and auditory), behavior, language, social, cognitive, perceptual and emotional skills. The screening must be linguistically and age appropriate, sensitive to the child's cultural background and must "utilize multiple sources of information on all aspect of each child's development and behavior, including input from family members, teachers and other relevant staff who are familiar with the child's typical behavior".

Performance Standard sections addressing mental health services specify that programs must secure the services of mental health professionals to ensure timely and effective intervention in mental health concerns. Mental health consultants should act as liaisons between community agencies and the program, and should act as advocates for the child and family. For children with identified disabilities, mental health consultants are to assist parents and staff in accessing community agencies and ensure that the Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) is properly implemented.

Early Identification for at risk-behaviors-Early identification for screening means the ability to identify at risk behaviors or symptoms that a child exhibits. At risk means an observable change in how a child or youth thinks, feels and acts. It is used to indicate those whose behavior appears outside of the expected norm for same-aged peers and may signal the possibility that more severe problems could develop over time if left unattended. When considering factors that might signal at risk concerns, current research- based knowledge suggests that biological, social, psychological and environmental factors are all important considerations.

In their book, *Antisocial Behavior in School: Strategies and Best Practices* (1995, Brooks/Cole Publishing Company), Walker, Colvin, and Ramsey provide a set of guidelines for screening and identification of antisocial behavior patterns. **Even though they provide this specifically in discussion about antisocial behavior, the guidelines apply to all screening for any mental health issues.**

Guidelines for Screening and Identification of Antisocial Behavior Patterns

- A *proactive* rather than a *reactive* process should be used to screen and identify students at risk for antisocial behavior.
- Whenever possible, a multi-agent (teacher, parent, observer) and multi-setting (classroom, playground, home setting) screening-identification approach should be used in order to gain the broadest possible perspective on the dimensions of the target student's at-risk status.
- At-risk students should be screened and identified as early as possible in their school careers—ideally at the preschool and kindergarten levels.
- Teacher nominations and rankings or ratings should be used in the early stages of screening and supplemented later in the process, if possible, by direct observations, school records, peer or parent ratings, and other sources as appropriate.

Walker, H.M, Colvin, G., & Ramsey, E. (1995)

Prevention is key for a youth's mental wellness that includes upfront efforts and activities that increase and promote healthy development in children and youth. Ideally, a continuum that includes prevention, early intervention, and systems of care would be found in all schools and programs and services thus ensuring the use of the least restrictive interventions needed.

Definition of a Mental Health Diagnostic Assessment- Is a more comprehensive, expensive, time consuming examination of the psychosocial needs and problems identified during the initial mental health screening. Assessments identify the type and extent of mental health disorders and make recommendations for treatment interventions. Assessments routinely include individualized data collection, often including psychological testing, clinical interviewing and reviewing of past records. Assessments typically require the expertise of a mental health professional to conduct the assessment and develop a comprehensive report. The purpose of a diagnostic assessment is to define the child or adolescent's concerns and use the information to develop a comprehensive treatment plan.

The Children and Family Services Division of the ND Department of Human Services contracts with Child Care Resource and Referral. They have a very sophisticated training division with all of their training researched based and approved through a higher education process. The Higher Education Training Approval Board is made up of college professors from the private and public colleges and universities in the state. Child Care Resource and Referral recognizes the need for a collaborative effort to coordinate with the mental health system regarding mental wellness in child care. The child care providers have been asking for training on how to care for children with mental health issues, as it is not unusual for children to be removed from child care settings due to behavioral issues. It would be desirable for child care providers to be present at Individual Education Plan (IEP) meetings since the children are in their care for most of the day and would be able to contribute to the discussion regarding behaviors and mental wellness.

Early mental health screening, assessment and referral to services are common practice

The Early Child Care, Educators, Mental Health, Juvenile Justice and Child Welfare work force must be able to provide collaborative, comprehensive, individualized, evidence-based services and systems or to be able to identify and refer children to such services and systems. The work force must be skilled in evidence-based promotion, prevention and intervention strategies with families.

Current services and efforts for mental health screenings, assessments and referrals for children and youth in North Dakota by such work forces are as follows;

1. Right Track-Ages: birth to 3 years of age. Provide developmental screenings, information on child growth and development, childhood concerns; sleep, nutrition, and managing behaviors, and referrals to local, state and national organizations
2. Birth Review check box- completed at the hospital on the birth certificate, if the family checks the box that they would like further information on child development they are referred to the human service center-developmental disabilities unit (Right Track)
3. Health Tracks- Pediatric Symptom Checklist 0-21 years of age for medical assistance recipients
4. Early Head Start and Head Start- Ages: birth to 5 years of age- Child Health and Developmental Screenings, which includes screening, assessment and referrals for Health; Dental, Mental Health, Cognitive, and Nutritional needs
5. Child Welfare- Ages and Stages Questionnaire Ages: 4 months to 60 months and the Pediatric Symptom Checklist Ages: 0 to 21 years of age
6. Juvenile Justice- Massachusetts Youth Screening Instrument (MAYSI-2) Ages: 12-17 years of age
7. Juvenile Courts- Youth Assessment Screening Assessment (YASI)
8. Emotional Disturbance Guidance Task Force- Development of an Emotional Disturbance Guidance Manual/Document for families and providers in the educational system. This document was developed to provide guidance to the system of care that supports children and youth birth to 21 years of age, with or at risk of developing emotional or mental health disorders and their families. More specifically, the intent behind the document is to:
   - Increase understanding of requirements and practices among system partners that will lead to greater continuity and move closer to a true comprehensive system of care.
   - Clarify various laws, regulations, or policies, especially where they impact eligibility decisions.
   - Strive for greater consistency in practice among school districts.
   - Provide information about best practice and tools for intervention and support.
9. Development of Early Learning Guidelines (Voluntary) is aligned with kindergarten standards for Ages birth to 5 years of age- part of Federal initiative No Child Left Behind and will address the social/emotional domain areas of childhood development. The stakeholders include Child Care Resource and Referral, Head Start, Early Head Start, Pre-school Special Education, Related Services; Physical Therapy, Speech Therapy and Occupational Therapy and Developmental Disabilities. The Guidelines are to be completed in June 2006 with implementation to follow.
10. Mental Health Screening Tool Kit Training- August 30, 2005 for Child Welfare, Mental Health, Juvenile Justice, Developmental Disabilities, Head Start, Private Providers and Tribal work force.

11. Training at the UND School of Medicine has a ½ time position for Early Childhood, training and looking at multidisciplinary approach and practice to screening, assessment and referral for mental health/wellness.
12. Child Abuse Prevention and Treatment Act (CAPTA)- Federal Law requiring Child Protection Services case managers of the Child Welfare system to make a referral to the Human Service Center for services required findings of abuse and/or neglect for children 0-3 years of age for screening. This is not a mandated service for families, it is voluntary, however, Wraparound Case Management allows the worker to explore the emotional/behavioral life domain for any risks, needs, strengths of the children and family and develop a plan to address those identified needs.
13. System of Care (Wraparound Case Management in mental health, juvenile justice, child welfare and education). Comprehensive community systems of care have emerged as a way to address the needs of community members in the community setting rather than in institutions or confined settings. Systems of care bring together a variety of community participants in an effort to extend resources and provide services designed to the needs of the child/youth and the family. These systems of care build on the community resources and include public and private resources as well as business and social units. These principles include:

Principle 1: A team centered approach to decision making with the child and family team;
Principle 2: Services recognize that the family is the primary support system for the child and participates as a full partner;
Principle 3: Services are delivered in the child's home community drawing on formal and natural supports;

Principle 4: Services are planned in collaboration with all child-service systems involved in the child's life;
Principle 5: Services are culturally competent;
Principle 6: Services take place in the least restrictive and least intrusive environment;
Principle 7: Services are delivered in a strengths-based approach with concentration on the strengths of the child, family, and community.

Tools used in the mental health system (System of Care) include: Child and Adolescent Functional Assessment Scale: (CAFAS): Ages 6 to 17 years of age. The Child & Adolescent Functional Assessment Scale (CAFAS) is a rating scale, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.

Preschool and Early Childhood Functional Assessment Scale: (PECFAS): The Preschool and Early Childhood Functional Assessment Scale Ages 4 to 7 years of age or preschool through second grade. It is used to assess a child's functional impairment.

The "system of care" exists at varying degrees of development and implementation in ND communities. As communities, and specifically as agencies serving children and youth work together to better understand

the issues and needs of children with emotional disturbance, the system of care will undoubtedly improve and develop more fully.

14. Positive Behavioral Supports (PBS)- Used in school settings as an intervention approach and can be seen as a powerful strategy for preventing and resolving challenging behaviors of young children.
15. Healthy North Dakota Early Childhood Alliance- To unify and strengthen North Dakota's early childhood system that promotes positive development and improved health for all children through a collaborative effort among many stakeholders from across the state.

The following needs have been identified for the mental wellness of families and youth in North Dakota

1. Limited resources for completion of assessments
2. Access to psychological and psychiatric services in a timely manner
3. Training opportunities for private, public, child serving agencies; Clergy, YMCA, Boys and Girls clubs, medical field, volunteers; Big Sister and Big Brother, child care providers
4. Training opportunities for families and youth
5. Advocacy and support to families and youth
6. Access to information and dissemination of information from Federal Entities; SAMHSA, MHA, Federation of Families
7. Insurance coverage for mental health services; CHIPS, Healthy Steps (SCHIPS)

Recommendations

1. Continue current services and efforts for mental health screenings, assessments, and referrals for children and youth in North Dakota as reflected in the white paper.
2. Disseminate the MHSA Fact Sheets on various topics regarding Mental Health and Substance Abuse.
3. Children's Screening Coordinating Committee is an avenue for dissemination of information regarding the mental health screening, assessment, intervention and referral process to meet the needs of children.
4. Provide education and training opportunities for pediatricians and family doctors.
5. Continue to raise awareness of the Healthy Families/Right Tracks programs, which promote early childhood programming prevention, screening, intervention, assessment and referrals.
6. Work with student health centers, clinics, and doctors at the University level to provide information about self-screenings and referral options.
7. May is Mental Health month. The first week of the month is Children's Mental Health week; work with the Federation of Families Green Ribbon

campaign to help raise awareness about early childhood mental health screening, assessment, and referral options.

8. Continue working with the Tribal Prevention Coordinators, knowing that the needs are great in rural ND and also on the Reservations.

North Dakota Mental Health Planning Council Members

JoAnne Hoesel	Mental Health	DHS, Division of MH and SA
Yvonne Smith	Vocational Rehabilitation	DHS, Disability Services Division
Ken Sorenson	Criminal Justice	Attorney's Genera's Office
Drinda Olsen	Education	Dept. of Public Instruction
VACANT	Housing	Div. of Community Services
Ken Gerhardt	Social Services	Morton County Social Services
Maggie Anderson	Medicaid	DHS, Medical Services Division
Cheryl Kulas	Minority	Indian Affairs Commission
Karen Quick	Aging Services	DHS, Aging Services Division
Susan Helgeland	Advocate	Mental Health Association in ND
Teresa Larsen	Advocate	Protection & Advocacy Project
Carlotta McCleary	Advocate	Federation of Families
Minerva Zimmerman	Advocate	Dickinson Alliance for the Mentally Ill
Jennifer Bitz	Consumer	
Petra Clemens	Consumer	
Debra Sederquest	Consumer	
Randy Solem	Consumer	
Debra Johnson	Family Member	
Diane M. Kleven	Family Member	
Becky Sevart	Family Member	
Sheri McMahon	Family Member	
Cathy Quintaine	Family Member	
Sen. Richard Brown	Legislator	
Carl Rodlund	General Public	
VACANT	General Public	

Non-voting, ex officio members

Alex Schweitzer	Institutions	DHS, State Hospital/Developmental Cntr
Marilyn Rudolph	Human Service Centers	DHS, NWHSC

Staff

Lauren J. Sauer	Administrator Adult MH	DHS, Division of MH/SA
Carla Kessel	Administrator Children's MH	DHS, Division of MH/SA
Mariah Tenamoc	MH Services Researcher	DHS, Division of MH/SA

Early Mental Health Screening, Assessment, and Referral

- The Mental Health Planning Council's (The Council) current strategic plan is based on the federal report, *Achieving the Promise: Transforming Mental Health Care in America,* published in July 2003. This publication was written by the President's New Freedom Commission on Mental Health (The Commission).

- The Commission was appointed to study the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

- Goal four of The Commission's report, also a goal of The Council's strategic plan, is "Early Mental Health Screening, Assessment, and Referral to Services are Common Practice."

What is early mental health screening, assessment, and referral?

- Screening is a relatively brief process designed to identify children and adolescents who are at risk of having disorders that warrant immediate attention, intervention or a more comprehensive review.

- Assessments are a more comprehensive, expensive, time-consuming examination of the psychosocial needs and problems identified during the initial mental health screening. Assessments identify the type and extent of mental health disorders and provide information for making recommendations for treatment interventions.

- Assessments typically require the expertise of a mental health professional to conduct the assessment and develop a comprehensive report. The purpose of a diagnostic assessment is to define the child or adolescent's concerns and use the information to develop a comprehensive treatment plan.

- Referrals are a process in which a parent, professional or other concerned party involved in the life of the child, adolescent or family will make to community resources for treatment interventions to address the identified diagnostic concerns resulting from the comprehensive assessment.

Why do we need early mental health screening, assessment, and referral?

- Children develop rapidly. Early delivery of mental health services and support early avoids life long consequences and can prevent mental health problems from worsening.
- 157,703 persons in ND are under the age of 18, as reported by Kids Count 2005.
    - 5,697 are diagnosed with a Serious Emotional Disturbance[1]
    - 2,779 are in need of services[2]
    - 1,538 received services in through the Human Service Centers in FY 2006[3]
- Serious Emotional Disturbance affects 1 in every 10 young people at any given time.
- Studies show that at least one in five children and adolescents have a mental health disorder.
- Nearly 2/3 of all mental health problems are undetected by primary care physicians.
- A comprehensive screening and referral plan increases the likelihood of early intervention and avoiding life long problems.

What can be done to increase early mental health screening, assessment, and referral?

- Help spread the word about the need for expanded early mental health screening, assessment, and referral services.
- Support funding and practice of screening, assessment, and referral in early childhood and child care programs.
- Help recognize and encourage the use of early mental health screening, assessment, and referral and treat it as a common practice throughout the life of a child.

[1] Estimation based on 4.1% of total State Population under age 18 as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)
[2] Estimation based on 2% of total State Population under age 18 as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)
[3] From ROAP children and adolescents with Pop Code 22

North Dakota Mental Health Planning Council
Mr. Lauren Sauer
Division of Mental Health & Substance Abuse Services
1237 W. Divide Avenue, Suite 1C
Bismarck, ND 58501-1208
Tel: 701-328-8920

Excellent Mental Health Care is Delivered and Research is Accelerated

A White Paper by the
North Dakota Mental Health Planning Council

October 20, 2006

Preface

A mental health planning and advisory council exists in every State and U.S. Territory as a result of federal law first enacted in 1986. The law requires States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds. Stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership on the council.

States are required to submit yearly applications to receive federal block grant funds. The Mental Health Block Grant program is administered by the Center for Mental Health Services (CMHS), which is an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of block grant planning, in general, is to support the State creation and expansion of comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance. The goal of the Mental Health Block Grant program is to help individuals with serious mental illnesses lead independent and productive lives. The block grant program has served as an impetus in promoting and encouraging States to reduce the number of people receiving care in State psychiatric hospitals and to develop community-based systems of care.

In North Dakota, this group is called the Mental Health Planning Council (The Council). The Council consists of 27 members who are appointed by the Governor along with two ex officio members. Membership includes: representatives of the principle State agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services; adults with serious mental illnesses who are receiving (or have received) mental health services (consumers); and the families of such adults or families of children with emotional disturbances.

A diverse membership brings vast strengths and varying perspectives to The Council. There is a shared knowledge of individual and general consumer situations, Medicaid, service delivery systems, reimbursement issues, housing and community development, legal issues, and community resources. Points of

view are presented from consumers of mental health services, family members, advocates, referral sources, schools, institutional and community-based service providers, the general disability community, and the criminal justice system. A majority of the membership has direct experience with issues concerning recovery, peer mentoring, service delivery, children's issues, and/or advocacy for mental health.

Introduction

The Council's current strategic plan is based on a federal report published in July 2003. Titled *Achieving the Promise: Transforming Mental Health Care in America*, the publication was written by the President's New Freedom Commission on Mental Health. The Commission was charged with studying the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

The Commission's study resulted in six goals: 1) Americans understand that mental health is essential to overall health; 2) mental health care is consumer and family driven; 3) disparities in mental health services are eliminated; 4) early mental health screening, assessment, and referral to services are common practice; 5) excellent mental health care is delivered and research is accelerated; 6) technology is used to access mental health care and information.

Goal five of the Commission's report, also a goal of The Council's strategic plan, is that excellent mental health care is delivered and research is accelerated. The Council decided to write a white paper on this topic in order to provide its perspective on the existing service delivery system, related problems and concerns, as well as to offer solutions for policymakers and other stakeholders.

Perspectives on North Dakota's System for Mental Health Care

The "mental health care system" is a collective term referring to an array of programs for adults with mental illnesses and children with emotional disturbance. These programs are embedded in the Department of Human Services, schools, the juvenile and criminal justice systems, agencies that serve the homeless, disability services, and many others. They are in the public and the private sectors. Programs may provide treatment, services, and other supports directly or they may purchase these on behalf of the individual and/or family.

The mental health delivery system in North Dakota has a number of strengths. The state is relatively small in population and its provider population is small as well. North Dakota's mental health professionals know one another; they are collegial and supportive. People care about each other and want to help. Still, North Dakota is large geographically and needed services are not readily

available in some areas. There are children who are sent out of state, or hundreds of miles away within the state, to receive services.

The Department of Human Services provides mental health services directly through the eight regional human service centers and the North Dakota State Hospital. The regional human service centers serve consumers in the community through an array of services including: crisis stabilization and resolution; inpatient services; psychiatric/medical management; partial care/day treatment; social services; residential services and supports; vocational and educational services and supported employment; and social and leisure activities.

The North Dakota State Hospital provides care to individuals with mental illness and/or substance abuse issues consisting of physical, medical, psychological, rehabilitative, social, recreational, and spiritual services.

As stated in the Block Grant application, the Division of Mental Health and Substance Abuse Services meets quarterly with each Human Service Center's program staff to plan and implement community-based mental health services statewide. It is further noted that the Human Service Centers regularly meet with regional stakeholders in addition to region-specific planning meetings that are held in every region throughout the year.[2] Discussion amongst consumers and family members indicate that there needs to be more focus on increasing the involvement of more consumers and family members in such activities.

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. North Dakota has embraced this movement and sent a team of eight, who received train-the-trainer education from the Recovery Institute on mental health recovery. This team consisted of staff members from two human service centers, the North Dakota State Hospital, and one consumer. Trainers will provide education to all case managers in North Dakota, direct care staff at the state hospital, and consumers throughout the state.

Each of the eight human service centers provides for the operation of a psychosocial rehabilitation center that serves individuals with mental illnesses. The centers provide a minimum of forty hours of programming, including evening and weekend activities, seven days a week. Consumers who participate in center activities report that the programs are supportive, inclusive, and recovery-oriented. There are no such centers in the more rural communities.

---

[2] ND FFY 2006 CMHS MH Block Grant Application

The Council believes that the mental health consumer network in North Dakota needs strengthening. Over the years, the effectiveness and productivity of the consumer movement has fluctuated for a variety of reasons. A consistent, adequate funding source is needed to sustain its leadership and viability.

As stated in the 2007 Community Mental Health Services Block Grant application, "The mission of the North Dakota Department of Human Services is to provide quality, efficient and effective human services that improve the lives of people." We have also adopted our Federal partner's vision of "A life in the community for everyone."

North Dakota understands that it faces several challenges that result in services not keeping pace with the demand. The Division of Mental Health and Substance Abuse Services envisions a service system of the future where consumers have greater access to services, have more services to choose from and receive increased effectiveness of those services. Through continued work with our partners, the implementation of new evidence-based and best practices, and continued evaluation and refinement of the system of care, North Dakota will transform the mental health system to ensure a life in the community for everyone. The Division is planning to implement SAMHSA's model of Supported Employment at West Central Human Service Center. The Division will continue to work with the regional human services centers and Vocational Rehabilitation to enhance when possible employment services for consumers statewide.

In May of 2006, a team from Southeast Human Service Center traveled to Ohio to receive training from the Ohio Substance Abuse/Mental Illness Coordinating Center of Excellence concerning implementation of Integrated Dual Disorders Treatment. With the assistance of SAMI, the Southeast Human Service Center team has rapidly prepared for the program with the official kickoff for the project occurring tomorrow. An evaluation component has been built into this pilot project. With favorable outcomes, IDDT will be rolled out to other human service centers.

The Council is supportive of this direction and looks forward to improved services for consumers and their families. To properly implement this and other evidence-based, best practices, and promising practices the mental health system of care will need adequate funding so that the quality of mental health services is excellent for all citizens of North Dakota.

Excellent Mental Health Care is Delivered and Research is Accelerated

The Council believes that in order to deliver excellent mental health care that is effective and useful the length of time for research to reach the field must be expedited. Members of the President's New Freedom Commission called for aggressive steps to publicize evidence-based practices, train providers to use them, and make them available to those who could benefit from them. The

Commission also encouraged the use of emerging best practices, which are promising but have less thorough documentation of their efficacy.

Currently, SAMHSA recognizes six strategies as evidence-based: supported employment, integrated treatment for co-occurring disorders, Assertive Community Treatment (ACT), illness management and recovery, medication management, and family psychoeducation.

The Council believes that when research that supports service delivery is based on old data, the outcomes are not useful in making timely decisions. They support evidence-based practices that are evaluated and that promote recovery. Some states are moving to integrate requirements for evidence-based practices into their arrangements with providers. The Council believes moving toward legislatively-mandated evidence-based practices would not be in the best interest of a consumer- and family-driven system where individualized planning is vital to recovery.

In order for excellent mental health care to be delivered methods should be reviewed and changed if they are not effective. Other methods such as promising and best practices should be looked at as well. In a small state such as North Dakota some of programs that are developed in large metropolitan areas do not fit the needs of our citizens.

Lack of adequate funding puts pressure on providers to look at better ways of providing services. The Council believes that providers need to get better at coordinating services so there is continuity of care. Services should be provided in a seamless manner throughout an individual's life. The entire system must be consumer-driven and family friendly. Communication is key to success of a mental health system. The Council emphasized the importance of maximizing natural supports (where appropriate) in service delivery that gives strength to the family and consumer driven philosophy that is inherent throughout the systems. In order for consumers and family members to be involved in their plan of care shared knowledge and provision of training must be incorporated.

Goal Statement

The following areas have been identified as current priorities under The Council's Goal, "Excellent Mental Health Care is Delivered and Research is Accelerated."

1. <u>How the North Dakota Mental Health Care System is Currently Delivered and How it Supports the Acceleration of Research.</u>

   a. The mental health system is often times driven by the funding available rather than by need. Data collection is driven by where the funding comes from and is responsive to mandated information leading to policies and laws that affect practice and implementation. The data available in North

Dakota is fragmented and does not capture the entire mental health system (a challenge exists capturing private provider information.)

b. Mental health service delivery is concentrated in urban areas while rural communities lack adequate supports due in part to a shortage of professionals and resources.
c. Evidence-based and research-based emerging practices need to be expanded and outcomes utilized to evaluate effectiveness.

2. Strengths of the North Dakota Mental Health Delivery System and Strengths of an Accelerated Research Effort.

a. The North Dakota mental health delivery system has experienced a number of positive steps. Specifically, the wrap-around process has been viewed as a strength for the children's system of care. Others mentioned include the medical assistance program accessed through drug companies; increased funding for services; a marked improvement in the collaboration of divisions; increased housing options; in-service trainings for professionals, family members and consumers; psychosocial centers that promote peer support and caring professionals who deliver quality services.
b. An accelerated research effort identifies needs of the individuals utilizing the mental health system that in turn drives funding mechanisms for improved services. This research ensures that individual needs are met sooner. In North Dakota it is recognized that research shows that early intervention reduces long-term debilitation.

3. What the North Dakota Mental Health System Needs to Accomplish Excellent Mental Health Care and Accelerate Research.

a. Adequate funding for service delivery enhancements is needed in North Dakota.
b. Independent life skills training, such as occupational therapy, is needed on site for consumers of all ages and needs.
c. Supportive service enhancements for times when the individual is not seeing a professional.
d. Transportation, especially evenings and weekends and for recreational/leisure activities.
e. Decreased caseloads for professionals so that individual goals can be developed and evaluated.
f. Greater communication with families.
g. Well-trained staff that can identify changes in client behavior and utilize earlier interventions.
h. Public education.
i. Dissemination of information (public education).
j. A holistic approach in service delivery so that overall health, including mental health is promoted.

Recommendations

The following areas have been identified by the North Dakota Mental Health Planning Council as desired results.

1. Planning Council Effectiveness
   a. The Planning Council can utilize the information to perform the mandated duties to monitor, review and evaluate the adequacies of mental health services in the state. Talking points summaries should be developed so the Council members are communicating in a unified voice. This is essential when advocating for systems changes with policy makers.
   b. The Planning Council can also utilize the information from the Consumer Satisfaction Surveys, which are completed on an annual basis by the 8 regional human service centers.

2. Communication Tool
   a. The white paper should be included in an annual report to the Governor outlining activities and priorities of the Council.
   b. Legislators should receive copies of the report so they can make informed decisions on policy changes. (i.e. Policy makers should be aware of caseload standards, a review of the compensation package for state professionals and how that impacts the shortages of those positions in the state.)

The following resources are needed to promote those results indicated in the previous section.

1. Communication Plan (Public Relations)
   a. The report should be utilized to ensure excellent mental health care is delivered and research is accelerated.

2. Mental Health Planning Council Staff Support
   b. An administrative support person is needed to assist the Council with administrative duties to enable them to carry out their duties effectively. A Planning Council quarterly budget report is requested so that members can provide feedback into expenditures. It is further recommended that the Planning Council develop a website similar to the Department of Public Instruction that links it to the Department of Human Services.

3. Planning Council Training
   a. Planning Council members requested technical assistance from NAMHPAC in specific areas of planning council structure and increasing member participation.

North Dakota Mental Health Planning Council Members

JoAnne Hoesel	Mental Health	DHS, Division of MH and SA
Yvonne Smith	Vocational Rehabilitation	DHS, Disability Services Division
Ken Sorenson	Criminal Justice	Attorney's Genera's Office
Drinda Olsen	Education	Dept. of Public Instruction
VACANT	Housing	Div. of Community Services
Ken Gerhardt	Social Services	Morton County Social Services
Maggie Anderson	Medicaid	DHS, Medical Services Division
Cheryl Kulas	Minority	Indian Affairs Commission
Karen Quick	Aging Services	DHS, Aging Services Division
Susan Helgeland	Advocate	Mental Health Association in ND
Teresa Larsen	Advocate	Protection & Advocacy Project
Carlotta McCleary	Advocate	Federation of Families
Minerva Zimmerman	Advocate	Dickinson Alliance for the Mentally Ill
Jennifer Bitz	Consumer	
Petra Clemens	Consumer	
Debra Sederquest	Consumer	
Randy Solem	Consumer	
Debra Johnson	Family Member	
Diane M. Kleven	Family Member	
Becky Sevart	Family Member	
Sheri McMahon	Family Member	
Cathy Quintaine	Family Member	
Sen. Richard Brown	Legislator	
Carl Rodlund	General Public	
VACANT	General Public	

Non-voting, ex officio members

Alex Schweitzer	Institutions	DHS, State Hospital/Developmental Cntr
Marilyn Rudolph	Human Service Centers	DHS, NWHSC

Staff

Lauren J. Sauer	Administrator Adult MH	DHS, Division of MH/SA
Carla Kessel	Administrator Children's MH	DHS, Division of MH/SA
Mariah Tenamoc	MH Services Researcher	DHS, Division of MH/SA

Excellent Mental Health Care is Delivered and Research is Accelerated

- The Mental Health Planning Council's (The Council) current strategic plan is based on the federal report, *Achieving the Promise: Transforming Mental Health Care in America,* published in July 2003. This publication was written by the President's New Freedom Commission on Mental Health (The Commission).

- The Commission was appointed to study the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

- Goal five of The Commission's report, also a goal of The Council's strategic plan, is "Excellent Mental Health Care is Delivered and Research is Accelerated."

What is excellent mental health care?

- Consumer and Family Driven

- Focused on Wellness and Recovery

- Accessible and Community Based

- Includes Early Mental Health Screening, Assessment, and Referral

How is research accelerated?

- Ongoing evaluation and assessment of:
  - Best Practices - treatment practices that work
  - Emerging Promising Practices - treatment practices, which are promising in effectiveness -

- Communication of data and outcomes of best practices and treatment interventions.

- Timely communication with universities to expedite knowledge transfer.

- Balance data collection practices, because it is strongly driven by reporting and funding requirements, which in turn set policies and laws that affect practice and implementation.

What can be done to accomplish excellent mental health care and accelerate research?

- Improve funding levels for better service delivery and increased research.

- Increase home and community based services for all ages.

- Increase mental health service delivery to the rural areas.

- Provide opportunities for more Psychosocial Centers and Peer Monitoring.

- Provide services that promote wellness in mind, body, and spirit.

- Expand the use of evidence based and research based emerging practices, with continued evaluation of effectiveness.

- Expand knowledge of how best practices are best adopted to rural settings.

- Recruit and retain well-trained professionals.

- Increase jargon free communication and involvement of the consumer and their selected support systems, such as families or friends.

- Increase public education and dissemination of information.

North Dakota Mental Health Planning Council
Mr. Lauren Sauer
Division of Mental Health & Substance Abuse Services
1237 W. Divide Avenue, Suite 1C
Bismarck, ND 58501-1208
Tel: 701-328-8920

North Dakota

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

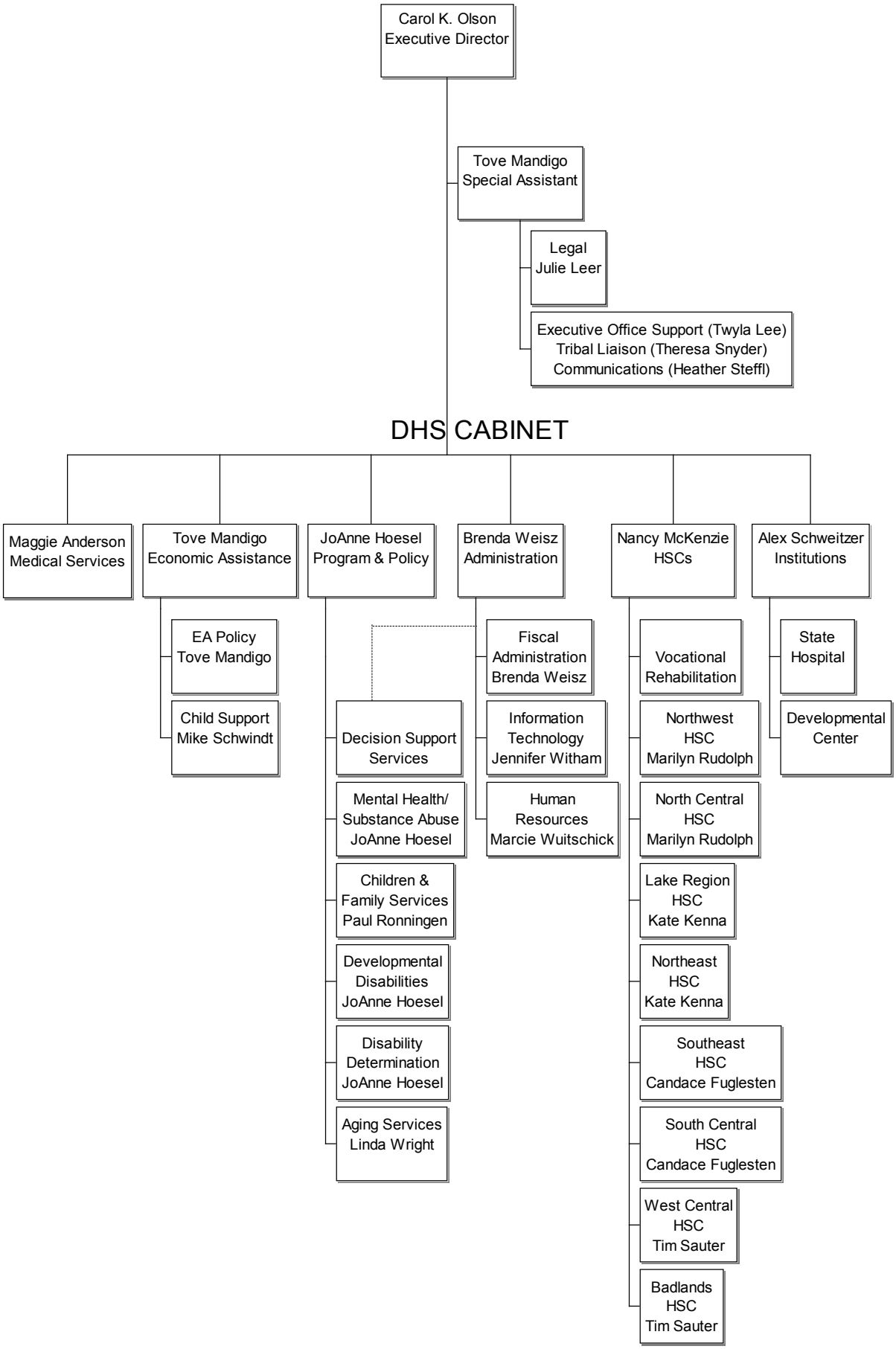
OVERVIEW OF NORTH DAKOTA'S PUBLIC MENTAL HEALTH SYSTEM

The Department of Human Services is the State governmental administrative agency that provides services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. The Department administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. It is an umbrella agency headed by an executive director appointed by the Governor. Comprised of over 2,000 employees, the Department of Human Services has six major organizational components overseen by the DHS Cabinet:

- Medical Services: Coordinates policy and operations of the Medicaid program in North Dakota.
- Economic Assistance: Directs policy for economic assistance programs and oversees policy and operations for Child Support Enforcement.
- Program and Policy: Coordinates administrative programs for the elderly, children and families, substance abuse, disability services, and mental health.
- Human Service Centers: Administers, supervises, and provides a wide range of public human services through the eight regional human service centers
- Institutions: Coordinates administration of the North Dakota State Hospital and the Developmental Center.
- Fiscal: Oversees all fiscal administrative functions for the Department.

Delivering human services involves a partnership between the Department, counties, tribes, and service providers. The Department receives and distributes funds furnished by the North Dakota Legislature and Congress. Funds may be sent directly to providers or to people whom the counties determine qualify for programs and benefits. The Department provides direction and technical assistance, sets standards, conducts training, and manages the computerized eligibility system.

The Division of Mental Health and Substance Abuse Services is a part of the Program and Policy component of the Department of Human Services. Its specific functions are detailed later in the application. The Division functions as the State Mental Health Authority. It works closely with other public agencies (such as the Department of Public Instruction, the Department of Health, and the Department of Corrections and Rehabilitation) as well as a myriad of private and not-for-profit human service agencies to ensure quality and effective mental health services are provided throughout the state.


Carol K. Olson
Executive Director
Tove Mandigo
Special Assistant
Legal
Julie Leer
Executive Office Support (Twyla Lee)
Tribal Liaison (Theresa Snyder)
Communications (Heather Steffl)
DHS CABINET
Maggie Anderson
Medical Services
Tove Mandigo
Economic Assistance
JoAnne Hoesel
Program & Policy
Brenda Weisz
Administration
Nancy McKenzie
HSCs
Alex Schweitzer
Institutions
EA Policy
Tove Mandigo
Child Support
Mike Schwindt
Decision Support
Services
Mental Health/
Substance Abuse
JoAnne Hoesel
Children &
Family Services
Paul Ronningen
Developmental
Disabilities
JoAnne Hoesel
Disability
Determination
JoAnne Hoesel
Aging Services
Linda Wright
Fiscal
Administration
Brenda Weisz
Information
Technology
Jennifer Witham
Human
Resources
Marcie Wuitschick
Vocational
Rehabilitation
Northwest
HSC
Marilyn Rudolph
North Central
HSC
Marilyn Rudolph
Lake Region
HSC
Kate Kenna
Northeast
HSC
Kate Kenna
Southeast
HSC
Candace Fuglesten
South Central
HSC
Candace Fuglesten
West Central
HSC
Tim Sauter
Badlands
HSC
Tim Sauter
State
Hospital
Developmental
Center

North Dakota

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Guidance received from CMHS that this section has been moved to the Implementation Report and does not need to be completed at this time.

North Dakota

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

NEW DEVELOPMENTS AND ISSUES – ADULTS

Guardianship Services: During the 2005 Legislative Session, SB 2028 provided for a guardianship services system for vulnerable adults who are ineligible for developmental disabilities case management services. Forty thousand dollars was appropriated for this system. The Division of Aging Services within the Department of Human Services was tasked with overseeing the implementation of the guardianship services system. Because of the limited funding ($40,000) and the need for such services from this target population, it was planned that twelve adults diagnosed with a serious mental illness would receive guardianship services through this program. A Request for Proposal was drafted for this program and training was conducted for attorneys, judges, and human service center case managers concerning guardianships for vulnerable adults. Unfortunately, there were no responses to the Request For Proposal.

To meet the legislative mandate, it was decided that the North Dakota Department of Human Services would pay for adult emergency or full guardianship establishment fees. This includes the attorney's fee, filing fee, and other fees connected with establishing the guardianships. There is no ongoing daily rate of pay. The target population for the program was individuals diagnosed with a serious mental illness, persons with Traumatic Brain Injury or persons over the age of 60. The work with the attorney, families, and proposed guardian is the responsibility of the regional human service centers. The cost for establishing the guardianship cannot exceed $2,500.

This program will be continued through the 2007-2009 biennium.

In addition, the Governor's Commission on the Olmstead Decision was created in August 2001. The commission's mission is to evaluate the state's service system in relation to the *Olmstead* decision and to recommend action that ensures compliance with the *Olmstead* decision. The commission includes legislators, executive branch officials, consumer representatives, advocacy groups and public representatives. Recently a subcommittee of the Commission was formed to meet the Commission's goal to "Educate legislators of the need for guardianship services." The Subcommittee met for the first time on August 13, 2008 and included representative from the Aging Services Division, Protection and Advocacy, the Division of Mental Health and Substance Abuse Services, Catholic Family Charities, the Veteran's Administration, AARP, an attorney in private practice, and two guardians. The group will continue to meet through the summer and fall in preparation of the legislative session, which starts in January, to develop educational formats to reach the Legislative Assembly and other system stakeholders on the need for guardianship services statewide.

Aging 2020 Project: In order to meet the growing needs for housing, transportation, medical services, financial services, and employment/retirement, a comprehensive look at the service needs is required. The Aging 2020 project -- through literature reviews, field research, and analysis of stakeholder comments and other data already collected and available -- will assess the aging needs in North Dakota to tell the story of the aging in our state through 2020 and beyond. The areas addressed in the Aging 2020 project are mental health, substance abuse, medical services, housing, transportation and public safety, workforce and economic development including civic engagement and volunteerism, recreation and social opportunities, education, and emergency preparedness within the North Dakota Department of Human Services. The Department of Human Services provides many services that impact the aging population of North Dakota. These are core areas affecting adults as they age and potentially

become more dependent on the community around them. For this reason, the project will focus, at least initially, on the persons that use the services of the NDDHS with a focus on mental health services, developmental disabilities services, economic assistance programs, and/or Medicaid services within each core area.

North Dakota

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

LEGISLATIVE INITIATIVES AND CHANGES - ADULTS

- During the 2007 Legislative Session, HB 1422 extended the exemption of psychotropic medications from Medicaid preauthorization. Section 3 of the bill reads:

  > Except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert or AB-rated generic equivalent drug for which the cost to the state post-rebate is less than the brand name drugs, in the aggregate, the department may not prior authorize or otherwise restrict single-source or brand name antipsychotic, antidepressant, or other medications used to treat mental illnesses, such as schizophrenia, depression, or bipolar disorder, and drugs prescribed for the treatment of:
  > a. Acquired immune deficiency syndrome or human immunodeficiency virus; and
  > b. Cancer.

  This provision will be reviewed during the 2009 Legislative Session.

- The 60th Legislative Assembly in 2007 recommended that the Legislative Council study the feasibility and desirability of establishing a transition to independence program for young adults with mental illness and report its findings and recommendations, together with any legislation required to implement the recommendations, to the Sixty-first Legislative Assembly, which convenes in January of 2009. This bill was chosen for study and assigned to the Long-Term Care Committee. A collaborative effort among the systems has occurred to provide testimony and information to the committee and both the Administrator of Adult Mental Health Services and the Administrator of Children's Mental Health Services testified.

Please refer to additional information in Child – Establishment of System of Care and Child – Legislative Initiatives and Changes.

North Dakota

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

DESCRIPTION OF REGIONAL RESOURCES - ADULT

Please refer to Available Services – Adults for a full description of the regional resources available to adults.

North Dakota

Adult - Description of State Agency's Leadership

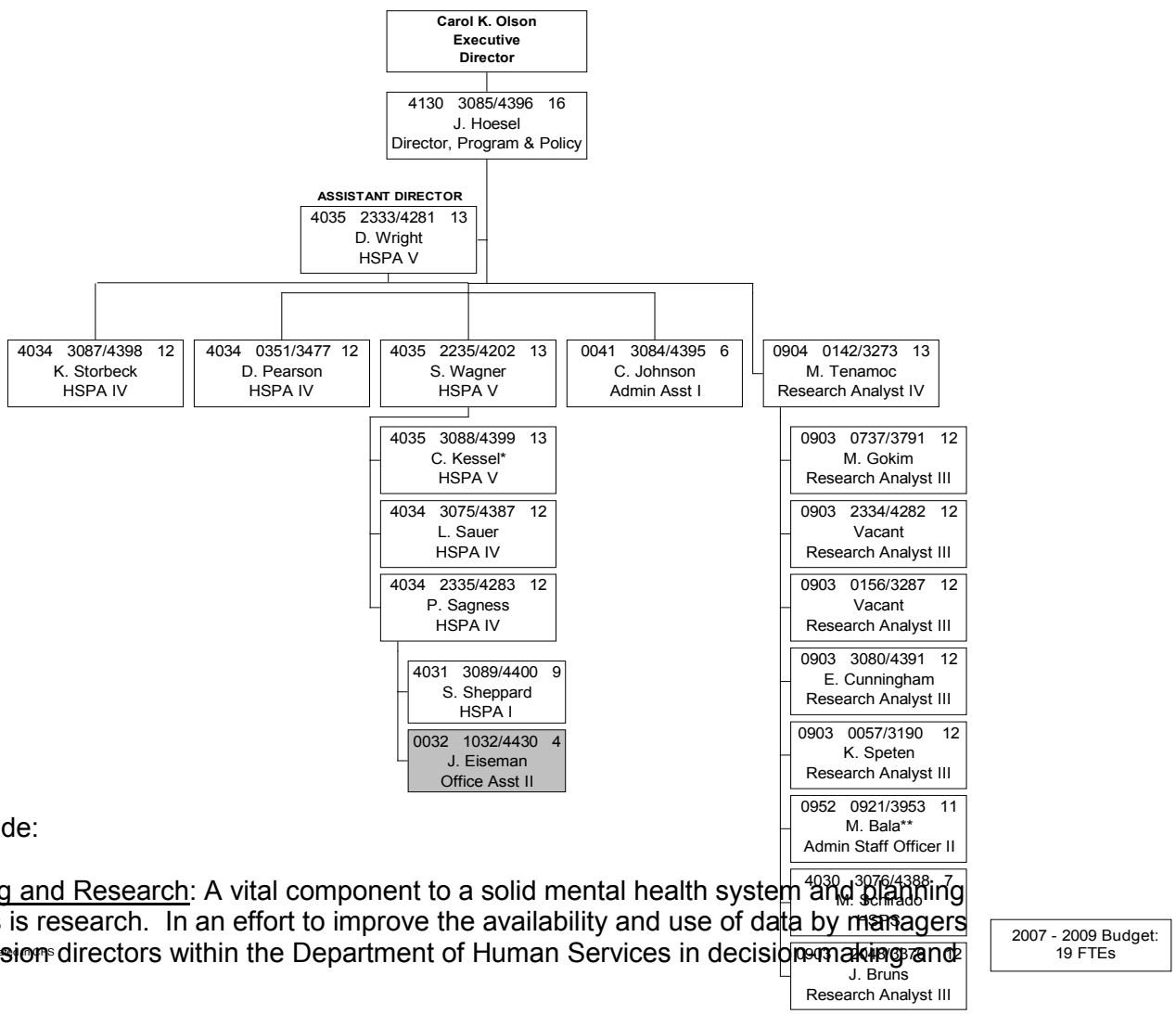
Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

DESCRIPTION OF STATE AGENCY'S LEADERSHIP

The Division of Mental Health and Substance Abuse Services – a part of Program and Policy – provides leadership to the field in developing systems and models of care for mental illness and substance abuse, including dual diagnosis (mental health/substance abuse). It is charged with licensing alcohol and drug abuse treatment programs as well as psychiatric residential treatment facilities for youth with serious emotional disorders. In addition, the Division seeks active involvement in a variety of interagency and multi-organization efforts designed to advance understanding of mental health and substance abuse issues.

The Division (Figure 1) performs leadership, planning, development, and implementation functions in the field of mental health for the State of North Dakota.

Figure 1. Division of Mental Health and Substance Abuse Services: Mental Health Unit Organizational Chart



These include:

- Planning and Research: A vital component to a solid mental health system and planning process is research. In an effort to improve the availability and use of data by managers and division directors within the Department of Human Services in decision making and

*Childrens' Mental Health Administration Leadership Team
**Member of ROAP Team

planning efforts, the Department has implemented the Mental Health Statistical Improvement Program Outcomes Project statewide. Interfaced with the Partnership Program Outcome Measurement project and other community mental health data systems. MHSIP will allow the Mental Health Services Researcher to compile data leading to an overall enhanced planning and reporting process.

Using appropriate data gathered via the above-mentioned data systems and working closely with the regional human service centers, consumers and their families, private providers, and other stakeholders, the Division drafts and implements the annual State Plan on Mental Health.

- Grant Writing: The Division currently works with the following grants and actively seeks other funding opportunities via the Federal government grant programs:
- The Community Mental Health Services Block Grant
- State Data Infrastructure Grant
- The Project for Assistance In Transition from Homelessness (PATH) Grant

- Policy Development and Implementation: The Division develops mental health programs and policies for the State of North Dakota. Implementation of these programs and policies, is a function of the regional human service centers and the North Dakota State Hospital. The Division provides technical assistance and consultation concerning mental health programs and policies to the human service centers as well as any other agency, organization, and/or citizen of North Dakota. It also serves as a liaison between the Federal government, state/local entities, and the citizens of North Dakota.

- Licensing of Psychiatric Residential Treatment Facilities: These facilities provide children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The Division provides regulatory oversight and provides a licensing survey process to ascertain if the facilities are meeting licensure standards. All six PRTFs in North Dakota have received accreditation. The MHSA and Medical Services Divisions made on-site visits to two of the facilities to discuss their experience with the accreditation process and to review the recommendations and plans from the respective accreditation agencies (COA and CARF). The facilities were issued a joint license for the time period of July 1, 2007 to June 30, 2009, by both the Medical Services (Medicaid) and Mental Health & Substance Abuse Services Divisions.

- Education: In addition to sponsoring training workshops and performing public speaking as requested, the Division contributes to the North Dakota Prevention Resource Center. The Prevention Resource Center maintains a large library of written and video materials covering a wide range of topics in mental health, substance abuse, aging, traumatic brain injury, suicide prevention, and disabilities. Items are loaned to any citizen of North Dakota free of charge.

North Dakota

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

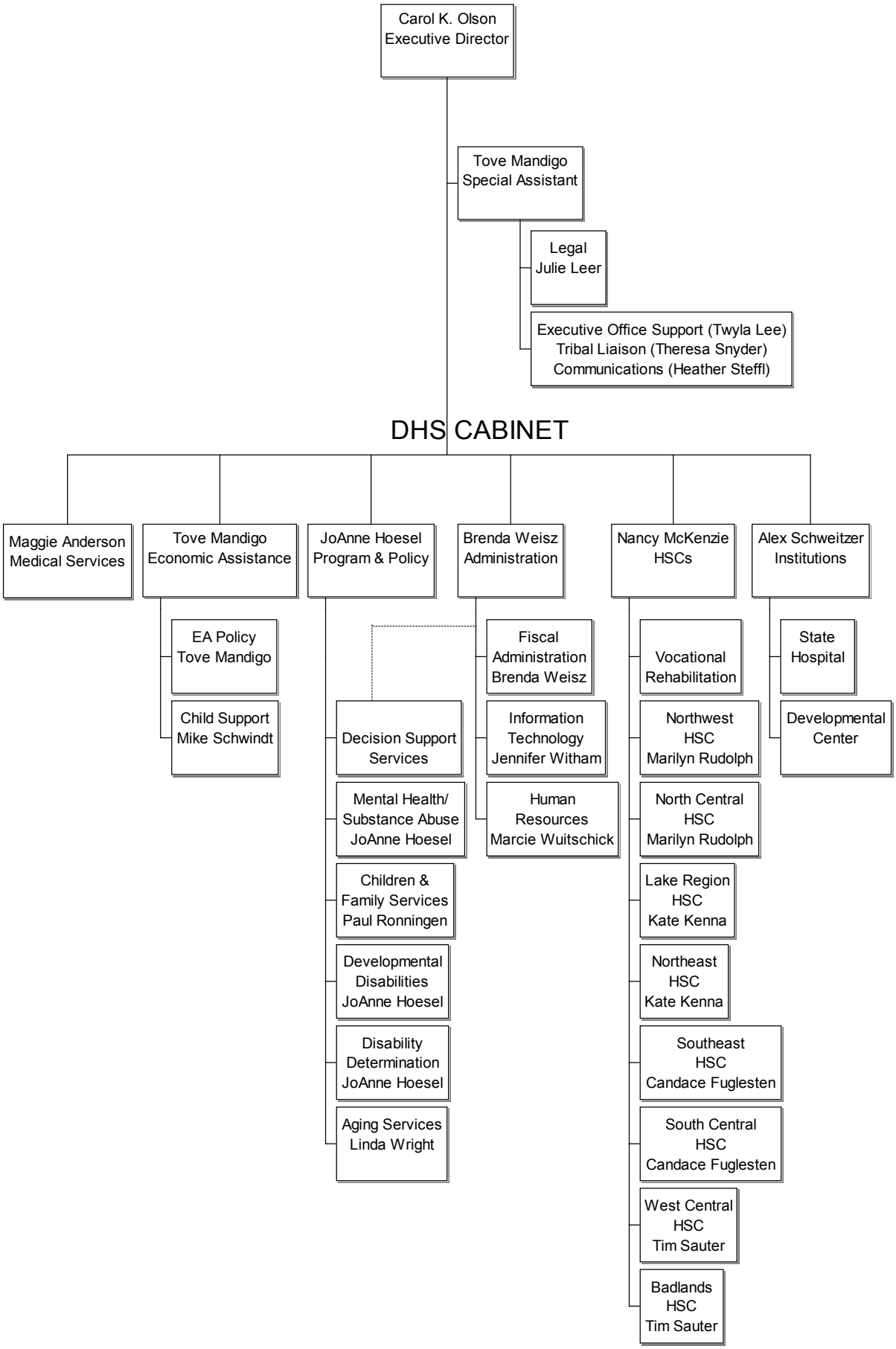
OVERVIEW OF NORTH DAKOTA'S PUBLIC MENTAL HEALTH SYSTEM

The Department of Human Services is the State governmental administrative agency that provides services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. The Department administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. It is an umbrella agency headed by an executive director appointed by the Governor. Comprised of over 2,000 employees, the Department of Human Services has six major organizational components overseen by the DHS Cabinet:

- Medical Services: Coordinates policy and operations of the Medicaid program in North Dakota.
- Economic Assistance: Directs policy for economic assistance programs and oversees policy and operations for Child Support Enforcement.
- Program and Policy: Coordinates administrative programs for the elderly, children and families, substance abuse, disability services, and mental health.
- Human Service Centers: Administers, supervises, and provides a wide range of public human services through the eight regional human service centers
- Institutions: Coordinates administration of the North Dakota State Hospital and the Developmental Center.
- Fiscal: Oversees all fiscal administrative functions for the Department.

Delivering human services involves a partnership between the Department, counties, tribes, and service providers. The Department receives and distributes funds furnished by the North Dakota Legislature and Congress. Funds may be sent directly to providers or to people whom the counties determine qualify for programs and benefits. The Department provides direction and technical assistance, sets standards, conducts training, and manages the computerized eligibility system.

The Division of Mental Health and Substance Abuse Services is a part of the Program and Policy component of the Department of Human Services. Its specific functions are detailed later in the application. The Division functions as the State Mental Health Authority. It works closely with other public agencies (such as the Department of Public Instruction, the Department of Health, and the Department of Corrections and Rehabilitation) as well as a myriad of private and not-for-profit human service agencies to ensure quality and effective mental health services are provided throughout the state.


Carol K. Olson
Executive Director
Tove Mandigo
Special Assistant
Legal
Julie Leer
Executive Office Support (Twyla Lee)
Tribal Liaison (Theresa Snyder)
Communications (Heather Steffl)
DHS CABINET
Maggie Anderson
Medical Services
Tove Mandigo
Economic Assistance
JoAnne Hoesel
Program & Policy
Brenda Weisz
Administration
Nancy McKenzie
HSCs
Alex Schweitzer
Institutions
EA Policy
Tove Mandigo
Child Support
Mike Schwindt
Decision Support
Services
Mental Health/
Substance Abuse
JoAnne Hoesel
Children &
Family Services
Paul Ronningen
Developmental
Disabilities
JoAnne Hoesel
Disability
Determination
JoAnne Hoesel
Aging Services
Linda Wright
Fiscal
Administration
Brenda Weisz
Information
Technology
Jennifer Witham
Human
Resources
Marcie Wuitschick
Vocational
Rehabilitation
Northwest
HSC
Marilyn Rudolph
North Central
HSC
Marilyn Rudolph
Lake Region
HSC
Kate Kenna
Northeast
HSC
Kate Kenna
Southeast
HSC
Candace Fuglesten
South Central
HSC
Candace Fuglesten
West Central
HSC
Tim Sauter
Badlands
HSC
Tim Sauter
State
Hospital
Developmental
Center

North Dakota

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Guidance received from CMHS that this section has been moved to the Implementation Report and does not need to be completed at this time.

North Dakota

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

NEW DEVELOPMENTS AND ISSUES - CHILDREN

North Dakota's Legislative Assembly convenes every two years. The next session will begin in January of 2009. Below is a summary of legislative initiatives and changes that occurred during the 2007-2009 session regarding insurance and healthcare.

SCHIP Program legislation

The Governor signed into law HB 1463, which is known as the SCHIP Bill. This bill amends and reenacts subsection 3 of section 50-24.1-02.6 and section 50-29-04 of the North Dakota Century Code, relating to medical assistance eligibility for minors and eligibility under the state children's health insurance program; to provide a contingent appropriation; and to provide an effective date. This law increases coverage for children who meet the eligibility requirements of 133% above the poverty level. Section 1 of the law becomes effective on the date the Department of Human Services certifies to the Legislative Council that the department has received approval to claim federal financial participation to expand medical assistance benefits to children. Section 2 becomes effective on the date the Department of Human Services certifies to the Legislative Council that the federal reauthorization of the state children's health insurance program resulted in an allotment to the state in an amount that is sufficient to fund the increase identified in Section 2.

The "Medicaid buy-in" bill is relating to medical assistance and other health coverage for families of children with disabilities; and to provide an appropriation. North Dakota was the first state in the Nation to pass this bill into law. The law allows for families 200% above the poverty level to purchase medical assistance coverage. The language of the law reads as follows:

> AN ACT to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance and other health coverage for families of children with disabilities; and to provide an appropriation.
>
> **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**
>
> **SECTION 1.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows: **Optional medical assistance for families of children with disabilities.** The department of human services shall establish and implement a buy-in program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred percent of the federal poverty line.
>
> **SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,059,932, or so much of the sum as may be necessary, and the sum of $1,673,835, not otherwise appropriated, or so much of the sum as may be necessary, from special funds derived from federal funds and other income, to the department of human services for the purpose of establishing and implementing a buy-in program to provide medical assistance and other health coverage options to families of children with disabilities and for implementing

> the waiver described in North Dakota Century Code section 50-24.1-26 to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care, for the biennium beginning July 1, 2007, and ending June 30, 2009. The department of human services is authorized one full-time equivalent position for implementing the programs described in this Act.

A collaborative effort between Medical Services, the Division of Mental Health and Substance Abuse Services, the Development Disabilities Division, and other system stakeholders will be exploring and implementing a Medicaid waiver to serve children with Autism and other Autism spectrum disorders.

North Dakota

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

LEGISLATIVE INITIATIVES AND CHANGES - CHILDREN

North Dakota's Legislative Assembly convenes every two years. The next session will begin in January of 2009. Below is a summary of legislative initiatives and changes that occurred during the 2007-2009 session.

The 60th Legislative Assembly amended NDCC 25.3.2-03.1 concerning the moratorium on the expansion of residential treatment center bed capacity. The law will no longer require review every two years during the Legislative Assembly. There will be a moratorium on bed expansion for North Dakota children. An amendment was added to the law to allow for the expansion of Psychiatric Residential Treatment Facilities (PRTFs) beds for youth from other states. This will not impact youth from North Dakota or have a fiscal impact on the state Medicaid program. The language of the law reads as follows:

> Notwithstanding sections 25-03.2-03 and 25-03.2-08, unless a needs assessment conducted by the department indicates a need for the licensing of additional bed capacity, the department may not issue a license under this chapter for any additional bed capacity for a residential treatment center for children above the state's gross number of beds licensed as of June 30, 2003. This section does not apply to nor prohibit the department from licensing additional bed capacity for a new psychiatric residential treatment facility for children if the additional beds are designated for the care of children and adolescents who are residents of other states.

The Governor signed into law on April 17, 2007, Senate Bill 2326. The "Medicaid buy-in" bill is relating to medical assistance and other health coverage for families of children with disabilities; and to provide an appropriation. North Dakota was the first state in the Nation to pass this bill into law. The law allows for families 200% above the poverty level to purchase medical assistance coverage. The language of the law reads as follows:

> AN ACT to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance and other health coverage for families of children with disabilities; and to provide an appropriation.
>
> **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**
>
> **SECTION 1.** A new section to chapter 50-24.1 of the North Dakota Century Code is created
> and enacted as follows: **Optional medical assistance for families of children with disabilities.** The department of human services shall establish and implement a buy-in program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred percent of the federal poverty line.
>
> **SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,059,932, or so much of the sum as may be necessary, and the sum of $1,673,835, not otherwise appropriated, or so much of the sum as may be

necessary, from special funds derived from federal funds and other income, to the department of human services for the purpose of establishing and implementing a buy-in program to provide medical assistance and other health coverage options to families of children with disabilities and for implementing the waiver described in North Dakota Century Code section 50-24.1-26 to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care, for the biennium beginning July 1, 2007, and ending June 30, 2009. The department of human services is authorized one full-time equivalent position for implementing the programs described in this Act.

SCHIP Program legislation

The Governor signed into law HB 1463, which is known as the SCHIP Bill. This bill amends and reenacts subsection 3 of section 50-24.1-02.6 and section 50-29-04 of the North Dakota Century Code, relating to medical assistance eligibility for minors and eligibility under the state children's health insurance program; to provide a contingent appropriation; and to provide an effective date. This law increases coverage for children who meet the eligibility requirements of 133% above the poverty level. Section 1 of the law becomes effective on the date the Department of Human Services certifies to the Legislative Council that the department has received approval to claim federal financial participation to expand medical assistance benefits to children. Section 2 becomes effective on the date the Department of Human Services certifies to the Legislative Council that the federal reauthorization of the state children's health insurance program resulted in an allotment to the state in an amount that is sufficient to fund the increase identified in Section 2. North Dakota received federal approval to expand the children's health insurance program. The NDDHS submitted an SCHIP State Plan amendment to CMS in March 2008. The higher eligibility level will allow uninsured children living in families with net incomes of up to 150 percent of the federal poverty to qualify. Under some circumstances, families could qualify at up to 200 percent of gross income. Our Governor, John Hoeven stated "We expect about 800 additional uninsured children to gain coverage during the first year of this expansion, to become effective October 1, 2008.

Transition Legislation

Youth are challenged by the transition to young adult roles in employment, education, independent living, and community life. During this transition period, young adults face decisions about future career and educational goals, social responsibilities, self-management of one's behavior, alcohol and drug use, social problem-solving competencies, and maintenance of friendships and intimate relationships. This period is especially challenging for young adults with or at risk of mental illness. Through Senate Concurrent Resolution 4005, the Sixtieth Legislative Assembly directed the Legislative Council to study the feasibility and desirability of establishing a transition to independence program for young adults with mental illness.

This study has been assigned to the Long-term Care Committee and the Division of Mental Health and Substance Abuse Services will follow proceedings closely. The Division has provided testimony to this committee regarding transition-aged youth policy and available programming to assist the youth and describing the systems of care.

High Risk Behavior Prevention Legislation

In 2005, 15 males between the ages of 10 and 19 committed suicide in North Dakota. During that time period a survey revealed that 15 percent of North Dakota high school students and 14 percent of North Dakota seventh and eighth grade students reported that they had considered suicide; 12 percent of North Dakota high school students and 8 percent of North Dakota seventh and eighth grade students reported that they had planned a suicide; and 6 percent of North Dakota high school students and 5 percent of North Dakota seventh and eighth grade students reported that they had attempted suicide. Through Senate Concurrent Resolution 4032, the Sixtieth Legislative Assembly directed the Legislative Council to study ways in which schools and school districts can better identify high-risk students and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

This study has been assigned to the Education Committee and the Division of Mental Health and Substance Abuse Services will follow proceedings closely. The Division is available to this committee to provide testimony and/or information regarding the identification of high risk students and identifying high risk behaviors that can lead to suicide attempts.

North Dakota

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

DESCRIPTION OF REGIONAL RESOURCES - CHILDREN

North Dakota is a rural, frontier state with an area of 72,000 square miles and an approximate population of 635,867. The largest city in the State is Fargo, which has a metropolitan statistical area population of 132,525 persons. Thirty-six of fifty-three counties are designated frontier areas, having less than seven persons per square mile. In 1982, to better serve the citizens of this rural state, the community mental health centers were merged with the area social service centers. This action created the regional human service centers and developed a one-stop system of care. The eight regional human service centers, listed below with their locations, provide public mental health programs to service areas ranging from three to ten counties.

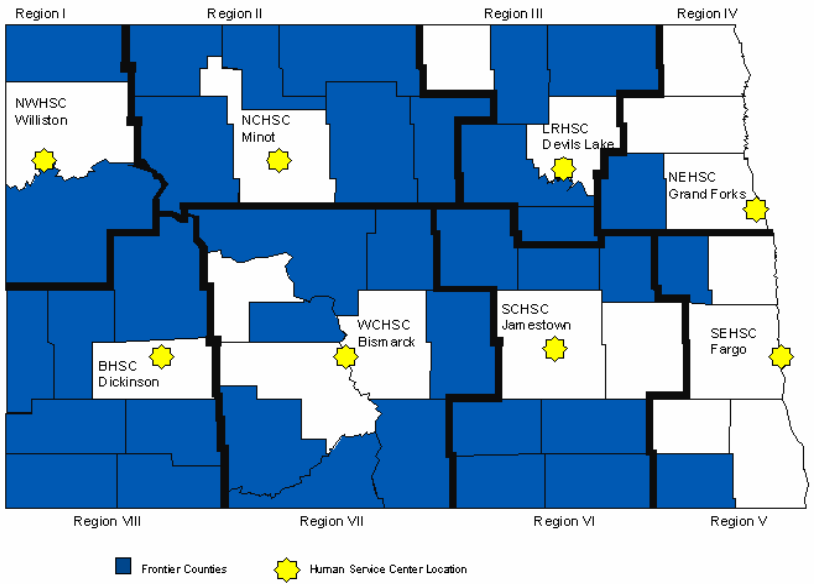
Northwest Human Service Center	Williston	Region I
North Central Human Service Center	Minot	Region II
Lake Region Human Service Center	Devils Lake	Region III
Northeast Human Service Center	Grand Forks	Region IV
Southeast Human Service Center	Fargo	Region V
South Central Human Service Center	Jamestown	Region VI
West Central Human Service Center	Bismarck	Region VII
Badlands Human Service Center	Dickinson	Region VIII

Adolescents and children are served in the community through a variety of rehabilitation services including:

- crisis stabilization and resolution;
- inpatient services;
- psychiatric/medical management including medication management and other health services;
- social services;
- residential services and supports;
- vocational and educational services and supported employment;
- social and leisure activities;
- evidence-based practices of Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Services at the regional human service centers are provided to all children regardless of the child's race, color, religion, national origin, sex, age, political beliefs, or disability in accordance with Title VI of the Civil Rights Act of 1984, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act, the Americans with Disabilities Act of 1990 and the North Dakota Human Rights Act (NDCC Chapter 14-02.4). All services are provided to Native Americans living on or off the reservations.

Figure 2: Regional human service center locations and frontier counties in North Dakota



<u>Please refer to the Available Services – Children section of the application for a full description of Regional Resources – Children.</u>

To include the following services:

- **Regional Intervention Service**
- **Medical and Dental Services**
- **Psychological Services**
- **Acute Treatment**
- **Outreach**
- **Educational Opportunities**
- **Vocational Rehabilitation**
- **Alcohol and Drug Addiction Services**
- **Children's Mental Health System of Care**
- **North Dakota State Hospital**
- **The County Social Service Boards**
- **Protection and Advocacy Services**

North Dakota

Child - Description of State Agency's Leadership

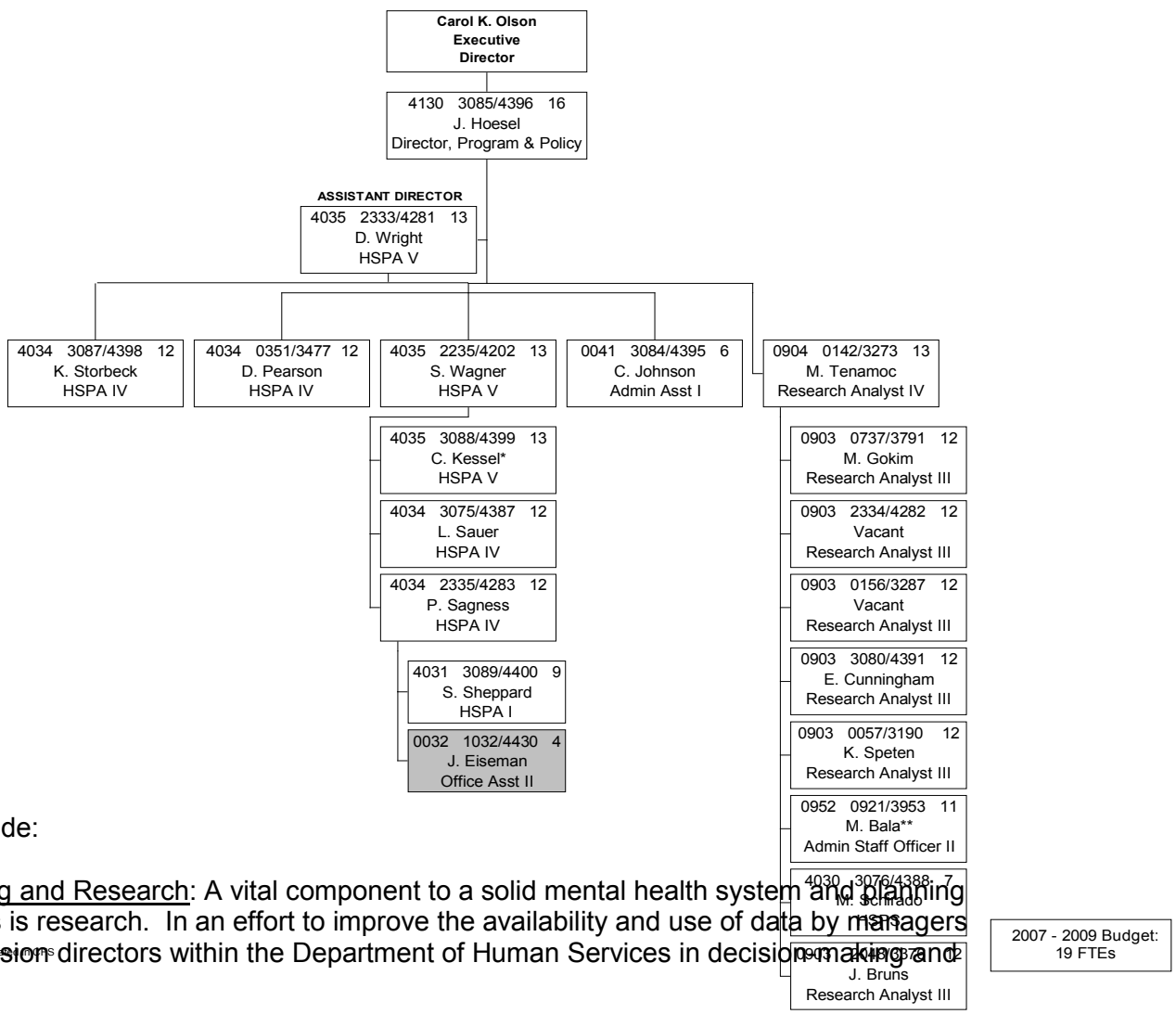
Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

DESCRIPTION OF STATE AGENCY'S LEADERSHIP

The Division of Mental Health and Substance Abuse Services – a part of Program and Policy – provides leadership to the field in developing systems and models of care for mental illness and substance abuse, including dual diagnosis (mental health/substance abuse). It is charged with licensing alcohol and drug abuse treatment programs as well as psychiatric residential treatment facilities for youth with serious emotional disorders. In addition, the Division seeks active involvement in a variety of interagency and multi-organization efforts designed to advance understanding of mental health and substance abuse issues.

The Division (Figure 1) performs leadership, planning, development, and implementation functions in the field of mental health for the State of North Dakota.

Figure 1. Division of Mental Health and Substance Abuse Services: Mental Health Unit Organizational Chart



These include:

- Planning and Research: A vital component to a solid mental health system and planning process is research. In an effort to improve the availability and use of data by managers and division directors within the Department of Human Services in decision making and

*Childrens' Mental Health Administrator/Leadership Services
**Member of ROAP Team

planning efforts, the Department has implemented the Mental Health Statistical Improvement Program Outcomes Project statewide. Interfaced with the Partnership Program Outcome Measurement project and other community mental health data systems. MHSIP will allow the Mental Health Services Researcher to compile data leading to an overall enhanced planning and reporting process.

Using appropriate data gathered via the above-mentioned data systems and working closely with the regional human service centers, consumers and their families, private providers, and other stakeholders, the Division drafts and implements the annual State Plan on Mental Health.

- Grant Writing: The Division currently works with the following grants and actively seeks other funding opportunities via the Federal government grant programs:
- The Community Mental Health Services Block Grant
- State Data Infrastructure Grant
- The Project for Assistance In Transition from Homelessness (PATH) Grant

- Policy Development and Implementation: The Division develops mental health programs and policies for the State of North Dakota. Implementation of these programs and policies, is a function of the regional human service centers and the North Dakota State Hospital. The Division provides technical assistance and consultation concerning mental health programs and policies to the human service centers as well as any other agency, organization, and/or citizen of North Dakota. It also serves as a liaison between the Federal government, state/local entities, and the citizens of North Dakota.

- Licensing of Psychiatric Residential Treatment Facilities: These facilities provide children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The Division provides regulatory oversight and provides a licensing survey process to ascertain if the facilities are meeting licensure standards. All six PRTFs in North Dakota have received accreditation. The MHSA and Medical Services Divisions made on-site visits to two of the facilities to discuss their experience with the accreditation process and to review the recommendations and plans from the respective accreditation agencies (COA and CARF). The facilities were issued a joint license for the time period of July 1, 2007 to June 30, 2009, by both the Medical Services (Medicaid) and Mental Health & Substance Abuse Services Divisions.

- Education: In addition to sponsoring training workshops and performing public speaking as requested, the Division contributes to the North Dakota Prevention Resource Center. The Prevention Resource Center maintains a large library of written and video materials covering a wide range of topics in mental health, substance abuse, aging, traumatic brain injury, suicide prevention, and disabilities. Items are loaned to any citizen of North Dakota free of charge.

North Dakota

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

SERVICE SYSTEM'S STRENGTHS AND WEAKNESSES ADULTS AND CHILDREN

As discussed in the Department Description section of the application, the Department of Human Services provides and administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. A strength of the system is the actual structure of the Department. This structure – with key components such as Medicaid, the regional human service centers, Mental Health and Substance Abuse located in one umbrella agency – facilitates stronger communication and the ongoing development of a solid community-based system of mental health care throughout the state. This is particularly evident within the regional human service centers. Located in each of the eight major cities, the regional human service centers offer a wide variety of mental health, substance abuse, vocational rehabilitation, and developmental disability services under one roof.

As detailed in other sections, the community-based public mental health system in North Dakota has made great strides in recent years. The growth of the community-based mental health delivery system in North Dakota has resulted in a decline in the daily inpatient census of the North Dakota State Hospital from over 2,000 individuals diagnosed with a mental illness in the 1960's to approximately 130 today. This has been a result of numerous diversion programs, legislation, and enhanced community programming. The Department is implementing and planning for more evidence-based practices including Integrated Dual Disorders Treatment, Supported Employment, and Structured Psychotherapy for Adolescents Responding to Chronic Stress and Trauma Focused Cognitive Behavioral Therapy. Evidence-based practices have been proven to consistently produce specific, intended results. Implementation will help to further strengthen the mental health system of care throughout North Dakota.

Though North Dakota has considerably strengthened its system of care during the past decade, challenges remain.

Demographics continue to challenge the state. North Dakota is a rural state with two-thirds of its counties designated as frontier areas. Nearly 40% of the state's population resides in the two eastern regions that lie on the border with Minnesota. In contrast, only ten percent of the population resides in the two regions that lie on the western border with Montana. In fact, the western half of the state has a sparse population density from 0.9 to 10.7 persons per square mile. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel. Round-trips of 200-300 miles or more to obtain services are not uncommon.

North Dakota has a long history as a farming community and has relied on this business for much of its economic livelihood. However, with the downswing in the rural economy, the population distribution became more urban than rural as farmers and ranchers closed their businesses, left their home communities, and moved into the cities seeking employment. This shift has resulted in fewer services available in some of the rural areas. It is very difficult to find qualified medical and human service personnel who desire to live in rural, often remote communities in the state. According to the University of North Dakota's Center for Rural Health, nearly eighty percent of the state -- or all but eleven counties -- has some area that is considered a health profession shortage area.

Though the state population's racial makeup remained virtually unchanged, the age of citizens has increased. The child population (0-17) decreased during the 1990's by nearly 13%. Adults age 18-34 and 60-74 decreased during the decade, as well (22.5% and 5.7%, respectively).

The causes of this phenomenon vary. Many young people are leaving North Dakota to seek opportunities elsewhere. The state has also been experiencing a steady decline in the birth rate, perhaps caused by young people leaving or the economic realities of today. Those who remain in the state are faced with needing to hold multiple jobs in order to make ends meet. In fact, 2000 Census figures indicated that North Dakota was the highest ranked state in the nation for the percentage of people who hold multiple jobs and a higher percentage of jobs in the state pay less than $12 per hour.

Another phenomenon being noticed is that some retired people – having left the state to seek opportunities elsewhere – are returning to North Dakota to spend their remaining years in the place they grew up. Similarly, as youth leave the rural areas, some elderly residents choose to remain behind in the towns they lived in most of their lives. The reality, however, is that services continue to decrease in these areas when the population in question will require more and more.

The phenomena mentioned above will impact service delivery in two major ways. With a decline in the 18-34 year old range – typically the largest source of caregivers in the state – it will become more difficult to find caregivers to offset the increases in the population of those 75 and older. This may become magnified in the future as the baby-boomers age. This is only compounded by the declining birth rate. Also, with an increase in elderly and decrease in younger people, the tax base will decline. In the next few years, an increasing number of residents will be moving into retirement and out of the workforce. The tax burden will be shifted to a dwindling workforce-age population. With declining income to pay for increased utilization, services may be in jeopardy. The Decision Support Services Unit, in conjunction with the Aging Service Division, is studying the impact of the aging population on the workforce, available employees, what services they will need, and future survey of those turning 60 in the year 2020.

There are continued challenges with the clinical workforce. The human service centers continue to fall behind in their ability to compete in the marketplace for salaries for professionals. Private providers tend to pay mental health professionals more than human service centers. In addition, many professionals are reluctant to live in the more rural areas of North Dakota or in North Dakota in general. Demand for the skills of certain professionals definitely exceeds the supply. Thus, there is considerable competition for licensed addiction counselors, clinical psychologists, psychiatrists, licensed certified/independent clinical social workers, and psychiatric nurses. In fact, clinicians are being offered as much as $50,000 more per year in salary from the private sector than what can be offered in the public sector. Just as private providers are able to pay higher wages than the public sector, they also tend to charge higher rates. This compounds the workforce shortage issue at the regional human service centers as many counties and courts prefer to refer to the human service centers for evaluations and other services because of the lower costs. This adds to the workload of an already strained workforce. The Department is working with various entities to address workforce issues. For instance, North Dakota is working with the Western Interstate Commission for Higher Education, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition, this program will help provide clinicians to those rural areas where often it is difficult to recruit for. The Department is working with various federal entities and the Center for Rural Health-University of North Dakota to recruit individuals in identified shortage areas and professions through the use of loan repayment and J1-Visa programs. The Division worked with the Western Interstate Commission for Higher Education, Mental Health Division, to develop a

workforce development plan. Recommendations from that plan have been incorporated into the overall strategies of the DHS HR division.

In the Department, workforce issues are being addressed through the following:

- Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future
- Meeting with divisions/supervisory staff to emphasize the flexibility that we do have in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
- Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, recruitment/referral/retention bonuses.
- Tuition assistance for employees who choose to obtain additional skills and knowledge
- Assessment of other options, such as non-traditional work hours
- Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce
- Development of the DHS Leadership Group (help to identify current and future leaders in DHS)

The Department continues to see more children in North Dakota presenting with more complex issues at an earlier age. This is particularly evident in the data from the Trauma- Focused Cognitive Behavioral Therapy implementation in that a majority of children involved in this therapeutic process have experienced an average of 6-7 trauma's in their young lives. This phenomenon presents at the same time that the child population is decreasing. The Department of Public Instruction is experiencing significant increases in the number of children qualifying for emotional disturbances services through the individualized education plan (IDEA). The Department of Human Services sees increases in the number of children that are referred at younger ages, as young as age two, and often they are presenting with multiple and complex issues. To compound this issue, budgetary constraints have lead to a decrease in the number of beds available to children at the state hospital while community resources are reaching capacity.

Overall, the human service centers are seeing more people with greater complexity of issues and often at a younger age. This includes consumers who have engaged in sexual offending behavior; significant substance abuse, mental health disorders, and histories of physical or emotional abuse and neglect; and the need for longer substance abuse treatment services in the community due to the severity of symptoms and use of methamphetamine. As you can see, the design of the human service centers as multidisciplinary teams is critical in comprehensively addressing the complex needs of the consumers served.

A Youth Advisory Council Initiative that is being developed will address issues in our systems and examine the complexity of today's youth. The goal of the Council is to provide youth with an active voice in effecting policy and program change in North Dakota.

For fiscal year 2007, there were 44,470 children age 0-21 that were eligible for a Health Tracks screening. 26,620 have had at least one screening with 62% of children having received a Health Tracks screening.

Health Tracks is a preventive health program that is free for children age 0 to 21 who are eligible for Medicaid. Health Tracks funds screenings, diagnosis, and treatment services to assist in the prevention and intervention of emotional/health concerns. Health Tracks utilizes the Pediatric Symptom Checklist to assess for emotional/developmental and behavioral risk factors. Health Tracks, Developmental Disabilities, Head Start, Child Welfare and Mental Health have initiated a work group to examine early prevention, intervention, screening and systemic points of entry for children and families. The work group (the North Dakota Children's Social, Emotional, Developmental Alliance) met to discuss the need for all children in ND to be screened for emotional, behavioral, developmental, physical and educational risk factors. A decision making tree was created that allows families and system partners to negotiate and understand the various systems program criterion in North Dakota to assist in meeting the needs of children and families. A Mental Health Screening Tool Kit training and training materials/videos are available to all system partners. A state form was developed known as the Preliminary Questions for Social/Emotional/Developmental/Screening that is used by the various systems. This form assists the staff from the various systems in discovering if the family has had prior mental health screening(s) or involvement in mental health services. Health Tracks also funds orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling, and other important health services. Health Tracks staff assist families with the scheduling of appointments for services, as well, as assist with finding transportation to the services.

Healthy Steps, North Dakota's SCHIP, currently serves 4,087children. According to the 2007 Annual EPSDT (Health Tracks) report, 11,148 individuals from birth to 21 years of age received a dental service, 6,984 a preventive dental service and 5,069 received dental treatment services.

Access to dental care continues to be an issue in North Dakota. According to the University of North Dakota's Center for Rural Health, 30% of the state's 53 counties are designated as Dental Health Professional Shortage Areas (as of 9-2007). Fifty-seven percent of North Dakota's population lives in Ward, Grand Forks, Cass and Burleigh counties, as do an overwhelming proportion of the state's dentists. As a result of growing concerns about a nation-wide shortage of dentists, and the number of designated dental HPSAs in North Dakota, the Center conducted a state-wide dental workforce survey to examine the demographics, practice profiles, and patient profile information of the state's 316 licensed dentists. North Dakota does not have a dental school, and over half of our dentists were trained at the University of Minnesota. Results from our 2004 survey indicate: just over half were born in ND, 73% practice general dentistry, the average age of North Dakota dentists is 52 years and 60% of dentists plan to retire in the next 15 years. In 2002 a state dental loan repayment program was established to attract dentists to areas of need across the state. There have been eight recipients of the loan program who located in 6 different communities (Minot, Fargo, New Rockford, Grand Forks, Bismarck, and West Fargo).

Finally, though strides have been made during the past few years in creating new housing opportunities for consumers, a number of barriers remain. North Dakota lacks sufficient affordable housing, especially for individuals in the low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is much more limited – transitional units, low income housing, and supported permanent housing are in very short supply. "Deep subsidy" funds like the Section 8 voucher, which is the only way the chronically homeless will be able to afford to pay for the housing portion of permanent supportive housing, are limited. Some zoning laws in the state contain provisions that make it difficult to site group living facilities, which is the category most permanent supportive housing

projects fall into. The specific regulatory language often involves definition of “non-household” living, rules regarding number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process.

There is a willingness to tolerate chronic homelessness as an “acceptable” situation in North Dakota. In part, this belief is fostered by people’s lack of direct experience with chronically homeless individuals. It is difficult to feel a sense of urgency about an issue with which one has little knowledge or first hand experience. The people of this state have a fundamental belief in “self-sufficiency.” This belief often leads people to believe that the chronically homeless do not deserve help because they are not working hard enough to help themselves. Again, the belief itself is an obstacle to building support for the creation of housing options that specifically serve this population. At times, consumers have difficulty accessing available housing resources because of poor rental and credit histories and criminal backgrounds. In addition, very low or no income and an inability to afford rent, whether it is because they are unable to find a job where the pay is sufficient to cover housing costs or because they are unable to keep a job because of a disability is an issue.

North Dakota

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

UNMET SERVICE NEEDS OF THE ADULT SYSTEM

North Dakota has engaged in a number of activities recently to identify needs in the community-based public service system. These efforts have included conversations with the North Dakota Mental Health Planning Council as well as Department Stakeholder Forums.

The North Dakota Mental Health Planning Council has identified the following as being issues that need to be addressed:

- There are limited resources for completion of assessments. Because of the challenges recruiting and retaining clinical staff, workloads at the regional human service centers have increased at times resulting in delays in receiving an assessment.
- There are limited employment opportunities for consumers.
- Access to psychological and psychiatric services in a timely manner can be challenging in some areas of the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.
- There is a need for increased training opportunities for families of consumers.
- Advocacy and support to families of consumers.
- Access to information and dissemination of information from Federal entities

The North Dakota Department of Human Services held stakeholder meetings across the state in the fall of 2007. Meetings were scheduled in Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston. Organizations and individuals involved in the delivery of human services in North Dakota were invited to attend and to discuss community needs, capacity, and resources. Issues raised included:

- Aging/Mental Health: Growing area of service need. Need more resources to help providers.
- Guardianship Issues: Need to fund guardianship services for vulnerable adults and elderly. Access is an issue and demand is high.
- Staff shortages are increasing wait times.
- Adults with serious and chronic mental illness need access to more job development and employment services to support their recovery.
- State needs more residential services and housing options for adults with chronic mental illness.
- Dual diagnosis population needs transition to community services and long-term residential housing and supports.
- Divert people from corrections by training law enforcement personnel and coordinating with mental health system.
- Support more peer support services to promote recovery.

Stakeholder meetings will be held again in the Fall of 2010.

Beginning in May of 2007, the Division of Mental Health and Substance Abuse Services implemented a project to analyze and enhance the system of care for adults with serious mental illness with an emphasis on community-based care: the Continuum of Care Project. The project consisted of the distribution of a statewide community needs assessment and a series of planning meetings with a group of stakeholders representing consumers of mental health services, agency partners and North Dakota Department of Human Service staff. Needs identified through this process included:

- Permanent housing for individuals with co-occurring mental health and substance abuse disorders based on stages of change model
- There is a need to increase long-term supportive housing as many individuals in transitional living homes across the state have been permanently placed in these institutions.
- There is a need to enhancing/expanding community-based options, mobile crisis services, and advanced directives
- Very little peer support in ND

North Dakota

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

PLANS TO ADDRESS UNMET NEEDS - ADULTS

Based on the needs identified previously, North Dakota is implementing or planning to implement the following:

- Access to psychological and psychiatric services in a timely manner can be challenging in some areas of the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.
- There is a need for increased training opportunities for families of consumers.
- Advocacy and support to families of consumers.
- Access to information and dissemination of information from Federal entities

- There are limited resources for completion of assessments. Because of the challenges of recruiting and retaining clinical staff, workloads at the regional human service centers have increased at times resulting in delays in receiving an assessment.
  - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition this program will help provide clinicians to those rural areas where often it is difficult to recruit for.

- There are limited employment opportunities for consumers.
  - The regional human service center staff assigned to the Extended Services and Supported Employment programs work extensively with employers to cultivate new job opportunities for consumers. In some areas of the state, employment opportunities are limited due to geographic location or job market. In Williston – currently experiencing a boom due to oil drilling – the job market is open and good paying positions are fairly easy to come by. Starting salaries are in excess of $9.00 per hour. However, opportunities in rural communities can be at times non-existent. The Division is exploring with Southeast Human Service Center the feasibility of implementing SAMHSA's model of Supported Employment. The Division will continue to work with the regional human service centers and Vocational Rehabilitation to enhance when possible employment services for consumers statewide.

- Access to psychological and psychiatric services in a timely manner can be challenging in some areas of the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.
  - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.

    In the Department, workforce issues are being addressed through the following:

    - Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future. Meeting with divisions/supervisory staff to emphasize the flexibility that we do

have in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
    - Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, recruitment/referral/retention bonuses, etc.
    - Tuition assistance for employees who choose to obtain additional skills and knowledge
    - Assessment of other options, such as non-traditional work hours
    - Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce
    - Development of the DHS Leadership Group (help to identify current and future leaders in DHS)

- There is a need for increased training opportunities for families.
  - A number of training opportunities are offered to families of consumers throughout the state. Often, stipends are made available allowing for free or reduced cost attendance. Some of these opportunities include the annual Family Connections Conference, the Children and Family Services Conference, the Indian Child Welfare Act conference, the North Dakota Family Based Services Conference, and the Clinical Forum on Mental Health Conference.

- Advocacy and support to families.
  - A number of advocacy and support groups exist throughout the state. These include Protection and Advocacy Project, Parent-to-Parent Support Program, Mental Health America of North Dakota, Family Voices of North Dakota and the North Dakota Consumer and Family Network. The Division will continue to assist these organizations whenever possible.

- Access to information and dissemination of information from Federal Entities
  - The Division of Mental Health and Substance Abuse Services developed Prairie Notes (fact sheets on numerous topics in mental health). These are available through the Department's website. In addition, the Research Team has developed Research Notes, compiling statistical data on mental health and substance abuse trends in North Dakota.

- Aging/Mental Health: Growing area of service need. Need more resources to help providers.
  - The Division of Mental Health and Substance Abuse Services is focusing attention on the enhancement of mental health services to the aged population throughout the State. This year North Dakota State University developed and implemented a training curriculum on mental health issues and older adults targeted to community-based mental health clinicians. The curriculum focused on mental health and the aging process; changes to the aging brain and the impact on mental health, wellness/prevention/medical issues associated with mental illness; assessment and diagnosis of mental health issues in older adults; treatment of mental illness in older adults including psychopharmacological treatment, psychosocial treatment, and barriers to treatment and how to address them; and community resources. The training was structured as a web-based program, which included core information, case studies, activities, and resources. The program was presented at the Aging Track of 2008 Clinical Forum on Mental Health Conference.

- Guardianship Issues: Need to fund guardianship services for vulnerable adults and elderly. Access is an issue and demand is high.
    - During the 2005 Legislative Session, SB 2028 provided for a guardianship services system for vulnerable adults who are ineligible for developmental disabilities case management services. Forty thousand dollars was appropriated for this system. The Division of Aging Services within the Department of Human Services was tasked with overseeing the implementation of the guardianship services system. Because of the limited funding ($40,000) and the need for such services from this target population, it was planned that twelve adults diagnosed with a serious mental illness would receive guardianship services through this program. A Request for Proposal was drafted for this program and training was conducted for attorneys, judges, and human service center case managers concerning guardianships for vulnerable adults. Unfortunately, there were no responses to the Request For Proposal.

      Due to the lack of RFP responders and to meet the legislative mandate, it was decided that the North Dakota Department of Human Services would pay for adult emergency or full guardianship establishment fees. This includes the attorney's fee, filing fee, and other fees connected with establishing the guardianships. There is no ongoing daily rate of pay. The target population for the program was individuals diagnosed with a serious mental illness, persons with Traumatic Brain Injury or persons over the age of 60. The work with the attorney, families, and proposed guardian is the responsibility of the regional human service centers. The cost for establishing the guardianship cannot exceed $2,500.

      This program will be continued through the 2007-2009 biennium.

- Staff shortages are increasing wait times.
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.

      In the Department, workforce issues are being addressed through the following:

        - Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future (results to be shared with each division shortly)
        - Meeting with divisions/supervisory staff to emphasize the flexibility that we <u>do have</u> in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
        - Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, recruitment/referral/retention bonuses, etc.
        - Tuition assistance for employees who choose to obtain additional skills and knowledge
        - Assessment of other options, such as non-traditional work hours

        - Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce (this is a project that we're working on with Decision Support and will be underway hopefully yet this month)
        - Development of the DHS Leadership Group (help to identify current and future leaders in DHS)

- Adults with serious and chronic mental illness need access to more job development and employment services to support their recovery.
    - The regional human service center staff assigned to the Extended Services and Supported Employment programs work extensively with employers to cultivate new job opportunities for consumers. In some areas of the state, employment opportunities are limited due to geographic location or job market. In Williston – currently experiencing a boom due to oil drilling – the job market is open and good paying positions are fairly easy to come by. Starting salaries are in excess of $9.00 per hour. However, opportunities in rural communities can be at times non-existent. The Division is exploring with Southeast Human Service Center the feasibility of implementing SAMHSA's model of Supported Employment. The Division will continue to work with the regional human service centers and Vocational Rehabilitation to enhance when possible employment services for consumers statewide.

- State needs more residential services and housing options for adults with chronic mental illness.
    - The Department of Human Services continues to monitor the need for residential options for adults with serious mental illness and works with stakeholders to implement new housing options. During the past year, new residential facilities have been opened in the Williston and Jamestown regions through the cooperative efforts of regional stakeholders.

- Dual diagnosis population needs transition to community services and long-term residential housing and supports.
    - Southeast Human Service Center is piloting Integrated Dual Disorders Treatment, an evidence-based practice. In May of 2006, a team from Southeast Human Service Center traveled to Ohio to receive training concerning implementation of IDDT from the Ohio Substance Abuse/Mental Illness Coordinating Center of Excellence (SAMI), a program of the Foundation for clinical Neuroscience Research & Education, INC. SAMI consultants are working closely with Southeast Human Service Center throughout the implementation of this project. In January of 2007 the program began working with adults diagnosed with a dual disorder. In January of 2008, a new team began working with individuals who are in the Quadrant Three subgroup of individuals diagnosed with a co-occurring disorder. During the most recent fidelity review, the IDDT program received one of the highest fidelity-to-model scores in the Nation. The Department is assessing the feasibility of implementing this program in another region.

- Divert people from corrections by training law enforcement personnel and coordinating with mental health system.
    - Department is working closely with the Department of Corrections and Rehabilitation to ensure that individuals who have a serious mental illness and are in prison have a smooth transition once they are released. Through the Release and Integration Program, case managers from the human service centers meet with inmates a few

months prior to their scheduled parole to begin preliminary work on securing housing and any other needed assistance. The goal of this program is to assist the consumer with transitioning back into the community and – through the establishment of an informal and formal support system – help the consumer avoid re-incarceration.

- The Department of Human Services is working with Protection and Advocacy, the Department of Corrections and Rehabilitation, and other stakeholders to implement Individual Justice Planning. For individuals that have or are at risk of coming into contact with the criminal justice system, an IJP can identify the training, services, and support necessary to prevent criminal behavior from re-occurring. The IJP will reference other treatment or service plans that provide detailed information to effectively provide care.
- The Department of Human Services is working with Cass County (the Fargo area) during their implementation of a post-booking diversion program. Cass County has been awarded a $250,000 grant from the U.S. Department of Justice for planning and implementation of diversion strategies to reduce recidivism, enhance public safety, and improve outcomes for individuals with a primary Axis I diagnosis who come into contact with law enforcement due to symptoms of their serious mental illness. The project is supported by ND Supreme Court Chief Justice VandeWalle, ND Attorney General Stenehjem, Eastcentral presiding District Judge Dawson, Cass County States Attorney Burdick, and many others. The Cass County Sheriff's Office is the lead agency, working collaboratively with Southeast Human Service Center, Judiciary, defense and prosecuting attorneys, and other community partners.

  Phase I of the Project focuses on post-booking diversion, and Phase II addressed pre-booking diversion. Post-booking diversion identifies those with serious mental illness who are booked into the Jail, links individuals to treatment and services, and works to dismiss legal charges when appropriate.

  Availability and accessibility of community-based services, including case management services and integrated treatment for co-occurring chemical dependency, are key to effective diversion programs. The Jail Intervention Coordinating Committee of Cass County worked to identify gaps in processes and service availability. Program implementation will begin in Fall of 2008.

- Support more peer support services to promote recovery.
  - North Dakota is implementing a Certified Peer Specialist Initiative statewide. A separate peer support program – implemented by Western Sunrise, Inc. in Williston, is already in place. The new program will prepare people who live with mental illnesses and use their experiences to work with others as peer specialists. A planned comprehensive training certification and curriculum will deliver a foundation in recovery principles, intervention techniques and ethical practice. Training curriculum will focus on the use of peer-delivered services to support the recovery of others.
  - The Division of Mental Health and Substance Abuse Services and the North Dakota Mental Health Planning Council will continue to support the Protection & Advocacy Project's implementation of mental health advanced directives. The Protection & Advocacy Project (P&A) and its Advisory Council for the Protection & Advocacy of Individuals with Mental Illness (PAIMI) have researched ways to more actively involve individuals with mental illness in their treatment planning. Mental Health Advance Directives (also known as Psychiatric Advance Directives) have been one

of the more promising innovations in recent years to give individuals with a severe mental illness a greater voice in their treatment. Mental Health Advance Directives are now widely recognized across the country. A Mental Health Advance Directive is a legal and medical document. Individuals are encouraged to use this tool as a way to inform and collaborate with their treatment providers. The goal is for the individual to receive the treatment most conducive to his or her mental health needs.

- Permanent housing for individuals with co-occurring mental health and substance abuse disorders based on stages of change model
    - DMHSAS staff will gather all information/needs assessments/etc. completed in the state related to housing needs.
    - DMHSAS staff will analyze the above information and determine if there is a need to do any additional assessment.
    - If further information/assessment is needed, DMHSAS staff will develop a questionnaire and identify the target audience.
    - DMHSAS staff will review the Housing Plan 2007 completed by Prairie Harvest Human Services Foundation for Region 3 and determine if this can be replicated in the other seven human service regions in North Dakota.
    - DMHSAS staff and system partners will assist the system to increase awareness of home ownership options for individuals with serious mental illness.
    - DMHSAS staff and system partners will support Prison Release Work Group (PRWG) efforts to secure transitional housing services for prison release when mental health issues are involved.

- There is a need to increase long-term supportive housing as many individuals in transitional living homes across the state have been permanently placed in these institutions.
    - DMHSAS staff will gather all information/needs assessments/etc. completed in the state related to housing needs.
    - DMHSAS staff will analyze the above information and determine if there is a need to do any additional assessment.
    - If further information/assessment is needed, DMHSAS staff will develop a questionnaire and identify the target audience.
    - DMHSAS staff will review the Housing Plan 2007 completed by Prairie Harvest Human Services Foundation for Region 3 and determine if this can be replicated in the other seven human service regions in North Dakota.
    - DMHSAS staff and system partners will assist the system to increase awareness of home ownership options for individuals with serious mental illness.
    - DMHSAS staff and system partners will support Prison Release Work Group (PRWG) efforts to secure transitional housing services for prison release when mental health issues are involved.

- There is a need to enhancing/expanding community-based options, mobile crisis services, and advanced directives
    - DMHSAS staff and system partners will support implementation of Crisis Intervention Teams (CIT) with the focus on launching the first team in the North Central region, Minot. A Train-the-Trainer model will be supported.

- DMHSAS staff and system partners will support all jail diversion/post booking efforts in ND
- DMHSAS staff will distribute information on the First Responders Model to those individuals/communities involved in implementing CIT for the purpose of determining if the model "fits with" CIT.
- DMHSAS staff will encourage/support the inclusion of CIT training at the ND Police Academy.
- DMHSAS staff and system partners will support/encourage the development of Individual Justice Planning for all those individuals who meet the criteria.
- DMHSAS staff and system partners will encourage staff at the regional human service centers to explore and develop options for consumers before they need to call 911 and to include these options in the development of treatment plans with consumers.
- DMHSAS staff and system partners will support training of consumers and professionals on Mental Health Advanced Directives or Psychiatric Advanced Directives.
- DMHSAS staff will collaborate with tribal mental health programs to establish the goals/objectives of the work of this workgroup, beginning with Standing Rock Sioux Tribe.
- DMHSAS will encourage regional human service centers and systems partners to expand/enhance current local, community-based efforts/practices in all areas of the state.
- DMHSAS staff will continue to work closely with HSC staff to research evidence-based practices for potential implementation.
- DHS division staff along with systems partners will analyze barriers to the availability of expanding the role of nursing facilities across the state to provide home and community-based services to individuals with serious mental illness.
- DMHSAS staff and system partners will encourage the utilization of existing mobile outreach services to implement mental health screening services in local communities.

- Very little peer support in ND
  - System partners will support the goals of the Transformation Transfer Initiative (Peer Support Project).
  - DMHSAS staff and system partners will advocate for consumer focus groups in each community or region that lead to an annual consumer conference.
  - System partners encourage the continuation of discussion at the executive level for the development of an Office of Consumer Affairs.
  - DMHSAS will work with the Psychosocial Rehabilitation Centers to discuss issues raised by the workgroup, including alignment with Recovery Model, consistency, consumer leadership, inclusion of all consumers, and training. This effort will join the work of the Peer Support Workgroup.

North Dakota

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

RECENT SIGNIFICANT ACHIEVEMENTS – ADULTS

- **Transformation**: North Dakota has made great strides in community-based mental health care, engaging in a number of transformation activities during the past year.

  Readers are referred to the Establishment of System of Care – Adults section for descriptions of these initiatives.

- **Olmstead Plan:** On June 22, 1999, the United States Supreme Court decided *Olmstead v. L.C. Olmstead v L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999) in which the Court determined that it is a form of discrimination under the Americans with Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals with mental disabilities when three factors are present:

  1. The state's treatment professionals have determined that community placement is appropriate;

  2. The individual does not oppose the transfer to a community setting; and

  3. The placement can be reasonably accommodated taking into account the resources available to the state and the needs of others with mental disabilities.

  The *Olmstead* plan aims to identify direct actions to protect and support the ability of people with disabilities to live in the most integrated setting appropriate to their needs. This plan was developed to implement the requirements of the ADA and the *Olmstead* decision in North Dakota, including the tribes, to allow residents with disabilities to live successfully in the community of their choice with appropriate and desired supports. The commission does meet on a quarterly basis.

- **State Epidemiology Work Group:** The state was awarded a State Epidemiology Work Group grant in 2006. The goal of this project is to improve data resources in order to begin formulation of the state prevention framework. Individuals are participating to bring ND data together and develop a state profile. This profile has been developed and continuing efforts to regionalize the profile are ongoing.

- **Comprehensive Employment Systems Infrastructure Development:** The North Dakota Center for Persons with Disabilities received $500,000 in funding from the U.S. Department of Health and Human Services Center for Medicaid and Medicare Services for a Comprehensive Employment Systems Infrastructure Development Grant (NDCES).

  During the first year, the NDCES project completed a state-wide strategic planning process that was driven by consumers, disability service providers, and the business/ economic development community, to develop a comprehensive employment system that will assist individuals with disabilities to seek and maintain gainful employment.

  The goals of the grant include the following:

  - Develop a state-wide Comprehensive Employment System that will:

- Maximize employment for people with disabilities.
- Increase the state's labor force through the inclusion of people with disabilities.
- Protect and enhance workers healthcare, other benefits and needed employment supports.

Their efforts continue to build upon the statewide initiative. The Division of Mental Health and Substance Abuse Services as well as the North Dakota Mental Health Planning Council will continue to monitor and assist this project when needed.

- **Suicide Prevention:** The North Dakota Department of Health, Division of Injury Prevention and Control, coordinates the North Dakota Suicide Prevention Coalition. The coalition's membership includes family survivors and a good cross-systems representation including North Dakota State University Extension, tribal representatives from all four reservations in the state, Public Health, IHS, the faith community, law enforcement, Mental Health American of North Dakota, the University of North Dakota, the North Dakota Indian Affairs Commission, the Native American Training Institute, Spirit Lake Little Hoop Community College, local hospital staff, Northwest Human Service Center, the North Dakota Department of Public Instruction, and North Dakota Department of Human Services - Division of Mental Health and Substance Abuse. The coalition meets quarterly. When the original Task Force was established in 1998, efforts were focused on adolescents as the need to respond to the high number of suicides in our state was significant, especially on the Standing Rock reservation. Much has been accomplished through training, mentoring projects, reducing stigma, and increasing screening and referral efforts. The North Dakota Suicide Prevention Plan for all age groups was developed in 2005 and released in 2006. The plan describes the incidence rates; priority goals, strengths, and action steps; and recommendations for necessary action in North Dakota.

  Since the beginning of 2007, the focus of the group has changed. The primary focus will be to provide oversight, assistance, and act as an advisory council for the implementation of the Garrett Lee Smith State and Tribal Youth Suicide Prevention Grant from SAMHSA. Congress passed the Garrett Lee Smith Memorial Act, which was signed, into law by President Bush on October 21, 2004. The Act memorializes Garrett Lee Smith, the son of Senator Gordon and Sharon Smith of Oregon, who committed suicide. The use of $82 million over three years is authorized to support States, Indian tribes, and colleges and universities to develop and implement various youth suicide prevention initiatives.

  The grant brings $1,200,000 to ND over a three-year period of time. Much of the funding will be distributed to specific tribal and county areas that have the highest rates of teen suicide fatalities over the past six years. Six areas in ND have been identified as those having the highest rate of suicides of young people between the ages of 10 and 24. Those areas are: 1. Burke county and portions of Renville, Mountrail, and Ward counties; 2. Rolette county; 3. Benson, Ramsey, Eddy, Foster, and Nelson counties and most of Wells county 4. LaMoure and Dickey counties; and 6. Sioux county. 85% of the grant funds must be used for direct services which refer youth to intervention and prevention services. Services can include but are not limited to training, assessment, post suicide intervention services, information and awareness campaigns, and other suicide prevention activities. This does not mean the money must be used for direct clinical services; rather, it is to support State-sponsored suicide prevention activities as described.

  The Division of Mental Health and Substance Abuse Services, with the assistance of a member of Decision Support Services, are in the process of developing a series of fact

sheets on the subject of suicide. Two are completed and available for you to read on the following DHS websites at: http://www.nd.gov/humanservices/info/pubs/abuse.html. or http://www.nd.gov/dhs/info/pubs/docs/mhsa/vol-1-no-1-prairienotes-suicide.pdf or http://www.nd.gov/dhs/info/pubs/docs/mhsa/vol-1-no-2-prairienotes-suicide-prevention.pdf

- **Transition Flex Funds:** In 2007, SAMHSA announced the opportunity for states to submit applications for financial support to assist in responding more effectively to the needs of adults with serious mental illness and children with serious emotional disturbance. The Bazelon Center for Mental Health facilitates this initiative. The Division of Mental Health and Substance Abuse (DMHSA) submitted an application and was approved for $20,000/year for three years. The plan for these funds includes:

  - Establish a "Transition Flex Fund" to assist youth in transition from the children's mental health system to the adult mental health system. To date, assistance has been provided to 13 youth.

  - Assist in funding training/consultation needed to implement a supported employment pilot project in the integrated dual disorder treatment (IDDT) pilot project in the Southeast region of North Dakota in year one and to expand the project to an additional site in years two and three. To date, the IDDT Workgroup has met to discuss/plan for expansion of services to other regions of the state. Further detailed discussions will be had with two regions and the NDSH by Fall of 2008.

  - Contract with a facilitator to assist the North Dakota Department of Human Services, Mental Health and Substance Abuse Division, in the creation of a coalition of stakeholders and the development of a comprehensive plan for a continuum of care for adults with serious mental illness to be presented for legislative consideration in the 2009 Legislative Session. The Continuum of Care Workgroup completed a series of five planning sessions and agreed upon three priorities areas with specific recommendations to the DHS Cabinet for consideration and implementation.

  - Assist in establishing a Youth Advisory Council aimed at providing an opportunity for youth to have a voice in shaping program and policy in the service delivery system in North Dakota. To date, the development of a statewide Youth Advisory Council has taken shape. A planning group meets on a regular basis. Systems partners were contacted in April 2008 with the details and an invitation to refer youth to serve on the Council. Application packets have been mailed to the youth. Applications will be reviewed and the first meeting will be held in the Summer of 2008.

  - Contribute a portion of the funds in year three to the effort by DHS to implement a Cultural Competency Plan for all employees. Progress to date includes planning for an initial training format, annual review of the information, and discussion of training at the Fifth Annual Clinical Forum on Mental Health in May 2009.

- **Anti-Stigma Campaign:** In an effort to reduce the stigma associated with mental illness, the Division is implementing an anti-stigma campaign. Using the "What A Difference A

Friend Makes" campaign material, the Division contracted with Newman Outdoor Advertising for the design and set-up of thirty-two billboards across the state. The billboards, targeted to young adults, read, "Mental Health Recovery…What A Difference A Friend Makes!" This campaign will continue and will focus on, "Mental Health Recovery: Hope…Empowerment…*Achievable*!"

North Dakota

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

NORTH DAKOTA'S VISION FOR THE FUTURE

The mission of the North Dakota Department of Human Services is: "To provide quality, efficient, and effective human services that improve the lives of people." We have also adopted our Federal partner's vision of "A life in the community for everyone".

North Dakota understands that we face several challenges. People are coming in for services with increasing complexity and at younger ages. Funding to provide services is not keeping pace with the demand for those services in the public sector. These challenges cannot be overcome alone and the Division of Mental Health and Substance Abuse Services will continue to work with our partners on a Federal, State, and local level to address them.

The Division of Mental Health and Substance Abuse Services envisions a service system of the future where consumers have greater access to services, have more services to choose from, and receive increased effectiveness of those services. Through continued work with our partners, the implementation of new evidence-based and best practices, and continued evaluation and refinement of the system of care, North Dakota will transform the mental health system to ensure a life in the community for everyone.

The Division in conjunction with the ND Mental Health Planning Council promotes and supports a focus and vision on mental health wellness and recovery that is consumer and family driven.

North Dakota

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

SERVICE SYSTEM'S STRENGTHS AND WEAKNESSES ADULTS AND CHILDREN

As discussed in the Department Description section of the application, the Department of Human Services provides and administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. A strength of the system is the actual structure of the Department. This structure – with key components such as Medicaid, the regional human service centers, Mental Health and Substance Abuse located in one umbrella agency – facilitates stronger communication and the ongoing development of a solid community-based system of mental health care throughout the state. This is particularly evident within the regional human service centers. Located in each of the eight major cities, the regional human service centers offer a wide variety of mental health, substance abuse, vocational rehabilitation, and developmental disability services under one roof.

As detailed in other sections, the community-based public mental health system in North Dakota has made great strides in recent years. The growth of the community-based mental health delivery system in North Dakota has resulted in a decline in the daily inpatient census of the North Dakota State Hospital from over 2,000 individuals diagnosed with a mental illness in the 1960's to approximately 130 today. This has been a result of numerous diversion programs, legislation, and enhanced community programming. The Department is implementing and planning for more evidence-based practices including Integrated Dual Disorders Treatment, Supported Employment, and Structured Psychotherapy for Adolescents Responding to Chronic Stress and Trauma Focused Cognitive Behavioral Therapy. Evidence-based practices have been proven to consistently produce specific, intended results. Implementation will help to further strengthen the mental health system of care throughout North Dakota.

Though North Dakota has considerably strengthened its system of care during the past decade, challenges remain.

Demographics continue to challenge the state. North Dakota is a rural state with two-thirds of its counties designated as frontier areas. Nearly 40% of the state's population resides in the two eastern regions that lie on the border with Minnesota. In contrast, only ten percent of the population resides in the two regions that lie on the western border with Montana. In fact, the western half of the state has a sparse population density from 0.9 to 10.7 persons per square mile. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel. Round-trips of 200-300 miles or more to obtain services are not uncommon.

North Dakota has a long history as a farming community and has relied on this business for much of its economic livelihood. However, with the downswing in the rural economy, the population distribution became more urban than rural as farmers and ranchers closed their businesses, left their home communities, and moved into the cities seeking employment. This shift has resulted in fewer services available in some of the rural areas. It is very difficult to find qualified medical and human service personnel who desire to live in rural, often remote communities in the state. According to the University of North Dakota's Center for Rural Health, nearly eighty percent of the state -- or all but eleven counties -- has some area that is considered a health profession shortage area.

Though the state population's racial makeup remained virtually unchanged, the age of citizens has increased. The child population (0-17) decreased during the 1990's by nearly 13%. Adults age 18-34 and 60-74 decreased during the decade, as well (22.5% and 5.7%, respectively).

The causes of this phenomenon vary. Many young people are leaving North Dakota to seek opportunities elsewhere. The state has also been experiencing a steady decline in the birth rate, perhaps caused by young people leaving or the economic realities of today. Those who remain in the state are faced with needing to hold multiple jobs in order to make ends meet. In fact, 2000 Census figures indicated that North Dakota was the highest ranked state in the nation for the percentage of people who hold multiple jobs and a higher percentage of jobs in the state pay less than $12 per hour.

Another phenomenon being noticed is that some retired people – having left the state to seek opportunities elsewhere – are returning to North Dakota to spend their remaining years in the place they grew up. Similarly, as youth leave the rural areas, some elderly residents choose to remain behind in the towns they lived in most of their lives. The reality, however, is that services continue to decrease in these areas when the population in question will require more and more.

The phenomena mentioned above will impact service delivery in two major ways. With a decline in the 18-34 year old range – typically the largest source of caregivers in the state – it will become more difficult to find caregivers to offset the increases in the population of those 75 and older. This may become magnified in the future as the baby-boomers age. This is only compounded by the declining birth rate. Also, with an increase in elderly and decrease in younger people, the tax base will decline. In the next few years, an increasing number of residents will be moving into retirement and out of the workforce. The tax burden will be shifted to a dwindling workforce-age population. With declining income to pay for increased utilization, services may be in jeopardy. The Decision Support Services Unit, in conjunction with the Aging Service Division, is studying the impact of the aging population on the workforce, available employees, what services they will need, and future survey of those turning 60 in the year 2020.

There are continued challenges with the clinical workforce. The human service centers continue to fall behind in their ability to compete in the marketplace for salaries for professionals. Private providers tend to pay mental health professionals more than human service centers. In addition, many professionals are reluctant to live in the more rural areas of North Dakota or in North Dakota in general. Demand for the skills of certain professionals definitely exceeds the supply. Thus, there is considerable competition for licensed addiction counselors, clinical psychologists, psychiatrists, licensed certified/independent clinical social workers, and psychiatric nurses. In fact, clinicians are being offered as much as $50,000 more per year in salary from the private sector than what can be offered in the public sector. Just as private providers are able to pay higher wages than the public sector, they also tend to charge higher rates. This compounds the workforce shortage issue at the regional human service centers as many counties and courts prefer to refer to the human service centers for evaluations and other services because of the lower costs. This adds to the workload of an already strained workforce. The Department is working with various entities to address workforce issues. For instance, North Dakota is working with the Western Interstate Commission for Higher Education, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition, this program will help provide clinicians to those rural areas where often it is difficult to recruit for. The Department is working with various federal entities and the Center for Rural Health-University of North Dakota to recruit individuals in identified shortage areas and professions through the use of loan repayment and J1-Visa programs. The Division worked with the Western Interstate Commission for Higher Education, Mental Health Division, to develop a

workforce development plan. Recommendations from that plan have been incorporated into the overall strategies of the DHS HR division.

In the Department, workforce issues are being addressed through the following:

- Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future
- Meeting with divisions/supervisory staff to emphasize the flexibility that we do have in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
- Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, recruitment/referral/retention bonuses.
- Tuition assistance for employees who choose to obtain additional skills and knowledge
- Assessment of other options, such as non-traditional work hours
- Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce
- Development of the DHS Leadership Group (help to identify current and future leaders in DHS)

The Department continues to see more children in North Dakota presenting with more complex issues at an earlier age. This is particularly evident in the data from the Trauma- Focused Cognitive Behavioral Therapy implementation in that a majority of children involved in this therapeutic process have experienced an average of 6-7 trauma's in their young lives. This phenomenon presents at the same time that the child population is decreasing. The Department of Public Instruction is experiencing significant increases in the number of children qualifying for emotional disturbances services through the individualized education plan (IDEA). The Department of Human Services sees increases in the number of children that are referred at younger ages, as young as age two, and often they are presenting with multiple and complex issues. To compound this issue, budgetary constraints have lead to a decrease in the number of beds available to children at the state hospital while community resources are reaching capacity.

Overall, the human service centers are seeing more people with greater complexity of issues and often at a younger age. This includes consumers who have engaged in sexual offending behavior; significant substance abuse, mental health disorders, and histories of physical or emotional abuse and neglect; and the need for longer substance abuse treatment services in the community due to the severity of symptoms and use of methamphetamine. As you can see, the design of the human service centers as multidisciplinary teams is critical in comprehensively addressing the complex needs of the consumers served.

A Youth Advisory Council Initiative that is being developed will address issues in our systems and examine the complexity of today's youth. The goal of the Council is to provide youth with an active voice in effecting policy and program change in North Dakota.

For fiscal year 2007, there were 44,470 children age 0-21 that were eligible for a Health Tracks screening. 26,620 have had at least one screening with 62% of children having received a Health Tracks screening.

Health Tracks is a preventive health program that is free for children age 0 to 21 who are eligible for Medicaid. Health Tracks funds screenings, diagnosis, and treatment services to assist in the prevention and intervention of emotional/health concerns. Health Tracks utilizes the Pediatric Symptom Checklist to assess for emotional/developmental and behavioral risk factors. Health Tracks, Developmental Disabilities, Head Start, Child Welfare and Mental Health have initiated a work group to examine early prevention, intervention, screening and systemic points of entry for children and families. The work group (the North Dakota Children's Social, Emotional, Developmental Alliance) met to discuss the need for all children in ND to be screened for emotional, behavioral, developmental, physical and educational risk factors. A decision making tree was created that allows families and system partners to negotiate and understand the various systems program criterion in North Dakota to assist in meeting the needs of children and families. A Mental Health Screening Tool Kit training and training materials/videos are available to all system partners. A state form was developed known as the Preliminary Questions for Social/Emotional/Developmental/Screening that is used by the various systems. This form assists the staff from the various systems in discovering if the family has had prior mental health screening(s) or involvement in mental health services. Health Tracks also funds orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling, and other important health services. Health Tracks staff assist families with the scheduling of appointments for services, as well, as assist with finding transportation to the services.

Healthy Steps, North Dakota's SCHIP, currently serves 4,087children. According to the 2007 Annual EPSDT (Health Tracks) report, 11,148 individuals from birth to 21 years of age received a dental service, 6,984 a preventive dental service and 5,069 received dental treatment services.

Access to dental care continues to be an issue in North Dakota. According to the University of North Dakota's Center for Rural Health, 30% of the state's 53 counties are designated as Dental Health Professional Shortage Areas (as of 9-2007). Fifty-seven percent of North Dakota's population lives in Ward, Grand Forks, Cass and Burleigh counties, as do an overwhelming proportion of the state's dentists. As a result of growing concerns about a nation-wide shortage of dentists, and the number of designated dental HPSAs in North Dakota, the Center conducted a state-wide dental workforce survey to examine the demographics, practice profiles, and patient profile information of the state's 316 licensed dentists. North Dakota does not have a dental school, and over half of our dentists were trained at the University of Minnesota. Results from our 2004 survey indicate: just over half were born in ND, 73% practice general dentistry, the average age of North Dakota dentists is 52 years and 60% of dentists plan to retire in the next 15 years. In 2002 a state dental loan repayment program was established to attract dentists to areas of need across the state. There have been eight recipients of the loan program who located in 6 different communities (Minot, Fargo, New Rockford, Grand Forks, Bismarck, and West Fargo).

Finally, though strides have been made during the past few years in creating new housing opportunities for consumers, a number of barriers remain. North Dakota lacks sufficient affordable housing, especially for individuals in the low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is much more limited – transitional units, low income housing, and supported permanent housing are in very short supply. "Deep subsidy" funds like the Section 8 voucher, which is the only way the chronically homeless will be able to afford to pay for the housing portion of permanent supportive housing, are limited. Some zoning laws in the state contain provisions that make it difficult to site group living facilities, which is the category most permanent supportive housing

projects fall into. The specific regulatory language often involves definition of “non-household” living, rules regarding number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process.

There is a willingness to tolerate chronic homelessness as an “acceptable” situation in North Dakota. In part, this belief is fostered by people’s lack of direct experience with chronically homeless individuals. It is difficult to feel a sense of urgency about an issue with which one has little knowledge or first hand experience. The people of this state have a fundamental belief in “self-sufficiency.” This belief often leads people to believe that the chronically homeless do not deserve help because they are not working hard enough to help themselves. Again, the belief itself is an obstacle to building support for the creation of housing options that specifically serve this population. At times, consumers have difficulty accessing available housing resources because of poor rental and credit histories and criminal backgrounds. In addition, very low or no income and an inability to afford rent, whether it is because they are unable to find a job where the pay is sufficient to cover housing costs or because they are unable to keep a job because of a disability is an issue.

North Dakota

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

UNMET SERVICE NEEDS OF THE CHILDREN'S SYSTEM

North Dakota has engaged in a number of activities since the last MHBG Review to identify needs in the community-based public service system. These efforts have included conversations with the North Dakota Mental Health Planning Council as well as Department Stakeholder Forums.

The North Dakota Mental Health Planning Council has identified the following as being issues that need to be addressed:

- There are limited resources for completion of assessments. Because of the challenges recruiting and retaining clinical staff, workloads at the regional human service centers have increased at times resulting in delays in receiving an assessment.
- Access to psychological and psychiatric services in a timely manner can be challenging in some areas of the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.
- There is a need for increased training opportunities for private, public, child serving agencies.
- There is a need for increased training opportunities for families and youth.
- Advocacy and support to families and youth
- Access to information and dissemination of information from Federal Entities
- Insurance coverage for MH services; SCHIPS (Healthy Steps), Health Tracks

The North Dakota Department of Human Services held stakeholder meetings across the state in the Fall of 2007. Meetings were scheduled in Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston. Organizations and individuals involved in the delivery of human services in North Dakota were invited to attend and to discuss community needs, capacity, and resources. Issues raised included:

- Need more funding, training, staff to meet the needs of children and adolescents with mental health, substance abuse, or sexual abuse treatment needs
- Voluntary placements are lacking, parents have to relinquish custody of children to obtain treatment
- Access to community based treatment and psychiatric/psychological services
- Need treatment centers for children/youth with sexual offending behaviors. Provide assessment, treatment, and follow-up services in the community.
- The state needs more crisis residential and shelter care beds for children and teens.
- • N.D. needs more intensive in-home, parent aide, and other preventive services to sustain children in their homes.
- Capacity issues exist across the system to appropriately serve children and youth transitioning into adult services.
- Transportation is an issue across the state and across delivery systems.
- Higher fuel prices make it hard for people to afford the transportation necessary to access a wide array of human services.
- Demand for outreach services is growing.
- Workforce concerns exist across the entire service delivery system from direct care workers to clinical specialists
- The required background check process takes too long. Some providers lose job applicants in child care and direct service while they wait for background checks to be completed.
- Capacity issues exist across the state's mental health system.

- Resources are needed to expand intensive in-home services and residential bed
- capacity for children.
- Community mental health inpatient service providers (hospitals) are stressed, and reimbursement is a key concern.
- Telemedicine and more expert outreach (from human service centers and the State Hospital) may help address mental health needs in underserved rural areas.
- Need education for families of children with SED. Growing number of children with co-occurring significant developmental disabilities
- Child and Family Services Review outcomes and Performance Improvement Plan
- A need for youth voice for policy and social change:

The stakeholder meeting will be held again in the fall of 2009.

North Dakota

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

PLANS TO ADDRESS UNMET NEEDS - CHILDREN

Based on the needs identified in the "Unmet Needs" section of this report, North Dakota is implementing or planning to implement the following:

- The Division of Mental Health and Substance Abuse Services has committed funding to continue support of the implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) for the next three years to address the mental health needs of children and adolescents who have experienced traumatic experiences; child abuse and neglect, sexual abuse, placement outside of the home.
- In the 2007-2009 Biennium, the Voluntary Treatment Program funding was doubled to meet the mental health needs of children without parents having to relinquish custody.
- Outreach services are available from the Human Service Centers along with county social services.
- The Department continues to look for treatment options for youth with sexual offending behaviors. There has been no response to a RFP that was issued last year.
- West Central Human Service Center located in Region VII - serving 10 counties has opened a crisis residential program with safety beds (crisis beds) and a treatment program for youth with substance abuse/use issues. The name of the program is Youth Residential Services, located in Bismarck, ND.
- A request to approve an Optional Adjustment Request will be submitted for the 2009-2011 biennium to the Legislative Session to request an increase in Family Preservation Services; to include intensive in-home family therapy, parent aide, respite care, etc.
- A legislative Interim Committee study was chosen to explore the needs of transitioned aged youth in all systems; mental health, education, child welfare, juvenile justice, vocational rehabilitation and developmental disabilities. A collaborative effort among the systems has occurred to provide testimony and information to the committee. The Children's MH Administrator is also involved with a nation transition aged youth workgroup, exploring areas such as, housing, employment, involvement in policy building and testimony. The Department also has a Transition Steering Council that has been working on this area.
- The Human Service Centers do provide outreach service to rural areas, the Division is also a member of WICHE that is examining the workforce needs, and service gaps in the rural areas. In the Department, workforce issues are being addressed through the following:

    - Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future
    - Meeting with divisions/supervisory staff to emphasize the flexibility that we do have in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
    - Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, recruitment/referral/retention bonuses.
    - Tuition assistance for employees who choose to obtain additional skills and knowledge
    - Assessment of other options, such as non-traditional work hours
    - Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce
    - Development of the DHS Leadership Group (help to identify current and future leaders in DHS)

- The Children and Family Services Division which processes the Background Checks for facilities and providers throughout the state did hire additional staff to address the back log of background checks. This task was accomplished and now the wait time from submission of background checks to reply is 2 weeks. This has allowed a faster response and turnaround time to allow facilities and providers to hire staff.
- The Human Service Centers are prioritizing the service needs of children through a thorough assessment to ensure the most vulnerable are able to access services.
- CMS has authorized a pilot at St. Joseph's Hospital in Region VIII- SW ND to meet the psychiatric needs of adults and children.
- Telemedicine is being used at a Human Service Center for medication monitoring, clinical services and assessments.
- The Parent-to-Parent Support Program implemented by the ND Federation of Families does provide education and outreach to families and children who have an emotional and/or behavioral disorder. A request has been made to increase the budget, thus allowing for more outreach services to provide education and advocacy.
- An Autism Workgroup at the Department has been developed to gather information from stakeholders to include parents to examine the service gaps, strengths, needs for children with Autism. The department will take this feedback and include in our budget building process, and will pursue a waiver dependent on funding from the 2009-2011 Legislative Session. Minot State University was awarded a grant to provide education and services targeting rural areas of the state. The program is called Great Plains Autism Spectrum Disorders Treatment Program. The program includes service, information, research and training.
- The Child Welfare System had a Child and Family Services Review in April 2008. The Children and Family Services Division along with stakeholders from across the state will be developing a program improvement plan to address major themes; Engagement of non-custodial parents, continued emphasis on Wraparound Process with families, Safety Plan development, and Engagement with Tribes.

North Dakota

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

RECENT SIGNIFICANT ACHIEVEMENTS - CHILDREN

The Division of Mental Health and Substance Abuse Services is leading the community-based public mental health system and its partners in implementing various mental health transformation activities. These include evidence-based practices (EBP) for children, early childhood screening, a youth initiative, Enforcing Underage Drinking Laws, Olmstead Plan, State Epidemiology Workgroup, Comprehensive Employment Systems Infrastructure Development, suicide prevention, transition flex funds, anti-stigma campaign, and Autism.

EBP's Children: Please refer to the Establishment of System of Care – Children section for detailed information on EBP's for children.

Early Childhood Screening: Please refer to the Establishment of System of Care – Children section under North Dakota Children's Social, Emotional and Developmental Alliance for detailed information on the Mental Health Screening Tool Kit efforts and planning.

A Youth Initiative: Please refer to the Establishment of System of Care – Children section under Youth Advisory Council.

Enforcing Underage Drinking Laws: The Division has developed specific strategies to reduce underage drinking and increase youth involvement in task force and other state, local, and federal committees.

Olmstead Plan: On June 22, 1999, the United States Supreme Court decided *Olmstead v. L.C. Olmstead v L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999) in which the Court determined that it is a form of discrimination under the Americans with Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals with mental disabilities when three factors are present:

1. The state's treatment professionals have determined that community placement is appropriate;

2. The individual does not oppose the transfer to a community setting; and

3. The placement can be reasonably accommodated taking into account the resources available to the state and the needs of others with mental disabilities.

The *Olmstead* plan aims to identify direct actions to protect and support the ability of people with disabilities to live in the most integrated setting appropriate to their needs. This plan was developed to implement the requirements of the ADA and the *Olmstead* decision in North Dakota, including the tribes, to allow residents with disabilities to live successfully in the community of their choice with appropriate and desired supports. The commission does meet on a quarterly basis.

State Epidemiology Work Group: The state was awarded a State Epidemiology Work Group grant in 2006. The goal of this project is to improve data resources in order to begin formulation of the state prevention framework. Individuals are participating to bring ND data together and develop a state profile. This profile has been developed and continuing efforts to regionalize the profile are ongoing.

Comprehensive Employment Systems Infrastructure Development: The North Dakota Center for Persons with Disabilities received $500,000 in funding from the U.S. Department of Health and Human Services Center for Medicaid and Medicare Services for a Comprehensive Employment Systems Infrastructure Development Grant (NDCES).

During the first year, the NDCES project completed a state-wide strategic planning process that was driven by consumers, disability service providers, and the business/ economic development community, to develop a comprehensive employment system that will assist individuals with disabilities to seek and maintain gainful employment.

The goals of the grant include the following:

Develop a state-wide Comprehensive Employment System that will:

• Maximize employment for people with disabilities.

• Increase the state's labor force through the inclusion of people with disabilities.

• Protect and enhance workers healthcare, other benefits and needed employment supports.

Their efforts continue to build upon the statewide initiative. The Division of Mental Health and Substance Abuse Services as well as the North Dakota Mental Health Planning Council will continue to monitor and assist this project when needed.

Suicide Prevention: The North Dakota Department of Health, Division of Injury Prevention and Control, coordinates the North Dakota Suicide Prevention Coalition. The coalition's membership includes family survivors and a good cross-systems representation including North Dakota State University Extension, tribal representatives from all four reservations in the state, Public Health, IHS, the faith community, law enforcement, Mental Health American of North Dakota, the University of North Dakota, the North Dakota Indian Affairs Commission, the Native American Training Institute, Spirit Lake Little Hoop Community College, local hospital staff, Northwest Human Service Center, the North Dakota Department of Public Instruction, and North Dakota Department of Human Services - Division of Mental Health and Substance Abuse. The coalition meets quarterly. When the original Task Force was established in 1998, efforts were focused on adolescents as the need to respond to the high number of suicides in our state was significant, especially on the Standing Rock reservation. Much has been accomplished through training, mentoring projects, reducing stigma, and increasing screening and referral efforts. The North Dakota Suicide Prevention Plan for all age groups was developed in 2005 and released in 2006. The plan describes the incidence rates; priority goals, strengths, and action steps; and recommendations for necessary action in North Dakota.

Since the beginning of 2007, the focus of the group has changed. The primary focus will be to provide oversight, assistance, and act as an advisory council for the implementation of the Garrett Lee Smith State and Tribal Youth Suicide Prevention Grant from SAMHSA. Congress passed the Garrett Lee Smith Memorial Act, which was signed, into law by President Bush on October 21, 2004. The Act memorializes Garrett Lee Smith, the son of Senator Gordon and Sharon Smith of Oregon, who committed suicide. The use of $82 million over three years is

authorized to support States, Indian tribes, and colleges and universities to develop and implement various youth suicide prevention initiatives.

The grant brings $1,200,000 to ND over a three-year period of time. Much of the funding will be distributed to specific tribal and county areas that have the highest rates of teen suicide fatalities over the past six years. Six areas in ND have been identified as those having the highest rate of suicides of young people between the ages of 10 and 24. Those areas are: 1. Burke county and portions of Renville, Mountrail, and Ward counties; 2. Rolette county; 3. Benson, Ramsey, Eddy, Foster, and Nelson counties and most of Wells county 4. LaMoure and Dickey counties; and 6. Sioux county. 85% of the grant funds must be used for direct services which refer youth to intervention and prevention services. Services can include but are not limited to training, assessment, post suicide intervention services, information and awareness campaigns, and other suicide prevention activities. This does not mean the money must be used for direct clinical services; rather, it is to support State-sponsored suicide prevention activities as described.

The Division of Mental Health and Substance Abuse Services, with the assistance of a member of Decision Support Services, are in the process of developing a series of fact sheets on the subject of suicide. Two are completed and available for you to read on the following DHS websites at: http://www.nd.gov/humanservices/info/pubs/abuse.html. or http://www.nd.gov/dhs/info/pubs/docs/mhsa/vol-1-no-1-prairienotes-suicide.pdf or http://www.nd.gov/dhs/info/pubs/docs/mhsa/vol-1-no-2-prairienotes-suicide-prevention.pdf

Transition Flex Funds: In 2007, SAMHSA announced the opportunity for states to submit applications for financial support to assist in responding more effectively to the needs of adults with serious mental illness and children with serious emotional disturbance. The Bazelon Center for Mental Health facilitates this initiative. The Division of Mental Health and Substance Abuse (DMHSA) submitted an application and was approved for $20,000/year for three years. The plan for these funds includes:

- Establish a “Transition Flex Fund” to assist youth in transition from the children’s mental health system to the adult mental health system. To date, assistance has been provided to 13 youth.

- Assist in funding training/consultation needed to implement a supported employment pilot project in the integrated dual disorder treatment (IDDT) pilot project in the Southeast region of North Dakota in year one and to expand the project to an additional site in years two and three. To date, the IDDT Workgroup has met to discuss/plan for expansion of services to other regions of the state. Further detailed discussions will be had with two regions and the NDSH by Fall of 2008.

- Contract with a facilitator to assist the North Dakota Department of Human Services, Mental Health and Substance Abuse Division, in the creation of a coalition of stakeholders and the development of a comprehensive plan for a continuum of care for adults with serious mental illness to be presented for legislative consideration in the 2009 Legislative Session. The Continuum of Care Workgroup completed a series of five planning sessions and agreed upon three priorities areas with specific recommendations to the DHS Cabinet for consideration and implementation.

- Assist in establishing Youth Advisory Council aimed at providing an opportunity for youth to have a voice in shaping program and policy in the service delivery system in North Dakota. To date, the development of a statewide Youth Advisory Council has taken shape. A planning group meets on a regular basis. Systems partners were contacted in April 2008 with the details and an invitation to refer youth to serve on the Council. Application packets have been mailed to the youth. Applications will be reviewed and the first meeting will be held later this summer.

- Contribute a portion of the funds in year three to the effort by DHS to implement a Cultural Competency Plan for all employees. Progress to date includes planning for an initial training format, annual review of the information, and discussion of training at the Fifth Annual Clinical Forum on Mental Health in May 2009.

Anti-Stigma Campaign: In an effort to reduce the stigma associated with mental illness, the Division is implementing an anti-stigma campaign. Using the "What A Difference A Friend Makes" campaign material, the Division contracted with Newman Outdoor Advertising for the design and set-up of thirty-two billboards across the state. The billboards, targeted to young adults, read, "Mental Health Recovery…What A Difference A Friend Makes!" This campaign will continue to focus on, "Mental Health Recovery: Hope…Empowerment…Achievable!"

Autism Medicaid Waiver Efforts: Please refer to the Establishment of System of Care – Children section for detailed information on Autism.

North Dakota

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

NORTH DAKOTA'S VISION FOR THE FUTURE

The mission of the North Dakota Department of Human Services is: "To provide quality, efficient, and effective human services that improve the lives of people." We have also adopted our Federal partner's vision of "A life in the community for everyone".

North Dakota understands that we face several challenges. People are coming in for services with increasing complexity and at younger ages. Funding to provide services is not keeping pace with the demand for those services in the public sector. These challenges cannot be overcome alone and the Division of Mental Health and Substance Abuse Services will continue to work with our partners on a Federal, State, and local level to address them.

The Division of Mental Health and Substance Abuse Services envisions a service system of the future where consumers have greater access to services, have more services to choose from, and receive increased effectiveness of those services. Through continued work with our partners, the implementation of new evidence-based and best practices, and continued evaluation and refinement of the system of care, North Dakota will transform the mental health system to ensure a life in the community for everyone.

The Division in conjunction with the ND Mental Health Planning Council promotes and supports a focus and vision on mental health wellness and recovery that is consumer and family driven.

North Dakota

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

ESTABLISHMENT OF SYSTEM OF CARE – ADULTS

North Dakota's public mental health delivery system is a coordinated, interagency effort made up of a variety of human service agencies and programs. The growth of the community-based mental health delivery system in North Dakota has resulted in a decline in the daily inpatient census of the North Dakota State Hospital from over 2,000 individuals diagnosed with a mental illness in the 1950's to approximately 150 today.

STATEWIDE PLANNING PROGRAM: The planning process in North Dakota continues to evolve. The Division works closely with the human service centers in planning for the Serious Mental Illness and Children's Mental Health systems of care. The Division meets quarterly with each regional human service center's program staff to plan and implement community-based mental health services statewide. The human service centers regularly meet with regional stakeholders. In addition, region-specific planning meetings are held in every region throughout the year. The format of these meetings varies from region to region. Some choose to hold separate planning meetings with the local stakeholders. Others invite stakeholders to the Human Service Center Advisory Council meeting and conduct the planning in conjunction with that already-scheduled session. Additional regional planning is conducted through the Regional Children's Services Coordinating Committee, which is coordinated through the regional human service center.

The Statewide Planning Program is utilizing data gathered through the Mental Health Statistics Improvement Program project to make informed planning choices. The Planning Program will continue to be refined during the upcoming years and that data gathered from the Mental Health Statistics Improvement Program will be used by regional planning representatives and Division staff to develop new initiatives and enhance existing programs.

From 1999 through to the present, the Department of Human Services has engaged in strategic business planning. This process has allowed the Department to better align systems, including the community-based mental health system. As a part of this process, the Department holds Regional Stakeholder Meetings in the eight largest cities. Organizations and individuals involved in the delivery of human services in North Dakota, clients, policymakers, and the public are invited to attend and discuss community needs, capacity, and resources. The North Dakota Mental Health Planning Council and the Division continue to strive towards integrating the State Plan on Mental Health and the Department's strategic plan, providing for a near-seamless flow between the two documents and planning processes. Division staff members are involved with both projects, which helps ensure linkage. Though great strides have been made with the strategic planning process, it is still in its early stages and more refinements are to be made. The Division and the Planning Council will continue to be active players in this process, ultimately providing for a stronger public mental health system throughout North Dakota. In addition, Division staff recently assisted the Planning Council with the development of their own strategic plan. The plan uses the goals of the New Freedom Commission report as a framework and will allow the Council to better monitor and advise concerning the adequacy of community-based mental health services in North Dakota. As a continuation of this process, the Division has assisted the Council with the Development of white papers to address the Council's Goal #2: Mental healthcare is consumer and family driven and Goal #5: Excellent mental health care is delivered and research is accelerated. More specifically, a position paper was written on August 8, 2005 to address the NDMHP Council's Goal #4: Early Mental Health Screening, Assessment and Referral to services are common practice. This position paper outlined the following; shared responsibility between public agencies, private providers and families to build

a shared understanding and common language to address the emotional and behavioral needs of children and youth, definition of mental health screening, healthcare system is a primary gateway for identification, screening, referral and access to services for young children, early identification for at-risk behaviors, definition of a mental health diagnostic assessment, current referral services and efforts of MH screening, assessments and referrals for children and youth in North Dakota and identified needs for mental wellness of families and youth in North Dakota.

The Division also assisted in developing Talking Points correlating to their position papers. The Division Director, Chair and Vice Chair of the NDMHPC met with the Governor's Office to share their stories about the Council, their involvement with the MH System of Care and provided the position papers and talking points.

REDUCTION IN HOSPITALIZATION: During the past few years the Department of Human Services has implemented programs to decrease the number of admissions to the North Dakota State Hospital. For instance, regional human service centers established diversion programs and dramatically decreased the number of hospital admissions. In fact, during FY 1998 there were 1,764 admissions to the State Hospital. This past year, however, showed only 626 admissions. In addition to the diversion programs, Section 25-03.1-04 of the North Dakota Century Code – as amended by the 1999 Legislature – requires that all admissions to the North Dakota State Hospital be screened at the regional human service centers prior to being admitted. Like the diversion programs, the overall goal of this amendment was to develop additional services in the community, enabling the consumer in a time of crisis to remain in their community rather than having to be transferred to the State Hospital for treatment.

The North Dakota State Hospital continues to support the evolution of community-based services. It works in collaboration with the Division, regional human service centers, consumers and family members, the Mental Health Association, the National Alliance for the Mentally Ill, Protection and Advocacy, the judicial system, local private providers, and other stakeholders to enhance current community-based programs and to design and implement new ones.

MEDICAL SERVICES: Medical services at the human service centers include the delivery of medication monitoring, medication administration, psychiatric evaluation, and psychotherapy/treatment by a licensed psychiatrist. Some services are delivered by a licensed psychiatric nurse or licensed nurse practitioner under the supervision of a physician. In addition, the human service centers contract with local hospitals for short-term emergency mental health services. These are accessed when all other community resources have been exhausted.

Adults diagnosed with serious mental illness who receive services from the public mental health system in North Dakota have access to medical services provided by local private physicians and local general hospitals. The consumer, consumer's insurance or medical assistance pays for services if the consumer qualifies. Case management staff in the human service centers work closely with consumers to ensure that their medical and dental needs are met. In addition, screening for enrollment in public health insurance programs is conducted by Community Resource Coordinators (CRCs) located in participating hospitals, clinics and public health departments. CRCs work one-on-one with people without health insurance to help them apply for free or low-cost insurance coverage.

In addition to health insurance programs, Community Resource Coordinators link people with other assistance programs, including: Women's Way, Children's Special Health Services, Child Care Assistance, Food Stamps, Heating Assistance, Vision Programs, Hearing Programs,

Women, Infants and Children (WIC).

Community Resource Coordinators assist needy people in applying for free or low-cost prescriptions through pharmaceutical companies' Prescription Assistance Programs. CRCs screen people for eligibility, help those who qualify complete applications, provide instructions on compiling documentation and complete other necessary processes to ensure that people get the medications they need.

Diabetes is a growing concern throughout the population in North Dakota. Recognizing this, the Dakota Diabetes Coalition was formed. This coalition, initiated by the ND Department of Health's Division of Chronic Disease, is a new statewide effort to improve diabetes prevention, self-care and treatment. This coalition has wide support because members work in teams on issues they deem most pressing. The Coalition endorses a two-pronged approach: diabetes control and diabetes self-management.

Diabetes Control - Part of this effort is to help clinics and hospitals improve their quality of diabetes care. Through a collaborative, doctors, nurses and other health care providers learn how to adjust their practices -- so that patients routinely get state-of-the-art diabetes care. This collaborative helps clinics challenge themselves to change how diabetes care is delivered. Those changes will result in a more satisfying professional life for doctors, nurses and dietitians. Meanwhile, patients benefit from a reinvigorated clinic atmosphere dedicated to patient care that is based on medical evidence.

Diabetes Self Management - Patients are key to diabetes control and they need the right tools in order to regularly test their blood sugar and follow their care plans. Many people cannot afford the test strips and other supplies that they need to take care of themselves. That is why this grant provides patients with vouchers for diabetes supplies. While there are programs available to help low-income people with medications, virtually no other program supplies test strips for people in need.

EVIDENCE-BASED PRACTICE: North Dakota has made great strides in community-based mental health care. Challenges do remain, however. Nearly one-quarter of the individuals admitted to the State Hospital in recent years had been admitted multiple times during the year. An estimated one in ten inmates in North Dakota's prison system has a serious mental illness diagnosis. Transition from the children's mental health system to the adult system can be a daunting task. In an attempt to address issues such as these and maximize community-based services, North Dakota is exploring various evidence-based practices. The Director of the Division of Mental Health and Substance Abuse Services held monthly teleconferences with staff from the regional human service centers to discuss the specifics of evidence based practices and the feasibility of implementing them. Topics included Programs of Assertive Community Treatment, Illness Management and Recovery, and Peer Support. Also, the annual Clinical Forum on Mental Health conference held in May of 2008 focused on evidence-based practice, mental health recovery, and mental health transformation. Southeast Human Service Center is piloting Integrated Dual Disorders Treatment, an evidence-based practice. In May of 2006, a team from Southeast Human Service Center traveled to Ohio to receive training concerning implementation of IDDT from the Ohio Substance Abuse/Mental Illness Coordinating Center of Excellence (SAMI), a program of the Foundation for clinical Neuroscience Research & Education, INC. SAMI consultants are working closely with Southeast Human Service Center throughout the implementation of this project. The program began working with adults who are dually diagnosed (Quadrant Four) in January of 2007. In January of 2008, a new team began working with individuals who are in the Quadrant Three subgroup of individuals diagnosed with

a co-occurring disorder. During the most recent fidelity review, the IDDT program received one of the highest fidelity-to-model scores in the Nation. Southeast Human Service Center and the Division of Mental Health and Substance Abuse Services is analyzing the feasibility of implementing SAMHSA's Supported Employment model in conjunction with the IDDT project. Based on outcomes, these initiatives may be rolled out statewide.

TRANSITIONAL SERVICES: The 2000 Census revealed that approximately 104,000 individuals in North Dakota were between the ages of 15 and 24. This period – when transition from adolescence to adulthood occurs – can be a difficult time for some. For those individuals who received services under the children's mental health system of care, attempting to navigate into the adult system can be a trying, daunting task. At times people find that services they received in the children's system are not available in the adult system or they simply no longer meet the eligibility criteria. In order to ensure that a full array of appropriate services are available during this critical time of transition, the Division will be working with consumers and family members, providers, advocates, and other stakeholders to identify gaps and develop and implement solutions to address this issue.

The Adult and Children's Mental Health Administrators conducted statewide on-site meetings at all 8 Regional Human Services Centers this past year to gather feedback and solutions to meet the needs of transitioning youth (Refer to Unmet Service Needs and Plans to Address Unmet Needs sections of this document for additional information). A statewide interactive video meeting was held on September 17, 2007. This meeting was an open forum for discussing youth transitioning from children's to adult MH services and also those youth aging out of foster care. The meeting was also an opportunity to discuss transformation activities across the state, strengths and gaps in the mental health system of care along with an update on evidence-based practices. Participants included county regional representatives, Division of Juvenile Services, Independent Living Coordinators, tribal entities, county child welfare, and program administrators from the Division of Mental Health and Substance Abuse Services.

The Division also established a Transition Flex Fund. The Transition Flex Fund is intended to improve the flexibility of the system of care by establishing a pool of funds for young adults with severe emotional disorders who are transitioning to the adult mental health system. The goal is to improve overall level of functioning, self-sufficiency, and ability of the young person to establish/sustain life in the community.

A legislative Interim Committee study was chosen to explore the needs of transition- aged youth in all systems; mental health, education, child welfare, juvenile justice, vocational rehabilitation and developmental disabilities. A collaborative effort among the systems has occurred to provide testimony and information to the committee and both the Administrator of Adult Mental Health Services and the Administrator of Children's Mental Health Services testified. The Department is also a member of the Department of Public Instruction's Transition Steering Council that has been working on this area. Members of the Transition Steering Council serve in an advisory role regarding reaction and information about student needs and the role of policy development and implementation.

In addition, the Department works closely with the Department of Corrections and Rehabilitation to ensure that individuals who have a serious mental illness and are in prison have a smooth transition once they are released. Through the Release and Integration Program, case managers from the human service centers meet with inmates a few months prior to their scheduled parole to begin preliminary work on securing housing and any other needed assistance. The goal of this program is to assist the consumer with transitioning back into the

community and – through the establishment of an informal and formal support system – help the consumer avoid re-incarceration. Also, the Director of the Division of Mental Health and Substance Abuse Services is in continued dialogue with the Director of the Department of Corrections and Rehabilitation concerning mental health services and the corrections system. This collaboration will continue to ensure that individuals with a serious mental illness who are in the corrections system have access to appropriate mental health services.

AGING AND MENTAL HEALTH SERVICES: North Dakota is an aging State. It is estimated that approximately 147,706 people in North Dakota are 55 years of age or older. This is projected to increase to 241,496 or 62% by the year 2015. Kessler, as cited in the Surgeon General's report on Mental Health, estimated that 0.8 percent of persons over the age of 55 have a serious mental illness. Based on this, approximately 1,182 persons are aged 55 or above and have a serious mental illness in North Dakota.

It is recognized that a number of barriers exists for this population including difficulty accessing care due to the rural/frontier nature of North Dakota, lack of specialized geriatric mental health care, as well as stigma and misperceptions surrounding mental health in the aging population. For this reason, the Division of Mental Health and Substance Abuse Services is focusing attention on the enhancement of mental health services to the aged population throughout the State. During phase one of this initiative, the Division worked with the Mental Health Association in North Dakota to develop and implement mental health and aging training programs to identify existing mental health services for older individuals, develop an understanding of those mental health services and collaboration among agencies, identify future service needs for the identified gaps, raise public awareness of the mental health needs of and services for older individuals. Trainings were at all human service centers to provide staff members with an understanding of the issues regarding mental health needs of the elderly and allow them to gain an appreciation for the multidisciplinary approach to meeting the health needs of older individuals. In addition, an aging/mental health track was incorporated into the Clinical Forum on Mental Health conference. Topics included the assessment of behavioral health issues in the elderly, substance abuse and the elderly, and understanding depression and suicide in the elderly.

Phase Two of the initiative focused education to the natural caregiver – those individuals – generally outside of the professional medical community – that older individuals routinely access for care and support in the community. This included (but not limited to) nursing home staff, family caregivers, parish nurses, clergy, personal care attendants, and first responders. The training included discussion of the aging process, wellness and prevention, and information and resources. North Dakota State University was awarded the contract and has extensive experience in the field of gerontology and mental health. They developed a four module-training program focused on positive aging and mental health. Thirty-two natural caregivers representing each region of the state were trained to conduct education on mental health and aging. They presented the four modules throughout North Dakota. The total attendance at the education sessions was 727 natural caregivers. The modules have been catalogued with the North Dakota State Library.

Phase Three of the initiative expanded from the natural caregiver training. North Dakota State University developed and implemented a training curriculum on mental health issues and older adults targeted to community-based mental health clinicians. The curriculum focused on mental health and the aging process; changes to the aging brain and the impact on mental health, wellness/prevention/medical issues associated with mental illness; assessment and diagnosis of mental health issues in older adults; treatment of mental illness in older adults including

psychopharmacological treatment, psychosocial treatment, and barriers to treatment and how to address them; and community resources. The training was structured as a web-based program, which included core information, case studies, activities, and resources. The program was presented at the Aging Track of 2008 Clinical Forum on Mental Health Conference.

During the upcoming year, the Natural Caregiver Program and the Mental Health Clinician Training Program will be continued. This will allow the Division to further increase the cadre of clinicians and others trained in mental health and aging.

This Spring, North Dakota applied for an Older Adults Targeted Capacity Expansion Grant through SAMHSA. The Department proposed implementing the Positive Aging of North Dakota Adults (PANDA) program. PANDA is designed to enhance the quality of life of persons 60 years of age and older by indentifying those individuals at risk of or experiencing mental health problems and providing them with mental health services on an outreach basis. Through a needs assessment, PANDA will also identify trends and areas of needs that will help guide future service delivery throughout North Dakota. PANDA will also enhance service delivery by establishing a gerontological counseling certification program enabling clinicians to receive specialized training in counseling older adults. The Division is awaiting the award announcement.

EMPLOYMENT SERVICES: The Division uses block grant dollars to augment Extended Employment Services for adults diagnosed with a serious mental illness. These funds are used to purchase employment coaching/job shadowing as well as assistance with locating/obtaining/maintaining employment. This service is provided by private agencies statewide and overseen by eight Extended Services case managers, one in each region of North Dakota. The goal is to help those individuals who are diagnosed with a serious mental illness and have the desire to work to obtain and maintain employment in the community of their choice, ultimately leading to increased self-sufficiency.

As mentioned before, Southeast Human Service Center and the Division of Mental Health and Substance Abuse Services is analyzing the feasibility of implementing SAMHSA's Supported Employment model in conjunction with the IDDT project. If piloted, an evaluation component will be built in to the project allowing Administration to determine its effectiveness compared to existing employment programs. If determined effective for North Dakota, the plan is to rollout the program to other human service centers.

DUAL DIAGNOSIS (MI/SA) SERVICES: The North Dakota Department of Human Services provides service to individuals who are dually diagnosed with a serious mental illness and a substance abuse disorder. The regional human service centers offer dual diagnosis programs ranging from group therapy to intensive case management. For instance, located in Fargo, Southeast Human Service Center offers the intensive Off Main program. Off Main is a scattered site residential program that provides rent subsidization, case management, medication monitoring, addiction counseling, family, group, and individual therapy to individuals who are dually diagnosed. To enhance these services, Southeast Human Service Center is piloting Integrated Dual Disorders Treatment, an evidence-based practice. In May of 2006, a team from Southeast Human Service Center traveled to Ohio to receive training concerning implementation of IDDT from the Ohio Substance Abuse/Mental Illness Coordinating Center of Excellence (SAMI), a program of the Foundation for clinical Neuroscience Research & Education, INC. SAMI consultants are working closely with Southeast Human Service Center throughout the implementation of this project. In January of 2007 the program began working with adults diagnosed with a dual disorder. In January of 2008, a new team began working with

individuals who are in the Quadrant Three subgroup of individuals diagnosed with a co-occurring disorder. During the most recent fidelity review, the IDDT program received one of the highest fidelity-to-model scores in the Nation. With positive results, the program will be rolled out to other regions as deemed appropriate.

In addition to the dual diagnosis programming offered throughout the state, the Dual Diagnosis Education Group – a collaboration of public and private mental health and substance abuse providers in southeastern North Dakota – offers the annual Dual Diagnosis Workshop. Presenters at this workshop have included Christine Reilly of the Beck Institute, Dr. Ken Minkoff, and Dr. Bert Pepper. The Division of Mental Health and Substance Abuse Services is an active supporter of this training event.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Substance Abuse Programs. This position is responsible for planning, policy development and implementation, and program oversight of the MI/SA system of care across North Dakota.

NORTH DAKOTA CONSUMER AND FAMILY NETWORK: It is widely recognized that transforming the mental health system to be more responsive to consumer needs and better assist in recovery requires the participation of consumers at all levels of policy planning and program development, implementation, and evaluation. Meaningful involvement of consumers in the mental health system can ensure they lead a self-determined life in the community, rather than remaining dependent on the mental health system for a lifetime.

To ensure meaningful involvement of consumers in the mental health system, consumers and family members need to organize, encourage one another, and become educated about the workings of the system. The Division of Mental Health and Substance Abuse Services has long supported consumer participation in public mental health policy design and service implementation. This support continues with the statewide Consumer and Family Network.

The focus of this project is to develop a new or enhance an existing network of consumers of mental health services and their families dedicated to 1) organizing mental health consumers and family members in North Dakota; 2) promoting an environment of recovery from mental illness; 3) strengthening organizational relationships throughout the system of care; 4) promoting skill development with an emphasis on leadership; and 5) identifying technical assistance needs of consumers and family members and providing training and support to ensure that they are the catalysts for transforming the mental health and related systems in North Dakota. In 2007, Mental Health America of North Dakota received a contract from the Division to carry out these activities. They developed a curriculum focusing on leadership and advocacy skills and trained consumers and family members statewide. This contract was awarded to Western Sunrise, Inc. in 2008. Western Sunrise, Inc. is a consumer-run non-profit corporation in Williston, North Dakota.

MENTAL HEALTH TRANSFORMATION: Mental health transformation takes many forms in North Dakota. The process uses a multifaceted transition approach that infuses the recovery concepts within the services delivery while initiating targeted evidence based practice initiatives within regional human service centers that have displayed readiness for implementation. At the same time, consistent message, work force development, contracted initiatives, and technical assistance covering a variety of transformation areas take place. The next step is to create and promote readiness in additional centers for future expansion efforts.

The Division of Mental Health and Substance Abuse Services is leading the community-based public mental health system and its partners in implementing various mental health transformation activities. These include an anti stigma campaign, Integrated Dual Disorders Treatment pilot program at Southeast Human Service Center in Fargo, SPARCS, Trauma Focused Cognitive Behavioral Therapy, Mental Health Recovery, collaboration with the University System concerning Science to Services, implementation of the Mental Health Consumer and Family Network, Mental Health and Aging Education initiative, Early Childhood Screening Collaborative, planning for SAMHSA's model of Supported Employment to be piloted at Southeast Human Service Center in Fargo (in conjunction with IDDT), Workforce Development in conjunction with WICHE, Person-centered Planning, Peer Support Services, and development of a prevention/promotion framework.

MENTAL HEALTH RECOVERY: The North Dakota Department of Human Services has embraced the mental health recovery model. In 2006, seven Department staff members and one consumer were sent to the Recovery Institute in Ohio to be trained as trainers in the recovery model. Since then, the group has trained all SMI case management staff (approximately 80 staff members) and is conducting ongoing training of direct care staff from the State Hospital. Consumers are being trained in the model at the State Hospital and the regional human service centers. In June of 2007, the Division brought Wilma Townsend to North Dakota to provide administrative and supervisory staff training on the model. Ms. Townsend was brought back to train additional consumer trainers: two trainers for each of the eight regions of North Dakota. The consumer-training portion has become a component of the North Dakota Consumer and Family Network.

The State Hospital has implemented the Treatment Mall, a recovery-focused alternative to the traditional inpatient model. This program supports the notion that treatment should not be provided within the "home environment" of the consumer. Rather the consumer must leave their "home" during the business day and go elsewhere for the array of treatment services. It also establishes a structure of living that would then more naturally follow the consumer when living independently.

Central to the purpose of the Treatment Mall is a full array of groups and learning experiences that can be selected on the basis of not only need but also by choice. The Treatment Mall is in a separate location on the hospital grounds where staff and consumers from multiple units come together to provide and receive mental health services. Consumers work with a coordinator and a treatment team to define a life goal through a Recovery Plan. The patient then chooses classes that will help develop the skills that will move them toward the goal of returning to the community. Consumers attend four to five classes fifty minutes in length offered Monday through Friday from 9:00am to 12:00pm and 1:00pm to 4:00pm. The Treatment Mall functions like a learning center and therefore follows a twelve-week semester format. Consumers select classes designed to help them reach their recovery goals. Consumers and the coordinator will then register for those classes during the registration process. The services provided through classes are designed to teach daily life skills, vocational training, education, illness education, medication management, and social skills that will strengthen and empower the consumer toward recovery and transition back into the community.

PEER TO PEER SUPPORT: North Dakota is implementing a Certified Peer Specialist Initiative This program will prepare people who live with mental illnesses and use their experiences to work with others as peer specialists. A planned comprehensive training certification and curriculum will deliver a foundation in recovery principles, intervention techniques and ethical

practice. Training curriculum will focus on the use of peer-delivered services to support the recovery of others.

PERSON-CENTERED TREATMENT PLANNING: In an effort to improve documentation of medical necessity and help more the community-based public mental health system more toward person-centered care, the Department requested technical assistance from the National Technical Assistance Center. Dr. Neal Adams, Diane Grieder, and Dr. Ed Diksa were consulted concerning implementation of Treatment Planning for Person-Centered Care. This model was chosen because it not only represents a growing and increasingly respected place in the national behavioral health care arena, but it also allows for the blending of valuing consumer strengths and goals while retaining recognition of the importance of good diagnosing and planning for the measurable clinical outcomes that reduce or resolve clinical barriers to consumer recovery. Fifty-nine staff from the regional human service centers received one-and-one-half days of preliminary training in this model. Phase 2 of the project consisted of training 24 human service center staff members as trainers of the model. This training was held in mid July of 2008. The trainers then returned to their human service center and began working with consumers on their caseloads to develop person centered treatment plans, with the continued consultation and guidance from the TA consultants. They also began training staff within the center on the practice. Phase III of the project will be a continuation and broadening of the activities of Phase II. Included will be training more clinicians on the model and modifying the Department's electronic record to aide in development of person-centered treatment plans and documenting medical necessity.

SERVICES TO SEXUAL OFFENDERS: In September 2006, the DMHSAS began a contract with Counseling and Psychotherapy Centers, Inc, (RULE CPC) of Needham, Massachusetts to provide community-based treatment to high risk sex offenders and those offenders who have victimized adults. Offenders must be under active supervision by the ND Dept of Corrections and Rehabilitation.The contract for services for this population of offenders rose out of the lack of community-based treatment services in ND. The provision of services began in December 2006 in the Jamestown region and has progressed to Minot, Grand Forks, Fargo, and Bismarck-Mandan regions. Fifty-six offenders are currently receiving services.

INDIGENT DEFENSE SERVICES: North Dakota recently enacted a law establishing a statewide commission on legal counsel for indigents and providing for the hiring of a director of indigent defense services. The commission is charged with developing and monitoring the delivery process for state-funded defense services for indigents accused of crimes. The director will administer and coordinate indigent defense services within the state.

The commission is charged with developing standards on eligibility for services, qualifications for attorneys, and attorney performance.

Prior to this reform being passed, North Dakota's system for providing indigent defense services was unique. Individual judges contracted with private attorneys to provide indigent defense services in their courtrooms. All of the contracts were awarded on a flat fee basis, requiring the attorney to handle however many indigent defense cases came into their district during the contract term. Contracts were generally awarded on the basis of lowest bid.

Indigent defense in North Dakota is state funded. In the past, the funding has been grossly insufficient. Indeed, per capita spending on indigent defense in North Dakota was among the lowest in the country. The reforms of 2005 doubled the funding, from approximately $5 million in the last two year period to $10 million for the next two year period. While the increase is a huge

step forward, additional funding will likely be needed for the North Dakota system to achieve full compliance with national standards.

North Dakota

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

AVAILABLE SERVICES - ADULT

North Dakota is a rural, frontier state with an area of 72,000 square miles and an approximate population of 635,867. The largest city in the State is Fargo, which has a metropolitan statistical area population of 132,525 persons. Thirty-six of fifty-three counties are designated frontier areas, having less than seven persons per square mile. In 1982, to better serve the citizens of this rural state, the community mental health centers were merged with the area social service centers. This action created the regional human service centers and developed a one-stop system of care. The eight regional human service centers, listed below with their locations, provide public mental health programs to service areas ranging from three to ten counties.

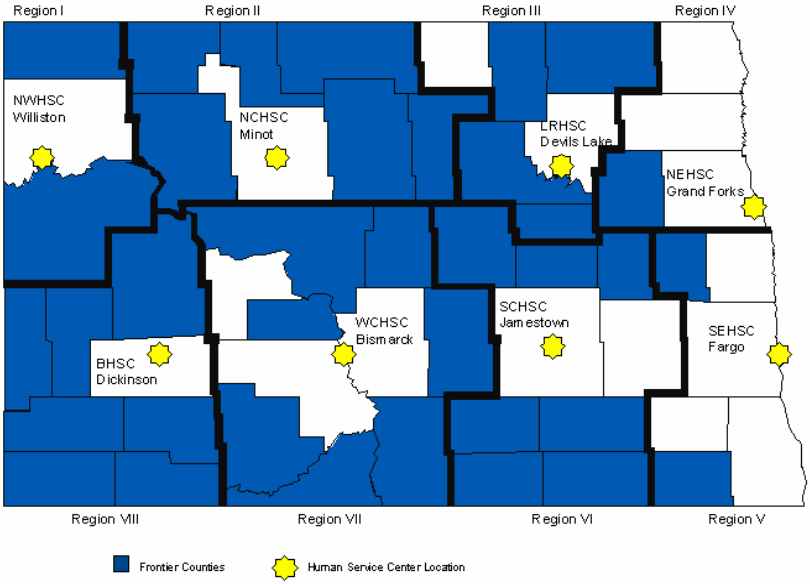
Northwest Human Service Center	Williston	Region I
North Central Human Service Center	Minot	Region II
Lake Region Human Service Center	Devils Lake	Region III
Northeast Human Service Center	Grand Forks	Region IV
Southeast Human Service Center	Fargo	Region V
South Central Human Service Center	Jamestown	Region VI
West Central Human Service Center	Bismarck	Region VII
Badlands Human Service Center	Dickinson	Region VIII

Consumers are served in the community through a variety of rehabilitation services including:

- crisis stabilization and resolution;
- inpatient services;
- psychiatric/medical management including medication management and other health services;
- social services;
- residential services and supports;
- vocational and educational services and supported employment;
- social and leisure activities;
- evidence-based practice of IDDT.

Services at the regional human service centers are provided to all consumers regardless of the consumer's race, color, religion, national origin, sex, age, political beliefs, or disability in accordance with Title VI of the Civil Rights Act of 1984, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act, the Americans with Disabilities Act of 1990 and the North Dakota Human Rights Act (NDCC Chapter 14-02.4). All services are provided to Native Americans living on or off the reservations.

Figure 1: Regional human service center locations and frontier counties in North Dakota



Regional Intervention Service

The Regional Intervention Service (RIS) provides 24-hour, seven days per week crisis assistance enabling the consumer, family, and significant others to cope with emergencies while maintaining the consumer in the community. With an interdisciplinary team that may include a psychologist, masters-degreed social worker, masters-degreed human relations counselor, psychiatric nurse, psychiatrist, and/or a licensed addiction counselor, Regional Intervention Service is able to provide the consumer with the best suited crisis intervention including short-term crisis residential placement and immediate access to a range of housing, medical, and counseling services within the community.

In addition, the Regional Intervention Service team has the responsibility of evaluating consumers who may need referral to the North Dakota State Hospital, ensuring that consumers are provided with the least restrictive treatment environment. The Aftercare Coordinator, a member of the Regional Intervention Service team, coordinates discharge planning with North Dakota State Hospital staff providing a smoother transition and greater community linkage to the consumer upon return to their region.

Medical and Dental Services

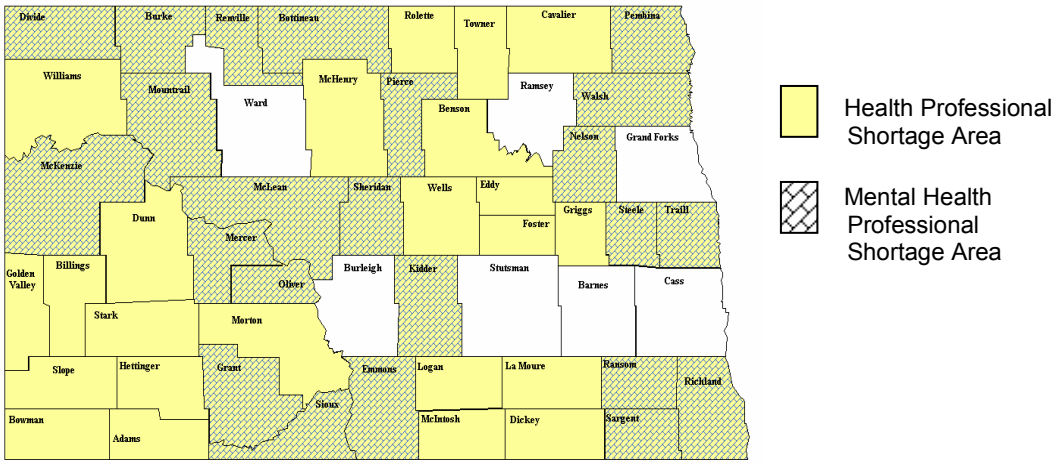
Medical services at the human service centers include the delivery of medication monitoring, medication administration, psychiatric evaluation, and psychotherapy/treatment by a licensed psychiatrist. Some services are delivered by a licensed psychiatric nurse or licensed nurse practitioner under the supervision of a physician.

Adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbances who receive services from the public mental health system in North Dakota have access to medical and dental services provided by local private physicians and local general hospitals. Services are paid for by the consumer, consumer's insurance or medical assistance

if the consumer qualifies. Case management staff in the human service centers work closely with consumers to ensure that their medical and dental needs are met.

As you can see in the figure below, much of North Dakota is considered a health and mental health professional shortage area. Eighty-one percent of the state (43/53 counties) is designated as partial or full county HPSAs. Many federal programs use HPSA designations as a means to target federal resources.

Figure 2. North Dakota Health and Mental Health Professional Shortage Areas



North Dakota had 1,461 licensed physicians in 2004. Of the state's 328 practicing family medicine physicians, 68 percent (222/328) graduated from the University of North Dakota, with a medical degree, or residency training, or both. Nationally, 11 percent of U.S. physicians practice in rural areas as compared to 32 percent in North Dakota (Rural Health Facts: Primary Care Providers, Center for Rural Health, UNDSMHS, Summer, 2005). Family medicine physicians provide the majority of patient care in rural areas. Similar to the rest of the United States, North Dakota is experiencing a decline in the number of medical graduates choosing a residency in Family Medicine.

One measure related to the demand for health care professionals is the number of unfilled positions or vacancies. In 2004, 92 physician vacancies were reported. Of those, 34 were reported in rural communities and 58 reported in three of the four state's urban cities. Vacancies in rural areas remain fairly stable with an average of 18 openings reported for Family Medicine each quarter from 1992-2005. Family Medicine constitutes the highest number of rural vacancies while subspecialty vacancies dominate in urban areas (North Dakota Physician Survey, Center for Rural Health, UNDSMHS, 2004). Vacancies across rural areas of North Dakota increased slightly between 2004 and 2005 (rural defined as communities other than Minot, Bismarck, Grand Forks, Bismarck/Mandan, Fargo, and Jamestown).

The high incidence of suicide in North Dakota may be due, in part, to the lack of access to mental health services. The most recent data ranks North Dakota 13th in the nation for suicides for all ages, 2nd in the nation in suicides for 10-14 year olds, and 6th in the nation for 15-19 year olds. For the Native American population of the state, the Aberdeen Area of Indian Health Service is 2nd only to Alaska in the rate of suicide. Please note that the Aberdeen Area includes

states other than North Dakota. Between 1994 and 2003, there were 797 reported suicides in the state, 700 whites, 89 Native Americans and 8 other ethnic minorities. Another indicator of the pervasiveness of mental health problems is the fact that the most frequently prescribed medications in the state are antidepressants, prescribed primarily by primary care physicians.

As we look forward, increased demand for mental health and other services may emerge associated with returning National Guard and other military personnel who have served on active duty in Iraq and Afghanistan. Given the number of returning Guard and the very thin mental health service infrastructure across the state, we could see unmet need for important services and further stress over an already fragile health care infrastructure.

Access to dental care continues to be an issue in North Dakota. According to the University of North Dakota's Center for Rural Health, 16 of the state's 53 counties are designated as Dental Health Professional Shortage Areas. Forty-nine percent of North Dakota's population lives in Ward, Grand Forks, Cass and Burleigh counties, as do an overwhelming proportion of the state's dentists. North Dakota is characterized by a chronic shortage of health professionals in rural areas. Forty-four of the state's 53 counties have six or fewer practicing dentists. As the rural areas experience the greatest loss of population, the number of dentists practicing in communities of 2,500 or fewer people also has declined. Only four counties have 16 or more dentists. Of all the dentists currently practicing in North Dakota, 60 percent will retire within the next 15 years, according to the University of North Dakota Center for Rural Health's 2005 survey of North Dakota dentists.

The Center for Rural Health also noted that between seven and twenty-five percent of dentists in North Dakota accept any and all Medicaid patients that present for treatment. Rural dentists tend to accept more Medicaid patients than do urban dentists. Human service center staff work closely with consumers to assist them with accessing dental care. At times case managers have needed to transport consumers hundreds of miles (roundtrip) to access dental care from a provider that accepts Medicaid patients.

In an attempt to address this issue, the Dakota Medical Foundation created the Dental Care Access Program (DCAP). DCAP is working to increase access to oral health care for the uninsured and underinsured of our communities. Under the direction of the dental coordinator, DCAP is networking with the North Dakota State Oral Health Department, Bismarck; Red River Valley Dental Access Project, Fargo; Bridging the Dental Gap Clinic, Bismarck; Dental Access Committee, Grand Forks; and federally qualified healthcare centers in Fargo, Northwood/Larimore, and Turtle Lake/Rolette/McCluskey.

Community Resource Coordinators (CRCs) located throughout the state have worked to ensure that whenever possible, oral health care is accessed by their clients. Through a program called Dental 1/90, case management is provided to uninsured clients. Dentists are fully reimbursed for charges incurred in the care of these patients while agreeing to see 1 new Medicaid patient every 90 days.

The Dental Care Access Program (DCAP) is dedicated to improved oral health access for children and families in North Dakota. Overseen by the Dakota Medical Foundation, DCAP is working to increase access to oral health care for the uninsured and underinsured citizens in communities. Under the direction of the dental coordinator, DCAP is networking with the North Dakota State Oral Health Department, Bismarck; Red River Valley Dental Access Project, Fargo; Bridging the Dental Gap Clinic, Bismarck; Dental Access Committee, Grand Forks; and federally qualified healthcare centers in Fargo, Northwood/Larimore, and Turtle

Lake/Rolette/McCluskey.

Many delivery systems, educational opportunities and policy changes are being examined to identify what will work best in North Dakota to reach the targeted populations. Through guidance from the State Oral Health Department and funding from the Centers for Disease Control, a North Dakota Oral Health Coalition has been formed and a State Oral Health Plan was drafted.

North Dakota has recently hired a new oral health program director and an oral health program coordinator. It has developed a state burden document demonstrating the burden of oral disease in the state, and has worked through their oral health coalition to develop and implement a state oral health plan. In 2006, North Dakota held a statewide oral health summit to release its state plan and burden document. The state continues to improve its oral health surveillance system.

The North Dakota Department of Health's Oral Health Program works collaboratively with six dental hygienists as oral health consultants throughout the state. Their function is to provide oral health education and promotion to schools, local public health units and long-term care facilities. In addition, they provide technical assistance to schools participating in the school fluoride program. The North Dakota State Dental Program funds, conducts or otherwise facilitates programs or activities in the following areas:

- Dental Screening
- Dental Sealants
- Early Childhood Caries/Baby Bottle Tooth Decay Prevention
- Fluoride Mouthrinse
- Fluoride Supplements (Tablets/Drops)
- Mouthguard/Injury Prevention
- Needs Assessment/Oral Health Surveys
- Oral Health Education/Promotion
- Smoke and Spit Tobacco Cessation

Access to preventive care remains a problem for some segments of the population, specifically low-income, minority individuals. Individual knowledge of how oral health relates to general health is limited, and the mouth is frequently fragmented from the rest of the body. Workforce issues remain despite the state's legislation enacting a dental loan repayment program.

Within that plan, delivery systems such as stand alone dental clinics, mobile dental vans, urgent care centers, dental clinics affiliated with hospitals and clinics and others will be analyzed and recommendations made for best practice.

Community Resource Coordinators (CRCs) located throughout the state have worked to ensure that whenever possible, oral health care is accessed by their clients. Through a program called Dental 1/90, case management is provided to uninsured clients. Dentists are fully reimbursed for charges incurred in the care of these patients while agreeing to see 1 new Medicaid patient every 90 days.

Psychological Services

These services, under the direction of a full-time licensed psychologist, include psychological evaluations, psychotherapy, and case and program consultation. Psychologists assist in developing treatment plans and diagnosing persons with mental illnesses.

Acute Treatment

Acute treatment, provided by a range of mental health professionals including social workers, psychologists, and case managers, refers to individual, group, and family therapy that is generally short-term in nature. Therapists use varied approaches to therapy including cognitive-behavioral, Gestalt, and psychodynamic techniques. When appropriate and with permission of the consumer, family members and/or significant others are involved in therapy to enhance the process.

Outreach

The service areas for eight regional human service centers range from three to ten counties. Each center has staff traveling to outlying rural communities and Native American reservations to provide mental health services.

Educational Opportunities

Consumers are offered a variety of educational opportunities by Department staff, either through staff presentations or via arranged speakers. These can include presentations concerning Social Security and community programs. Consumers who desire to further their education – whether by obtaining their high school diploma/GED, college degree, or other opportunity – may be assisted by human service center staff with accessing appropriate programs. This may include referral to Vocational Rehabilitation for assessment and assistance or accessing information from an educational institution.

Vocational Rehabilitation

Vocational Rehabilitation provides and/or purchases services that result in competitive employment of eligible individuals with physical or mental impairments. Vocational Rehabilitation services include, but are not limited to, diagnosis and evaluation, vocational counseling and planning, information and referral, adaptive equipment, vocational training, job placement and follow-up.

Alcohol and Drug Addiction Services

These services, provided to adults and adolescents, include addiction evaluation; intensive outpatient programs; day treatment; individual, group, & family therapy; pre-treatment programs; and the treatment recidivist program which includes social detoxification, short-term residential, and a case manager aide program.

THE SERIOUS MENTAL ILLNESS SYSTEM OF CARE

Individuals diagnosed with a serious mental illness, in most cases, are provided service through the **Extended Care Treatment Units** in each regional human service center. Below are the core services offered through the Extended Care Treatment Units, either directly or through public/private provider partnership or contracting:

Case Management: Case management assists consumers with accessing the various services they need and want, and helping them make informed choices about opportunities and services in the community. The case manager helps ensure the consumer receives timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services enabling the consumer to meet their goals. Case management is provided in the environment of the consumer's choice.

The goals of case management are:

- To provide for each individual a single point of referral to needed service within and outside of the mental health system
- To assure consumer access to appropriate services and supports
- To assure that services are not only relevant to consumer need but that services meet that need
- To ensure continuity and coordination of service provision for eligible consumers, including transfers from community to hospital and back
- To educate consumers in how to negotiate the mental health and social services system when needed or desired
- To empower consumers by enabling them access to experience new roles and responsibilities
- To integrate consumers into normalized community living, i.e., providing a place to live, work, and learn in the environment of their choice
- To provide therapy, supportive counseling, and daily living skills training as needed and appropriate to consumers

Community Residential Options: Housing options available to adults diagnosed with a serious mental illness who are receiving services through the regional human service centers include:

- Nursing Facility - A twenty-four hour highly supervised facility for consumers with medical problems. The human service center provides consultation/technical assistance and case management as requested.
- Long-Term Residential - Twenty-four hour supervised care providing room and board for five years or longer. The human service center provides or contracts for consultation/technical assistance and case management as requested.
- Transitional Living -Twenty-four hour minimal supervision, six to eight consumers in a group setting, room and board provided up to one year. This is provided by the human service center or through a contract with a local provider.
- Homeless Shelters - Minimal supervision, one night to several months as needed, room and board provided. The human service center provides case management as requested.
- Single Room Occupancy - House managers live in the facility and provide minimal supervision. Peer support and case management is provided by the agency. The human service center provides case management as requested.

- Supported Housing - Independent living arrangement with staff and financial support from the agency. The human service center provides case management and financial support as needed and requested.
- Independent Living - Independent living apartment rented by the consumer with case management and skills training provided if requested by the consumer.
- Fairweather Lodge Program - a program dedicated to improving the lives of adults with mental illness by providing safe, affordable housing, employment and social services.

Psychosocial Rehabilitation Centers: Psychosocial rehabilitation centers were developed to assist adults who have mental illness with learning appropriate socialization and leisure/recreational skills. Services provided include: social/recreational milieu, information and referral and community awareness activities. Psychosocial rehabilitation centers are open during the day, evenings, and on weekends, and reach many individuals who do not normally seek services available at the regional human service centers.

Supported Employment (Extended Service): This is a service designed to provide ongoing employment-related support for individuals in supported employment upon completion of training which may include job development, replacement in the event job loss occurs, job training contacts, and other support services as needed to maintain employment.

Community Supportive Care Program: The Community Supportive Care Program uses community people to provide emotional and other types of support within their communities to persons with serious mental illnesses. The volunteers/companions are selected because of their human qualities that enable them to respond skillfully to human needs. All of these people volunteer on a part-time basis. The volunteers/companions meet regularly with clinical staff at the human service center to review cases and complete administrative functions. The training that volunteers/companions receive comes through the reviewing of cases and discussion of problems.

Other Supportive Services: Adults served through the serious mental illness system of care access supportive services through other units of the human service centers. These services include group, individual, and family therapy, psychological services, and medication monitoring.

NORTH DAKOTA STATE HOSPITAL

The North Dakota State Hospital, Jamestown, was established in 1883. The only state hospital in North Dakota, it is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified. The North Dakota State Hospital is utilized only when it has been determined by the regional human service center to be the most appropriate option. The North Dakota State Hospital provides total care consisting of physical, medical, psychological, rehabilitative, social, educational, recreational and spiritual services through a variety of clinical and non-clinical staff. The goal of the treatment process is to implement appropriate therapeutic modalities at the earliest time so that the period of hospitalization can be reduced to a minimum. This requires integration with a system of aftercare services in the community. North Dakota State Hospital staff work closely with community agencies on both a programmatic and an individualized basis to maintain continuity of care and treatment.

THE COUNTY SOCIAL SERVICE BOARDS OR DISTRICTS

There are fifty-three local county social service boards or districts. The county social service board delivery system is county-administered and state-supervised. The staff of county social service boards provide social support services primarily to the following target populations: children, adults and families, older adults, and those individuals with a physical disability.

In addition, county social service boards provide supportive services such as: home and community-based services; information and referral to individuals who have a chemical dependency, individuals diagnosed with a mental illness, individuals with a developmental disability, individuals with a physical disability, as well as other targeted population groups; parent aide and family preservation services – such as wraparound case management, Family Group Decision Making process/meetings, Kinship Care Program and intensive in-home service contracts – through the State.

Economic assistance programs administered by the county social service boards are financed through a combination of Federal, State, and local funds.

PROTECTION AND ADVOCACY SERVICES

Protection and advocacy, a vital service in North Dakota, ensures the quality of services provided to consumers. Protection and advocacy services to individuals with mental illness and serious emotional disturbances are provided by the North Dakota Protection and Advocacy Project, an independent State agency. The Protection and Advocacy Project employs full-time mental health advocates who are located across the state providing services at no cost to individuals with a mental illness and serious emotional disturbances. Services include information/referral, case advocacy, legal counsel, and protective services.

Advocacy services are easily available to ensure the protection of consumer rights and to help provide access to entitled services. Advocates ensure that grievance procedures and other mechanisms to protect the rights of consumers are in place and utilized in mental health and residential facilities. Legal services are available to protect consumer rights, to obtain entitled services, and to represent consumers in administrative and judicial proceedings.

North Dakota

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Table 3: Estimates of Prevalence, Need, and Numbers Served for Adults with Serious Mental Illness at the Human Service Centers (2007 Census)

REGION	Population >17 (2007 Census)	Population with a Serious Mental Illness (1)	Population with a Serious Mental Illness in Need of Services (2)	Actual Number Served at the Human Service Center (FY 2007) (3)	Actual Number Served at the Human Service Center (FY 2008) (3)	Estimated Number to be Served at the Human Service Center (FY 2009) (4)
I	21,308	1,151	426	350	463	472
II	62,214	3,360	1,244	595	817	833
III	29,462	1,591	589	379	513	523
IV	70,146	3,788	1,403	1,274	989	1,009
V	134,600	7,268	2,692	2,223	1,718	1,752
VI	44,849	2,422	897	659	833	850
VII	105,393	5,691	2,108	1,205	1,095	1,117
VIII	28,934	1,562	579	387	567	578
TOTAL	496,906	26,833	9,938	7,072	6,995	7,135

Table 4: Estimates of Prevalence, Need, and Numbers Served for Children with Serious Emotional Disturbance at the Human Service Centers (2007 Census)

REGION	Population <18 (2007 Census)	Population with a Serious Emotional Disturbance (5)	Population with a Serious Emotional Disturbance in Need of Services (6)	Actual Number Served at the Human Service Center (FY 2007) (7)	Actual Number Served at the Human Service Center (FY 2008) (7)	Estimated Number to be Served at the Human Service Center (FY 2009) (4)
I	5,853	240	117	97	89	91
II	20,106	824	402	111	204	208
III	10,996	451	220	51	71	72
IV	18,596	762	372	280	220	224
V	39,181	1,606	784	312	304	310
VI	10,744	441	215	188	167	170
VII	29,724	1,219	594	260	263	268
VIII	7,609	312	152	218	131	134
TOTAL	142,809	5,855	2,856	1,517	1,449	1,478

(1) & (2) Estimation based on 5.4% and 2%, respectively, of total State Adult Population as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)

(3) From ROAP adults with a completed SMI Form, and Program Enrollment Codes for Medication Only, Extended Care, and Acute Outpatient Services with no SMI Form.

(4) Estimation based on anticipated 2% growth.

(5) & (6) Estimation based on 4.1% and 2%, respectively, of total State Population under age 18 as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)

(7) From ROAP children and adolescents with a completed SED Form.

North Dakota

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

QUANTITATIVE TARGETS – ADULTS AND CHILDREN

MHSIP PROGRAM: The Nation is at a time where there is an increasing demand for accountability in the delivery of mental health services. Federal agencies, the State Legislature, consumers, and other stakeholders are demanding outcome data to justify funding levels for mental health services. The Mental Health Services Researcher is charged with the oversight and refinement of the data gathering and analysis projects for the community-based mental health system. North Dakota has a number of data collections systems that are used to derive mental health statistics: Regional Office Automation Program, State Hospital Patient Care System, the Single Plan of Care (SPOC), and the Mental Health Statistics Improvement Program.

The North Dakota Department of Human Services implemented an electronic financial and clinical data collection system. Referred to as the Regional Office Automation Program (ROAP), this system allows the Mental Health Services Researcher to have total access to the data gathered through the system and allows for the creation of detailed reports concerning the mental health services delivered at the regional humans service centers.

The North Dakota State Hospital has its own data collection system, the State Hospital Patient Care System, which is operated independently of the ROAP System. It does, however, collect data on patient admission, discharge, length of stay, demographic information, etc.

The Division of Mental Health & Substance Abuse Services continues to refine its performance outcomes measurement system. The MHSIP Outcomes Project has moved to an annual survey approach. This will allow the Division to measure the impact that the mental health services provided are having on consumer recovery and quality of life including access to care, quality/appropriateness, satisfaction, and outcome while minimizing the data collection burden for the clinician. Similarly, the Partnership Program now uses a web-based application. Using tools such as Access, Excel, and SPSS, the Mental Health Services Researcher is able to compile data from these different systems leading to an overall enhanced planning and reporting process. In the Single Plan of Care (SPOC), outcomes are directly entered into a web-based system by human service center staff. This has streamlined the outcome reporting process.

North Dakota participates in the Western States Decision Support Group of the Western Interstate Commission for Higher Education's Mental Health Program. This group, made up of fifteen western states, meets three times per year to discuss and work on state and regional mental health data collection and research projects. The Mental Health Services Researcher is the Division's liaison to this group.

TARGET POPULATION: The Federal Register, Volume 62, No. 60 dated Friday, March 28, 1997, defines serious mental illness and the Federal Register, Volume 64, No. 121 dated Thursday, June 24, 1999 estimates that North Dakota has 25,024 individuals with serious mental illnesses. In SFY 2008, the estimate for adults with serious mental illness (26,833) and children and adolescents (5,855) is 32,688.

Definition of Adults with Serious Mental Illnesses

Pursuant to Section 1912 (c) of the Public Health Service Act, as amended by Public Law 102-321 "adults with a serious mental illness" are persons:

- age 18 and over
- who currently, or at any time during the past year
  - have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specific within DSM-IV
  - that has resulted in functional impairment which substantially interferes with or limits one or more major life activities

These disorders include any mental disorders (including those of biological etiology) listed in DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders and developmental disorders which are excluded unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts.

Definition of Children with Severe Emotional Disturbance (SED)

Children with Severe Emotional Disturbances (SED) meet the following eligibility criteria:

- Age 18 or less
- Diagnosed with an emotional, behavioral, or mental disorder
- Placed out-of-home, are at imminent risk of out-of-home placement, or have a Global Assessment of Functioning score (GAF) of 50 or below
- Have service needs involving two or more community agencies such as mental health, substance abuse, education, juvenile justice, health, or child welfare
- Must have or be expected to have the disorder for one year or more

ESTIMATE OF PREVALENCE: Because North Dakota has not engaged in any formal estimate of prevalence studies for mental health services, the Division used estimate of prevalence information for adults with serious mental illness developed by the Substance Abuse and Mental Health Services Administration and presented in the Thursday, June 24, 1999 Federal Register (Vol. 64, No.121). Based on this documentation, a prevalence rate for serious mental illness of 5.4% of the total state population was used. For SFY 2006, estimates of prevalence are based on U.S. Census 2004 county and state population estimates. It is anticipated that approximately 2% of the total state population has a serious mental illness and is in need of mental health services. Not all persons in the priority population will seek services from the Department of Human Services. In general, individuals who can afford it tend to seek care from private providers. Some eligible persons do not seek services, engage in activities that place them in other settings such as the criminal justice system, or are assisted by family or non-traditional caregivers. At this time, the Division does not have a mechanism in place to determine how many consumers are receiving formal or informal mental health services outside of the public system.

The Division used a similar method as the one mentioned above to determine the estimate of prevalence for children with a serious emotional disturbance. Because no formal estimate of

prevalence studies have been conducted for children's mental health services, the Division used estimate of prevalence information developed by the Substance Abuse and Mental Health Services Administration and presented in the Friday, July 17, 1998 Federal Register (Vol. 63, No. 137). Not all children will seek services from the Department of Human Services. In general, individuals who can afford services tend to seek care from private providers. Some eligible children and their parents do not seek services or are assisted by other family outside the household or non-traditional caregivers. At this time, the Division does not have a mechanism in place to determine how many children/consumers are receiving formal or informal mental health services outside of the public system.

Please refer to the estimate of prevalence table for the latest prevalence information and the performance indicators for the targets for the upcoming year.

North Dakota

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

OUTREACH TO HOMELESS – ADULTS

Homelessness continues to be an issue in North Dakota. The state lacks sufficient affordable housing, especially for low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is much more limited – transitional units, low demand housing, and supported permanent housing are in very short supply. "Deep subsidy" funds like the Section 8 voucher, which is the only way the chronically homeless will be able to afford to pay for the housing portion of permanent supportive housing, are limited. Some zoning laws in the state contain provisions that make it difficult to site group living facilities, which is the category most permanent supportive housing projects fall into. The specific regulatory language often involves definition of "non-household" living, rules regarding number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process. In North Dakota there is a willingness to tolerate chronic homelessness as an "acceptable" situation. In part, this belief is fostered by people's lack of direct experience with chronically homeless individuals. It is difficult to feel a sense of urgency about an issue with which one has little knowledge or first hand experience. The people of this state have a fundamental belief in "self-sufficiency." This belief often leads people to believe that the chronically homeless do not deserve help because they are not working hard enough to help themselves. Again, the belief itself is an obstacle to building support for the creation of housing options that specifically serve this population. At times, consumers have difficulty accessing available housing resources because of poor rental and credit histories and criminal backgrounds. In addition, very low or no income and an inability to afford rent, whether it is because they are unable to find a job where the pay is sufficient to cover housing costs or because they are unable to keep a job because of a disability.

The most recent Point-In-Time Survey found 832 homeless persons in North Dakota including 556 adults, 248 children and 28 persons for whom age was unknown. Of these, 177 people or 21% were long-term homeless.

Table 6. Homelessness in North Dakota by Region (January 30, 2008)

	Adults	Children	Age Missing	Total Individuals	Chronically Homeless	Long-Term Homeless	Mental Illness	Substance Abuse
Region I	18	0	1	19	0	7	9	12
Region II	19	16	0	35	0	5	10	5
Region III	28	13	2	43	0	11	5	7
Region IV	102	36	3	141	15	25	17	19
Region V	191	56	18	265	24	91	68	87
Region VI	24	0	0	24	0	8	21	17
Region VII	159	113	3	275	7	30	44	50
Region VIII	15	14	1	30	0	0	7	4
Total - ND	556	248	28	832	51	177	181	201

It is anticipated that approximately 993 persons who are homeless or at risk of becoming homeless and have a mental illness or a co-occurrence of mental illness and a substance abuse disorder will be provided services during FY 2009. Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness Grant provide persons who are homeless and mentally ill with intensive case management services including therapy, skills training, supportive residential services and coordinate obtaining other community mental health

and addiction services from staff of the human service centers. Persons who are homeless and mentally ill are provided outreach services, screening for treatment services, housing services, and referral for health, education, and entitlements.

The North Dakota Coalition for Homeless People, Inc. is the lead entity in the state working to decrease homelessness in North Dakota. Comprised of over sixty organizations (including the North Dakota Department of Human Services), the Coalition is committed to reducing the incidence of homelessness in North Dakota communities, assisting homeless individuals and families to move to self-sufficiency and permanent housing as quickly as possible, and ending chronic homelessness in North Dakota. The Coalition is also the lead entity for the statewide Continuum of Care process.

In 2008, a total of $1,319,578 was awarded in Continuum of Care grants to support local programs throughout North Dakota. These funds are expected to provide critically needed assistance to persons and families living without a home of their own. The following Continuum of Care Grants were awarded. Some groups have multiple projects:

* Grand Lodge of ND, IOOF (Transitional Housing) - $46,676
* Fargo Housing & Redevelopment Authority (Shelter Plus Care) - $333,780
* Share House Inc. (Permanent Supportive Housing) - $150,000
* YWCA Cass Clay (Transitional Housing) - $213,519
* Prairie Harvest Human Services Foundation - $84,999
* Abused Adult Resource Center - $78,682
* Society of St Vincent de Paul (Transitional Housing) - $15,277
* Community Violence Intervention Center (Transitional Housing) - $94,772
* Women's Alliance, Inc. Domestic Violence and Rape Crisis Center (Transitional Housing) - $37,600
* ND Dept of Commerce, Division of Community Services (HMIS) - $230,520
* NDAD (Transitional Housing) - $33,753

In addition to these projects, partnerships between local stakeholders have increased housing options for individuals diagnosed with serious mental illness in many regions. For instance, North Central Human Service Center, in partnership with other public and private stakeholders, is developing Harmony Heights, a four-apartment housing program located above the psychosocial rehabilitation center in Minot. With a case manager located on site, residents will have greater access to services, helping them remain in the community.

The Center for Persons with Disabilities out of Minot State University has facilitated two task forces created to enhance housing for persons with disabilities. The Visitability Task Force is working to advance visitability efforts in North Dakota and reviewing efforts in other states where visitability laws have already been passed. Passage of a visitability law would significantly impact the amount of accessible homes available for purchase by people with disabilities. The Section 8 Housing Task Force is working to get more Public Housing Authorities to sign on and use the public assistance program, which allows for Section 8 vouchers to be used toward home ownership. This program would significantly assist people with disabilities and minorities in purchasing homes by allowing them to use their Section 8 voucher as a mortgage payment.

The past few years have been pivotal for engaging both local and state elected officials in the NDC's work toward the goal of ending chronic homelessness. The Governor of North Dakota met with Coalition members in August 2004 to discuss developing a 10-year plan for ending chronic homelessness. Working with Coalition members, the Governor committed to having a

plan in place and -- by Executive Order -- established a 19-member North Dakota Interagency Council on Homelessness (NDICH) to develop the plan. The NDICH reports to the Governor and the North Dakota Legislature, which assembles biannually. In addition to state agency directors and NDC members, elected officials included on the NDICH are Dr. Wayne Sanstead, Superintendent of Public Instruction and Mayors Warford, Walaker, and Brown of the cities of Bismarck, Fargo, and Grand Forks respectively. Mayor Warford, in addition to serving on the NDICH and helping to develop the state's 10-year plan to end chronic homelessness, has committed to a 10-year plan for his jurisdiction of Bismarck. A 10-year plan has also been developed for the cities of Bismarck, Fargo, Grand Forks, Minot, Jamestown, Williston, Dickinson, and Devils Lake. In addition, the Three Affiliated Tribes and the Turtle Mountain Band of Chippewa Indians have each developed 10-year plans. In February 2005 the NDICH held its inaugural meeting at the State Capitol. The Director of the Division of Mental Health and Substance Abuse Services is a member of this council.

North Dakota

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

RURAL AREA SERVICES – ADULTS AND CHILDREN

North Dakota is a rural state with two-thirds of its counties designated as frontier areas. Nearly 40% of the state's population resides in the two eastern regions that lie on the border with Minnesota. In contrast, only ten percent of the population resides in the two regions that lie on the western border with Montana. In fact, the western half of the state has a sparse population density from 0.9 to 10.7 persons per square mile. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel. Round-trips of 200 miles or more to obtain services are not uncommon.

The eight regional human service centers serve catchment areas ranging from three to ten counties. In attempts to address the difficulty rural residents have with accessing needed services, each center has staff traveling to outlying rural communities to provide mental health services, e.g., diagnostic screening, evaluations, follow-up counseling, information and referral. Services are delivered to outreach sites as follows:

Region I	Permanent full-time outreach to two sites; other communities when needed or requested
Region II	Permanent full-time outreach divided between two sites, weekly outreach to two sites, other communities or individuals when needed or requested
Region III	Permanent full-time outreach to one site, biweekly outreach to ten sites, weekly outreach to two sites, other communities when needed or requested
Region IV	Permanent full-time satellite offices in one site; weekly outreach to one other site; other communities when needed or requested
Region V	Weekly or biweekly outreach to five sites, other communities when needed or requested
Region VI	Biweekly outreach to three sites, one site three times per week, other communities when needed or requested
Region VII	Biweekly outreach to six sites; one permanent site with outreach to four counties; other communities when needed or requested
Region VIII	Permanent part-time outreach to one site; biweekly outreach to four sites; other communities when needed or requested

The delivery of services to persons residing in rural areas has been and continues to be a major concern of the North Dakota Mental Health Planning Council. The mental health delivery system in the future will need to depend more on the assistance of other professionals who work and live in rural communities. County/city public health nurses and county social workers will need training to work with persons with serious mental illnesses and serious emotional disorders residing in rural North Dakota. Paraprofessionals will need to be trained to deliver quality care to this population.

In addition to the outreach sites listed above, case managers and care coordinators travel throughout the regions making home visits when appropriate and needed. Case management occurs in the environment of the person's choice such as their home, a public place, or in the human service center. When appropriate and with the individual's permission, family members are involved in support and planning, this is especially true for care coordination through the child and family team process.

North Dakota

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

OLDER ADULTS

North Dakota is an aging State. It is estimated that approximately 147,706 people in North Dakota are 55 years of age or older. This is projected to increase to 241,496 or 62% by the year 2015. Kessler, as cited in the Surgeon General's report on Mental Health, estimated that 0.8 percent of persons over the age of 55 have a serious mental illness. Based on this, approximately 1,182 persons are aged 55 or above and have a serious mental illness in North Dakota.

During the past fiscal year, the regional human service centers in North Dakota provided services to 1,344 older adults over the age of 60. Ninety-four percent of those were Caucasian and two percent were Native American. Veterans accounted for just over six percent of those seen for services. The most common diagnoses for this group were Depressive Disorders (22.7%), Schizophrenia (9.7%) and Bipolar Disorder (6.5%). Individual therapy, medical services (including psychiatric assessment/therapy, nursing), and case management were the most common services received by this group.

Suicide continues to be an issue in North Dakota. According to the North Dakota Suicide Prevention Plan (2005), national trends show suicide rates decreasing in middle-aged adults and increasing again in the senior citizen age group. These trends are reversed for North Dakota. As a state, North Dakota is experiencing an increase in suicide rates in adult age groups, with a decrease in senior citizen age groups. The current highest suicide rate for North Dakota is 17.6 per 100,000 population in the 45 to 54 age group. For the 65 to 74 age group, suicide rates were12.3 per 100,000 population and 13.9 per 100,000 population for the 75 to 84 age group. Females account for 58 percent of suicide attempts, with a rate of 68.5 per 100,000 per year. Males account for 42 percent of suicide attempts, with a rate of 50.8 per 100,000 per year. Although the white population had seven times more deaths by suicide than the Native American population in the last 10 years, because of the population base, the suicide rates for Native Americans were almost three times that of the white population. In some tribal areas of North Dakota, the rate was five times higher than that of the white population. Suicide takes a financial toll in North Dakota, as well. The average medical cost per case of suicide attempt is $7,516. The average work-loss per suicide fatality is $780,802.

It is recognized that a number of barriers exists for this population including difficulty accessing care due to the rural/frontier nature of North Dakota, lack of specialized geriatric mental health care, as well as stigma and misperceptions surrounding mental health in the aging population. For this reason, the Division of Mental Health and Substance Abuse Services is focusing attention on the enhancement of mental health services to the aged population throughout the State. During phase one of this initiative, the Division worked with the Mental Health Association in North Dakota to develop and implement mental health and aging training programs to identify existing mental health services for older individuals, develop an understanding of those mental health services and collaboration among agencies, identify future service needs for the identified gaps, raise public awareness of the mental health needs of and services for older individuals. Trainings were at all human service centers to provide staff members with an understanding of the issues regarding mental health needs of the elderly and allow them to gain an appreciation for the multidisciplinary approach to meeting the health needs of older individuals. In addition, an aging/mental health track was incorporated into the Clinical Forum on Mental Health conference. Topics included the assessment of behavioral health issues in the elderly, substance abuse and the elderly, and understanding depression and suicide in the elderly.

Phase Two of the initiative focused education to the natural caregiver – those individuals – generally outside of the professional medical community – that older individuals routinely access for care and support in the community. This included (but not limited to) nursing home staff, family caregivers, parish nurses, clergy, personal care attendants, and first responders. The training included discussion of the aging process, wellness and prevention, and information and resources. North Dakota State University was awarded the contract and has extensive experience in the field of gerontology and mental health. They developed a four module-training program focused on positive aging and mental health. Thirty-two natural caregivers representing each region of the state were trained to conduct education on mental health and aging. They presented the four modules throughout North Dakota. The total attendance at the education sessions was 727 natural caregivers. The modules have been catalogued with the North Dakota State Library.

Phase Three of the initiative expanded from the natural caregiver training. North Dakota State University developed and implemented a training curriculum on mental health issues and older adults targeted to community-based mental health clinicians. The curriculum focused on mental health and the aging process; changes to the aging brain and the impact on mental health, wellness/prevention/medical issues associated with mental illness; assessment and diagnosis of mental health issues in older adults; treatment of mental illness in older adults including psychopharmacological treatment, psychosocial treatment, and barriers to treatment and how to address them; and community resources. The training was structured as a web-based program, which included core information, case studies, activities, and resources. The program was presented at the Aging Track of 2008 Clinical Forum on Mental Health Conference.

During the upcoming year, the Natural Caregiver Program and the Mental Health Clinician Training Program will be continued. This will allow the Division to further increase the cadre of clinicians and others trained in mental health and aging.

In March of 2008, North Dakota applied for an Older Adults Targeted Capacity Expansion Grant through SAMHSA. North Dakota will use a five-pronged approach to implementing the Positive Aging of North Dakota Adults (PANDA) program involving a needs assessment, Gatekeeper Training and Referral, mental health outreach services, public education, and a gerontological counseling certification program.

If awarded, the North Dakota Department of Human Services will contract with one of the state's public universities to conduct a needs assessment of mental health services of individuals aged 60 years and older. Results will be used to guide future program development and implementation. In North Dakota, state agencies are able to directly contract with one another without going through a formal procurement process. This will speed implementation of this section of the program.

The Department of Human Services will contract with North Dakota State University to provide Gatekeeper Training and Referral. NDSU will use the Natural Caregiver training program that has already been developed. In North Dakota, state agencies are able to directly contract with one another without going through a formal procurement process. This – coupled with implementing an already-developed training program – will speed implementation of this section of the program.

The Mental Health Outreach component will be divided into two parts: Senior Center Outreach and Veterans Administration Outreach.

The Department of Human Services will contract with one of the larger senior centers in the target area. Senior centers, located throughout North Dakota, offer a variety of healthcare, nutritional, recreational, and social activities. Many employ licensed social workers. The Regional Program Manager will be located within this facility. This primary contractor will in turn subcontract with three additional senior centers, one in each region. The senior centers will provide outreach to the target population within their respective regions.

Outreach care coordinators/therapists will provide assessment, care coordination, and individual therapy to the target population. They will make regular contact and coordinate care with the regional human service centers as well as primary care physicians and their staff, helping move toward more seamless service delivery for the older adult. Consultation services and coordination will be offered to long-term care facilities and other senior centers, as well.

Each outreach care coordinator/therapist will also make regular contact and coordinate care with Indian Health Services, Tribal governments, and other Native American entities. The Department's Tribal Liaison will be consulted to help the team gain entry to the Tribal areas and to enhance ongoing communication with Tribal governments and other Tribal entities concerning the program. Outreach care coordinators/therapists will also work closely with Community Health Representatives. Possessing cultural and historical knowledge and training in health promotion and social support, community health representatives (CHRs) are uniquely equipped to broker the needed relationship between a world shaped by culture and history and the world of conventional scientific knowledge. Grounded in principles of social support and interpersonal communication, as well as an understanding of their community's strengths and history in health protection, CHRs are bridges distinctively positioned to connect these two worlds.

For the second part of the Mental Health component, the Division will contract with the Veterans Administration. The Veterans Administration operates a hospital in Fargo and community-based outreach clinics in Williston, Minot, Grafton, Jamestown, Bismarck, and Dickinson. The outreach care coordinators/therapists will provide services to veterans age 60 and above throughout North Dakota. The team will make regular contact with Veterans Home in Lisbon, veterans' centers, the National Guard Family Assistance Centers, and other military/veteran agencies.

The Department of Human Services will go through a formal procurement process to obtain a contractor for the public education campaign. The public education campaign will promote the program, encourage older adults to seek services if needed, and reduce stigma associated with mental illness. This campaign will compliment the Department's ongoing mental health anti-stigma efforts: Mental Health Recovery – What a Difference a Friend Makes.

The Department of Human Services will contract with one of the public universities to develop and implement a gerontological counseling certification program. This program will increase the number of clinicians that have advanced training in gerontological counseling. In North Dakota, state agencies are able to directly contract with one another without going through a formal procurement process.

North Dakota

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

RESOURCES FOR PROVIDERS – ADULTS AND CHILDREN

BUDGETING FOR MENTAL HEALTH SERVICES: Mental health services in North Dakota are provided by State funds, Federal funds, third party payer, and other specialty funds. The Division of Mental Health and Substance Abuse Services prepares a budget one year ahead of the legislative session. North Dakota's legislature meets every other year, therefore, the budgets are developed for a biennium. The Division develops a budget for its operation, which includes contracting with private providers for training, consultation, education, extended services, and homeless programs. Each human service center as well as the North Dakota State Hospital prepares its own budget. All budgets are then presented to the Executive and Fiscal division of the Department of Human Services for approval. Once approved, the budgets are reviewed by the Office of Management and Budget as well as the Governor's Office. When final approval has been granted by the Governor's Office, the budgets are presented to the Legislature for approval. During the legislative session, consumers, families, and other advocates appear before the legislative committees to testify on behalf of all mental health programs in the state.

BLOCK GRANT FUNDING: Funding has been broken into the block grant function categories as: Carrying out the Plan; and Planning, Administration and Evaluation. Descriptions of initiatives can be found in the criteria narratives while a brief description is found below.

- Supported Employment Pilot: Pilot program at Southeast Human Service Center in Fargo to explore the feasibility of implementing SAMHSA's model of Supported Employment in North Dakota.
- Aging Mental Health Services: Mental health and aging education targeted to mental health clinicians.
- IDDT Pilot: Continued implementation of Integrated Dual Disorders Treatment program at Southeast Human Service Center in Fargo.
- Mental Health Recovery: Continued implementation of the Mental Health Recovery Model throughout the state.
- Suicide Prevention: Support for suicide prevention efforts throughout the state.
- Consumer Network: Support for the North Dakota Mental Health Consumer and Family Network.
- Parent-to-Parent Support: Continued support of program matching experienced parents of children with SED to those with newly diagnosed children.
- Voluntary Out-of-Home Treatment Program for Children with Severe Emotional Disturbances: Continued support of program giving parents the option to access out-of-home treatment for their children without relinquishing legal custody.
- Anti-Stigma: Support for statewide media campaign to fight stigma associated with mental illness.
- MH Clinical Forum: Annual conference for providers focusing on evidence-based practice, recovery, transformation and other mental health topics.
- Evidence-Based Practice Training: Support for ongoing training for clinicians on evidence-based practices.
- Wraparound Training: Support for training of direct service staff on the fundamentals of Wraparound.
- Emergency Services Training/Primary Care: Training of first responders in mental health issues.

- Planning Council: Travel, per diem, printing, training opportunities, and other expenses associated with operation of the Council including full Council meetings and separate committee meetings.
- Carrying Out the Plan: Expenses associated with carrying out and administering the programs mentioned.
- Evaluating the Plan: Expenses associated with evaluating the community-based public mental health system.
- HSC-Partnerships: Continued delivery of the Partnerships Program in all eight regions.
- Extended Services: Enhancement of job placement and job coaching services for individuals diagnosed with a serious mental illness assisting them with obtaining and maintaining employment.

STAFFING: The regional human service centers employ approximately 830 FTE's. These include licensed clinical psychologists, licensed professional counselors, licensed addiction counselors, licensed certified/independent clinical social workers, occupational therapists, early childhood specialists, marriage and family therapists, vocational specialists, case managers, psychiatrists, and nurses. In addition, the Division of Mental Health and Substance Abuse Services employs twenty staff to oversee the mental health and substance abuse service system in North Dakota.

TRAINING: Mental health block grant dollars are also used to provide training to mental health professionals through the State concerning issues and innovations in the field. For instance, block grant dollars are used to fund the Clinical Forum on Mental Health Conference, Wraparound certification training, evidence-based practices training, and supports the annual Family-Based Services Conference, and the Indian Child Welfare Act Conference.

As required by block grant law, training will also focus on the recognition of psychiatric symptoms and strategies for dealing with situations resulting from psychiatric symptomology specifically targeted towards emergency personnel including emergency medical technicians, physicians, and law enforcement. The Division will collaborate with the North Dakota Law Enforcement Training Academy to train first responders.

North Dakota

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

EMERGENCY SERVICES PROVIDER TRAINING
ADULTS AND CHILDREN

As required by block grant law, training will also focus on the recognition of psychiatric symptoms and strategies for dealing with situations resulting from psychiatric symptomology specifically targeted towards emergency personnel including emergency medical technicians, physicians, and law enforcement. The Division will collaborate with the North Dakota Law Enforcement Training Academy to train first responders.

Mental health block grant dollars are also used to provide training to mental health professionals through the State concerning issues and innovations in the field. For instance, block grant dollars are used to fund the Clinical Forum on Mental Health Conference, Wraparound certification training, evidence-based practices training, and supports the annual Family-Based Services Conference, and the Indian Child Welfare Act Conference.

North Dakota

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Mental Health Block Grant 2008 Budget
October 2008 - September 2009

	TOTAL BUDGET		POPULATION BREAKOUT	
			Child	Adult
Transformation Activities		**$ 337,500.00**		
Supported Employment Pilot	$ 7,500.00		$ -	$ 7,500.00
Aging Mental Health	$ 30,000.00		$ -	$ 30,000.00
IDDT Pilot	$ 25,000.00		$ -	$ 25,000.00
Mental Health Recovery	$ 15,000.00		$ 7,500.00	$ 7,500.00
Suicide Prevention	$ 5,000.00		$ 2,500.00	$ 2,500.00
Consumer Network	$ 60,000.00		$ -	$ 60,000.00
Parent to Parent Support	$ 75,000.00		$ 75,000.00	
Voluntary Treatment	$ 75,000.00		$ 75,000.00	
Trauma-Focused EBP	$ 40,000.00		$ 20,000.00	$ 20,000.00
Anti Stigma	$ 5,000.00		$ 2,500.00	$ 2,500.00
Training		**$ 84,104.00**		
MH Clinical Forum	$ 50,000.00		$ 25,000.00	$ 25,000.00
EBP Training	$ 23,104.00		$ 11,552.00	$ 11,552.00
Wraparound Training	$ 6,000.00		$ 6,000.00	$ -
Emergency Services Training/Primary Care	$ 5,000.00		$ 2,500.00	$ 2,500.00
Planning Council	$ 20,000.00	**$ 20,000.00**	$ 10,000.00	$ 10,000.00
Carry Out the Plan	$ 33,317.00	**$ 33,317.00**	$ 16,658.50	$ 16,658.50
Evaluating the Plan	$ 17,800.00	**$ 17,800.00**	$ 8,900.00	$ 8,900.00
HSC Partnerships	$ 216,503.00	**$ 216,503.00**	$ 216,503.00	
Extended Services	$ 70,000.00	**$ 70,000.00**		$ 70,000.00
Total	**$ 779,224.00**	**$ 779,224.00**	**$ 479,613.50**	**$ 299,610.50**

Table C. MHBG Funding for Transformation Activities
State: North Dakota

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☒		5,000
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		150,000
GOAL 3: Disparities in Mental Health Services are Eliminated	☒		6,000
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☒		5,000
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☒		240,604
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☐		
Total MHBG Funds	N/A	0	406,604

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

North Dakota

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State"s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

TRANFORMATION EFFORTS AND ACTIVITIES – ADULT & CHILDREN

Mental health transformation takes many forms in North Dakota. The process uses a multifaceted transition approach that infuses the recovery concepts within the service delivery system while initiating targeted evidence-based practice initiatives within regional human service centers that have displayed readiness for implementation. At the same time, consistent message, work force development, contracted initiatives, and technical assistance covering a variety of transformation areas take place. The next step is to create and promote readiness in additional centers for future expansion efforts.

The Division of Mental Health and Substance Abuse Services is leading the community-based public mental health system and its partners in implementing various mental health transformation activities. These include:

GOAL 1: AMERICANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

In an effort to reduce the stigma associated with mental illness, the Division is implementing an anti-stigma campaign. Using the "What A Difference A Friend Makes" campaign material, the Division will be airing two localized television ads and one radio ad. In addition, the Division contracted with Newman Outdoor Advertising for the design and set-up of thirty-two billboards across the state. The billboards, targeted to young adults, will read, "Mental Health Recovery…What A Difference A Friend Makes!"

GOAL 2: MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN

In 2006, seven Department staff members and one consumer were sent to the Recovery Institute in Ohio to be trained as trainers in the recovery model. Since then, the group has trained all SMI case management staff (approximately 80 staff members) and is conducting ongoing training of direct care staff from the State Hospital. Consumers are being trained in the model at the State Hospital and the regional human service centers. In June of 2007, the Division brought Wilma Townsend to North Dakota to provide administrative and supervisory staff training on the model. Ms. Townsend was brought back to train additional consumer trainers: two trainers for each of the eight regions of North Dakota. The consumer-training portion has become a component of the North Dakota Consumer and Family Network.

The State Hospital has implemented the Treatment Mall, a recovery-focused alternative to the traditional inpatient model. This program supports the notion that treatment should not be provided within the "home environment" of the consumer. Rather the consumer must leave their "home" during the business day and go elsewhere for the array of treatment services. It also establishes a structure of living that would then more naturally follow the consumer when living independently.

Central to the purpose of the Treatment Mall is a full array of groups and learning experiences that can be selected on the basis of not only need but also by choice. The Treatment Mall is in a separate location on the hospital grounds where staff and consumers from multiple units come together to provide and receive mental health services. Consumers work with a coordinator and a treatment team to define a life goal through a Recovery Plan. The patient then chooses classes that will help develop the skills that will move them toward the goal of returning to the community. Consumers attend four to five classes fifty minutes in length offered Monday

through Friday from 9:00am to 12:00pm and 1:00pm to 4:00pm. The Treatment Mall functions like a learning center and therefore follows a twelve-week semester format. Consumers select classes designed to help them reach their recover goals. Consumers and the coordinator will then register for those classes during the registration process. The services provided through classes are designed to teach daily life skills, vocational training, education, illness education, medication management, and social skills that will strengthen and empower the consumer toward recovery and transition back into the community.

The Parent-to-Parent Support Program involves coaching and assisting families with children with emotional/behavioral disorders/needs by increasing their knowledge of their child's needs, assisting with the process of choosing service providers, explanation and interpretation of policies and procedures, and training to assist parents in accessing mental health services for their children. The Division of Mental Health and Substance Abuse continued the contract for the 2007-2009 biennium was awarded to the North Dakota Federation of Families for Children's Mental Health to provide the parent-to-parent support services effective July 1, 2007.

The N.D. Department of Human Services through collaboration between the Division of Mental Health and Substance Abuse Services and the Children and Family Services Division administers the Voluntary Out-of-Home Treatment Program. The program is an option for parents to access out-of-home treatment for their children without relinquishing legal custody when the child's circumstances fall within the intent of this program. The child must be covered by Medicaid program and the application be approved by the Division.

A parent was invited to become a member of the NDSEDA, at this time, has not initiated involvement with the Alliance.

It is widely recognized that transforming the mental health system to be more responsive to consumer needs and better assist in recovery requires the participation of consumers at all levels of policy planning and program development, implementation, and evaluation. Meaningful involvement of consumers in the mental health system can ensure they lead a self-determined life in the community, rather than remaining dependent on the mental health system for a lifetime.

To ensure meaningful involvement of consumers in the mental health system, consumers and family members need to organize, encourage one another, and become educated about the workings of the system. The Division of Mental Health and Substance Abuse Services has long supported consumer participation in public mental health policy design and service implementation. This support continues with the statewide Consumer and Family Network.

Please refer to Establishment of System of Care- Adults section for detailed information about the North Dakota Mental Health Consumer and Family Network.

The Division also collaborates with ND Family Voices a statewide advocacy and information network and warehouse.

According to North Dakota Administrative Code 75-05-04-03, each client who has been admitted for service to the human service center shall have an individual plan based on the admission data and needs of the client. This has been in place since at least the late 1980s. The chapter is being revised to reflect best practices and enhanced consumer involvement. The proposed section concerning treatment planning will include:

> The professional staff member assigned the client shall develop and review the individual plan with the client, at whatever level the client can participate, shall document the review in the client's record, indicating the extent of their client's involvement in developing the individual plan and shall have the client sign the treatment plan. In the event the client refuses or is unable to sign the treatment plan, this must be documented in the chart.

This will help to ensure that consumers have the opportunity to fully participate in their treatment and the development of their individualized treatment plan.

Please refer to System of Integrated Services- Child section for detailed information about the Single Plan of Care and the creation of a Front-End System to support individualized care plans.

Please refer to Establishment of System of Care- Adults section for detailed information about the implementation of the person-centered treatment planning initiative in North Dakota.

GOAL 3: DISPARITIES IN MENTAL HEALTH SERVICES ARE ELIMINATED

A portion of North Dakota's New Freedom Initiative funding has been earmarked for the implementation of a Cultural Competency Plan for all employees. This will include an ongoing training component.

Key to the children's mental health system of care is a strong partnership with families and integrating services across systems. Parents are actively involved in the design and implementation of the programming, serve on the local and state advisory boards and provide on-going support to parents negotiating services for their children.

The Wraparound Process Certification Training has a cultural component, which is taught to participants to assure adherence to the philosophy of Wraparound and to build culturally competent practice among the field.

Dr. D BigFoot from the Indian Country Child Trauma Center, University of Oklahoma Health Sciences Center and Dr. Susan Schmidt from Center on Child Abuse and Neglect, University of Oklahoma (partner's of the National Child Traumatic Stress Network) provided training on June 5 and June 6, 2008. The Human Service Center clinicians and other private clinicians from the Treatment Collaborative for Traumatized Youth (TCTY) were trained on how to adapt Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with Native American children/youth. The training was called Honoring Children, Mending the Circle.

In September 2004, The Department of Human Services, Aging Services division, was awarded a Real Choice System Change Rebalancing Initiative grant. The grant was funded for a three-year period of time. The goals of the grant are: to develop a mechanism to balance state resources for continuum of care services to strengthen opportunities for choice and self-direction; to develop a system to provide a single point of entry for continuum of care services; and to develop practical and sustainable public information services for all continuum of care services in North Dakota. The grant goals will be achieved through research; focus groups and questionnaires targeting consumers, providers, and family members; stakeholder meetings involving more than 100 agencies and organizations; and a broad-based steering committee.

To date, the following outcomes have been achieved: 1)a forum was developed for building consensus on a shift from reliance on institutional forms of long-term care and services toward the increased availability, diversity, and utilization of home and community-based services for the elderly and individuals with disabilities; results of the input from various stakeholders groups, surveys and personal interviews has been compiled and a formal report is forthcoming; 2)recommendations for legislative consideration to shift public financing of programs and services from over-reliance on institutional forms of long-term care and services toward the increased availability, diversity, and utilization of home and community-based long-term care and services with an integrated service quality assurance mechanism consists of a draft of "Rebalancing Road Map", consumer interviews and stakeholder meetings, and a report of the results of those meetings and interviews resulting in an increased knowledge and understanding of rebalancing best practice; 3)plans to develop and implement a single point of entry mechanism to long-term home and community-based and institutional services for elderly and people with disabilities; an agreed upon list of 21 key Single Point of Entry/Aging and Disability Resource Center (SPE/ADRC) components is drafted, final single Point of Entry/Aging and Disability Resource Center (SPE/ADRC) legislation prepared for consideration of the 2007 Legislative assembly; a report and recommendations from the work of the common assessment sub-committee of a common referral tool; listing of potential Single Point of Entry (SPE) alternative funding options; and 4) the development and implementation of a program of public choice and access information about assistance services for individuals seeking long-term supportive services for the elderly and individuals with disabilities and individuals considering transition from institutional services to home and community-based services. Recommendations prepared for the Sixtieth Legislative Assembly included a Senate Concurrent Resolution expressing support for long-term care choices, including home and community-based services, for North Dakotans with disabilities and older adults and the Aging and Disability Resource Center (ADRC) Initiative which would create partnerships in North Dakota to improve the efficiency of government programs and reduce the frustration and confusion that consumers face when trying to learn about and access the long-term care service system.

Access to dental care continues to be an issue in North Dakota. According to the University of North Dakota's Center for Rural Health, 30% of the state's 53 counties are designated as Dental Health Professional Shortage Areas (as of 9-2007). Fifty-seven percent of North Dakota's population lives in Ward, Grand Forks, Cass and Burleigh counties, as do an overwhelming proportion of the state's dentists. As a result of growing concerns about a nation-wide shortage of dentists, and the number of designated dental HPSAs in North Dakota, the Center conducted a state-wide dental workforce survey to examine the demographics, practice profiles, and patient profile information of the state's 316 licensed dentists. North Dakota does not have a dental school, and over half of our dentists were trained at the University of Minnesota. Results from our 2004 survey indicate: just over half were born in ND, 73% practice general dentistry, the average age of North Dakota dentists is 52 years and 60% of dentists plan to retire in the next 15 years. In 2002 a state dental loan repayment program was established to attract dentists to areas of need across the state. There have been eight recipients of the loan program who located in 6 different communities (Minot, Fargo, New Rockford, Grand Forks, Bismarck, and West Fargo).

The Center for Rural Health also noted that between seven and twenty-five percent of dentists in North Dakota accept any and all Medicaid patients that present for treatment. Rural dentists tend to accept more Medicaid patients than do urban dentists. Care coordinators work closely with children and families to assist with accessing dental care. At times care coordinators have needed to transport children and their families hundreds of miles (roundtrip) to access dental care from a provider that accepts Medicaid patients.

In an attempt to address this issue, the Dakota Medical Foundation created the Dental Care Access Program (DCAP). DCAP is working to increase access to oral health care for the uninsured and underinsured of our communities. Under the direction of the dental coordinator, DCAP is networking with the North Dakota State Oral Health Department, Bismarck; Red River Valley Dental Access Project, Fargo; Bridging the Dental Gap Clinic, Bismarck; Dental Access Committee, Grand Forks; and federally qualified healthcare centers in Fargo, Northwood/Larimore, and Turtle Lake/Rolette/McCluskey.

Access to preventive care remains a problem for some segments of the population, specifically low-income, minority individuals. Individual knowledge of how oral health relates to general health is limited, and the mouth is frequently fragmented from the rest of the body. Workforce issues remain despite the state's legislation enacting a dental loan repayment program.

Healthy Steps, North Dakota's SCHIP, currently serves 4,087children. According to the 2007 Annual EPSDT (Health Tracks) report, 11,148 individuals from birth to 21 years of age received a dental service, 6,984 a preventive dental service and 5,069 received dental treatment services.

Healthy People 2010 Oral Health State Plan Statistics

During the 2004-2005 school year, the North Dakota Department of Health (NDDoH) conducted a statewide Oral Health Survey of third-grade children enrolled in public, state or Bureau of Indian Affairs elementary schools in the state. This survey found that 56 percent had cavities and/or fillings (decay experience) – substantially higher than the *Healthy People 2010* objective of 42 percent. Seventeen percent had untreated dental decay (cavities) compared to the *Healthy People 2010* objective of 21 percent. Compared to white non- Hispanic children in North Dakota, a significantly higher proportion of minority children have decay experience, untreated decay and urgent dental needs.

The Oral Health program has 5 oral health consultants located around the state. The consultants provide oral health education and oral health screenings. The consultants also provide technical assistance to schools participating in the fluoride mouth rinse and tablet schools programs. Within that plan, delivery systems such as a stand alone dental clinics, mobile dental vans, urgent care centers, dental clinics affiliated with hospitals and clinics and others will be analyzed and recommendations made for best practice.

Community Resource Coordinators (CRCs) located throughout the state have worked to ensure that whenever possible, oral health care is accessed by their clients. Through a program called Dental 1/90, case management is provided to uninsured clients. Dentists are fully reimbursed for charges incurred in the care of these patients while agreeing to see 1 new Medicaid patient every 90 days.

The Adult and Children's Mental Health Administrators conducted statewide on-site meetings at all 8 Regional Human Services Centers last year to gather feedback and solutions to meet the needs of transitioning youth (Refer to Unmet Service Needs and Plans to Address Unmet Needs sections of this document for additional information). A statewide interactive video meeting was held on September 17, 2007. This meeting was for an open forum for discussing youth transitioning from children's to adult MH services and also those youth aging out of foster care. We will also be discussing Transformation Activities across the state, strengths and gaps in the MH system of care along with an update on Evidence-Based Practices. Participants will include county regional representatives, Division of Juvenile Services, Independent Living

Coordinators, tribal entities, county child welfare, and program administrators from the Division of Mental Health and Substance Abuse Services.

A significant need exists to assist children in the transition from the children's mental health care system to the adult mental health care system. This issue is brought to the forefront in the technical assistance visits from DMHSA staff to the human service centers, MHPC meetings, and regional stakeholders meetings. A portion of funding from the New Freedom Initiative Grant will be used to establish a "Transition Flex Fund" that young adults, age 18-21, can access through a care coordinator or adult case manager at the human service center. Funds will be used to assist with housing, medication and other health care, transportation, clothing, and other individualized needs. An existing referral and payment system will be utilized to implement this effort.

A legislative Interim Committee study was chosen to explore the needs of transitioned aged youth in all systems; mental health, education, child welfare, juvenile justice, vocational rehabilitation and developmental disabilities. A collaborative effort among the systems has occurred to provide testimony and information to the committee. The Children's MH Administrator is also involved with a nation transition aged youth workgroup, exploring areas such as, housing, employment, involvement in policy building and testimony. The Department also has a Transition Steering Council that has been working on this area.

North Dakota's Money Follows the Person Demonstration grant will develop services to assist people who want to transition from institutions to qualifying community living arrangements by actively identifying individuals for transition services, and strengthening transition services and ongoing community supports. ND will focus on: people with developmental disabilities and individuals residing in skilled nursing facilities.

ND has established a strong single-point-of-entry and case management services to support community living of persons with developmental disabilities and recently launched an Independence Plus waiver for that population. ND also instituted a bed buy-out program, and also has a moratorium on new nursing facility beds, and a single budget line item for long-term care services, however, challenges remain. These include the lack of coordinated transition services for institutionalized persons and a fragile caregiver infrastructure in sparsely populated rural areas.

ND goals are for this program are: increase the use of home and community-based services (HCBS); eliminate barriers that restrict the use of Medicaid to enable people to receive support for long-term care services in a setting of their choice; increase the Medicaid program's ability to support HCBS; and ensure quality assurance procedures are in place for individuals receiving Medicaid HCBS.

Please refer to Legislative Initiatives and Changes-Child section for an update on SCHIP in North Dakota and other legislative laws from the 2007-2009 Legislative Assembly.

GOAL 4: EARLY MENTAL HEALTH SCREENING, ASSESSMENT, AND REFERRAL TO SERVICES ARE COMMON PRACTICE

Please refer to Establishment of System of Care- Child section for detailed information about the North Dakota Social, Emotional, Developmental Alliance (NDSEDA) to support early mental health screening, assessment and referral to services.

The North Dakota Department of Health, Division of Injury Prevention and Control, coordinates the North Dakota Suicide Prevention Coalition. The Division of Mental Health and Substance Abuse Services is a member of the Coalition.

Please refer to Recent Significant Achievements - Adults section for detailed information about the suicide prevention efforts in North Dakota.

GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND PROGRAMS ARE EVLUATED

The Department of Human Services is committed to working with multiple systems to enhance coordination of care for consumers. The State Review Team was established to help with this. The State Review Team is a consumer/child specific review process incorporating the involved systems and agencies to address challenges, barriers, and gaps preventing appropriate care, services and/or education. The team looks at items ranging from clinical/education reports, placement options/attempts, housing options, and funding streams. It works toward braiding together possible options in the best interest of the individual discussed.

The State Review Team is a problem-solving, creative options think tank that addresses not only individual cases but also explores systemic issues. It is not a forum to resolve disputes or appeal system decisions or replace local team responsibilities.

The agencies represented on the State Review Team are:

Division of Juvenile Services
Adult Corrections
Department of Public Instruction/Special Education
Children & Family Services Division-DHS
Medical Services-DHS
Mental Health and Substance Abuse-DHS
Developmental Disabilities/Vocational Rehabilitation-DHS
Aging Services Division – DHS
Institutions – State Hospital and Developmental Center
Regional Human Service Centers

Please refer to System of Integrated Services- Child for detailed information about Wraparound Certification and Re-certification and the Single Plan of Care (SPOC) collaborative efforts with multiple systems. The SPOC is used by juvenile corrections, child welfare, and mental health systems, private providers, and education. There are over 500 child welfare and system partners certified in the Wraparound Process. 43 participants completed Wraparound Certification Training this past year.

Please refer to the Establishment of System of Care- Child section for detailed information about Evidence-Based Practices, Youth Advisory Council Initiative, and the North Dakota Social, Emotional, Developmental Alliance (MH Screening Tool Kit) for the improvement of collaboration and coordination of care among multiple systems.

The North Dakota Department of Human Services provides service to individuals who are dually diagnosed with a serious mental illness and a substance abuse disorder. The regional human

service centers offer dual diagnosis programs ranging from group therapy to intensive case management.

Please refer to Establishment of System of Care- Adults section for detailed information about the provision of services for co-occurring mental and substance use disorders for adults.

Please refer to Establishment of System of Care- Children section for detailed information about the provision of services for co-occurring mental and substance use disorders for children.

The Division uses block grant dollars to augment Extended Services for adults diagnosed with a serious mental illness. These funds are used to purchase employment coaching/job shadowing as well as assistance with locating/obtaining/maintaining employment.

Please refer to Establishment of System of Care- Adults section for detailed information about the provision of Supported Employment and Extended Services.

North Dakota has made great strides in community-based mental health care. Challenges do remain, however. Nearly one-quarter of the individuals admitted to the State Hospital in recent years had been admitted multiple times during the year. An estimated one in ten inmates in North Dakota's prison system has a serious mental illness diagnosis. Transition from the children's mental health system to the adult system can be a daunting task. In an attempt to address issues such as these and maximize community-based services, North Dakota is exploring various evidence-based practices.

Please refer to Establishment of System of Care- Adults section for detailed information about the provision of evidence-based practices for adults.

Please refer to Establishment of System of Care- Child section for detailed information about the provision of children's evidence-based practices.

Please refer to #1 - Improving Coordination of Care among Multiple Systems section in this document for detailed information about the State Review Team to align financing for MH services maximum benefit.

Western Sunrise, Inc. is a nonprofit, consumer-run organization located in Williston that exists to promote wellness for individuals with a mental illness. The focus of Western Sunrise is to bring people together and serve the needs of the broad spectrum of community-based mental health recovery, rehabilitation, and peer support. Since its inception in 1986, Western Sunrise has created a bridge between consumer input and the regional care program. Increasing and enhancing employment programs was ranked the number one priority during the most recent planning session. Western Sunrise has provided two volunteer programs that provide earning (a reward stipend) for consumer's volunteer efforts. In July of 2003, Western Sunrise added a transitional employment component to their portfolio and works cooperatively with the regional office of Vocational Rehabilitation to receive referrals that are appropriate for the transitional employment programs.

Western Sunrise's most immediate priority is to provide a peer support network that provides outreach, respect, self and help groups related to recovery and empowerment, and the "Living in Place" peer support and Bridge program. The goals of the "Living in Place" Program are to successfully maintain community living in the consumer's current residence, and to discover lost identities through years of institutionalization, mental health myths and stigma. This program is

patterned after a similar program in New York State and is also related to Mary Ann Copeland's WRAP program. The Peer Support program focuses on developing a relationship that is centered on recovery and builds a sense of family and community that is mutually responsible and focused on recovery and social action. The Peer Support specialists have shared similar experiences and model successful lives to those they work with.

Please refer to Establishment of System of Care- Adults section for detailed information about the implementation of the statewide peer support specialist program.

Mental health block grant dollars are used to provide training to mental health professionals through the State concerning issues and innovations in the field. For instance, block grant dollars will be used to fund the mental health portion of the Dual Diagnosis Education Consortium's Annual Workshop and Clinical Forum on Mental Health Conference. In addition, block grant dollars are used to provide Wraparound certification training and to support the annual Family-Based Services Conference, and the Indian Child Welfare Act Conference.

As required by block grant law, training will also focus on the recognition of psychiatric symptoms and strategies for dealing with situations resulting from psychiatric symptomology specifically targeted towards emergency personnel including emergency medical technicians, physicians, and law enforcement. The Division will work with the Department of Health's Division of Emergency Medical Services and the North Dakota EMS Association to train personnel at the Annual EMS conference.

The human service centers are falling behind in their ability to compete in the marketplace for salaries for professionals. Private providers tend to pay mental health professionals more than human service centers. In addition, many professionals are reluctant to live in the more rural areas of North Dakota or in North Dakota in general. Demand for the skills of certain professionals definitely exceeds the supply. Thus, there is considerable competition for licensed addiction counselors, clinical psychologists, psychiatrists, licensed certified/independent clinical social workers, and psychiatric nurses.

In order to help address this issue, the Sixtieth Legislative Assembly provided a five percent increase for contracted service providers for the delivery of public mental health services.

Please refer to the Service Systems Strengths and Weaknesses- Adult and Child section for detailed information about the Workforce efforts and the division's collaboration with WICHE to address workforce development activities.

GOAL 6: TECHNOLOGY IS USED TO ACCESS MENTAL HEALTH CARE AND INFORMATION

The Department of Human Services has implemented an electronic financial and clinical data collection system. Referred to as the Regional Office Automation Program (ROAP), this system allows clinicians at the regional human service centers to document electronically. In addition, the system allows research staff to access the data gathered through the system and allows for the creation of detailed reports concerning the mental health services delivered at the regional humans service centers.

Please refer to System of Integrated Services- Child section for detailed information about the Single Plan of Care and the creation of a Front-End System to support for integrated electronic care plans and collaborative efforts between mental health and child welfare.

The Department of Human Services is working towards a Master Client Index (MCI), which includes the indexing of approximately 500,000 records currently contained in an internally written master client index. This is the first of several indexing projects the DHS will undertake in next few years. It is the goal of the Department to index all DHS applications. The project will index clients for the following applications: Medicaid, Food Stamps, Temporary Assistance for Needy Families (TANF), Developmental Disabilities, Vocational Rehabilitation, Child Welfare, Child Support, Mental Health and Substance Abuse, State Institutions, Aging Services, Low Income Heating Assistance, and Child Care Assistance. In addition, we anticipate opportunities for data linking with applications from other departments such as the Department of Health, Department of Public Instruction, and Job Service of North Dakota. The Wraparound Program will be the first to integrate with the MCI system; the Children's MH Administrator has been active in this project.

North Dakota

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

ESTABLISHMENT OF SYSTEM OF CARE - CHILDREN

North Dakota's public mental health delivery system is a coordinated, interagency effort made up of a variety of human service agencies and programs. The growth of the community-based mental health delivery system in North Dakota has resulted in a decline in the daily inpatient census of the North Dakota State Hospital from over 2,000 individuals diagnosed with a mental illness in the 1950's to approximately 130 today.

STATEWIDE PLANNING PROGRAM: The planning process in North Dakota continues to evolve. The Division works closely with the human service centers in planning for the Children's Mental Health Systems of Care. The Division meets quarterly with each regional human service center's program staff to plan and implement community-based mental health services statewide. The human service centers regularly meet with regional stakeholders. In addition, region-specific planning meetings are held in every region throughout the year. The format of these meetings varies from region to region. Some choose to hold separate planning meetings with the local stakeholders. Others invite stakeholders to the Human Service Center Advisory Council meeting and conduct the planning in conjunction with that already-scheduled session. Additionally, some regional planning is conducted through the Regional Children's Services Coordinating Committee, which is coordinated through the regional human service center.

The Statewide Planning Program is utilizing data gathered through Decision Support Services Unit to make informed planning choices. The Planning Program will continue to be refined during the upcoming years and data gathered by the Decision Support Services Unit will be used by regional planning representatives and Division staff to develop new initiatives and enhance existing programs.

From 1999 through to the present, the Department of Human Services has engaged in strategic business planning. This process has allowed the Department to better align systems, including the community-based mental health system. The North Dakota Mental Health Planning Council and the Division continue to strive towards integrating the State Plan on Mental Health and the Department's strategic plan, providing for a near-seamless flow between the two documents and planning processes. Division staff members are involved with both projects, which ensures linkage. The Division and the Planning Council will continue to be active players in the process, ultimately providing for a stronger public mental health system throughout North Dakota. In addition, Division staff assisted the Planning Council with the development of their own strategic plan. The plan uses the goals of the New Freedom Commission report as a framework and will allow the Council to better monitor and advise concerning the adequacy of community-based mental health services in North Dakota. The Division also assisted in developing Talking Points correlating to their position papers.

North Dakota ranks 8th best among all states on child well-being according to the national 2007 KIDS COUNT Data Book, a state-by-state study that reports on the well-being of America's children. North Dakota ranked in the top 10 nationally in seven out of the 10 indicators of child well-being.

REDUCTION IN HOSPITALIZATION: During the past few years the Department of Human Services has implemented programs to decrease the number of admissions to the North Dakota State Hospital. For instance, regional human service centers established diversion programs and dramatically decreased the number of hospital admissions. In fact, during FY 1998 there were 1,764 admissions to the State Hospital. This past year, however, showed only 75

admissions. In addition to the diversion programs, Section 25-03.1-04 of the North Dakota Century Code – as amended by the 1999 Legislature – requires that all admissions to the North Dakota State Hospital be screened at the regional human service centers prior to being admitted. Like the diversion programs, the overall goal of this amendment was to develop additional services in the community, enabling the child in a time of crisis to remain in their community rather than having to be transferred to the State Hospital for treatment.

The North Dakota State Hospital continues to support the evolution of community-based services. It works in collaboration with the Division, regional human service centers, children and family members, Mental Health America of North Dakota, the National Alliance for the Mentally Ill, Protection and Advocacy, the judicial system, local private providers, and other stakeholders to enhance current community-based programs and to design and implement new ones.

MEDICAL SERVICES: Medical services at the human service centers include the delivery of medication monitoring, medication administration, psychiatric evaluation, and psychotherapy/treatment by a licensed psychiatrist. Some services are delivered by a licensed psychiatric nurse or licensed nurse practitioner under the supervision of a physician. In addition, the human service centers contract with local hospitals for short-term emergency mental health services. These are accessed when all other community resources have been exhausted.

Screening for enrollment in public health insurance programs is conducted by Community Resource Coordinators (CRCs) located in participating hospitals, clinics and public health departments. CRCs work one-on-one with people without health insurance to help them apply for free or low-cost insurance coverage. Programs people may qualify for include: Medicaid, Healthy Steps (SCHIP), and the Caring Program for Children.

In addition to health insurance programs, Community Resource Coordinators link people with other assistance programs, including: Women's Way, Children's Special Health Services, Child Care Assistance, Food Stamps, Heating Assistance, Vision Programs, Hearing Programs, Women, Infants and Children (WIC) and many other programs.

Community Resource Coordinators assist needy people in applying for free or low-cost prescriptions through pharmaceutical companies' Prescription Assistance Programs. CRCs screen people for eligibility, help those who qualify complete applications, provide instructions on compiling documentation and complete other necessary processes to ensure that people get the medications they need.

EVIDENCE-BASED PRACTICES: North Dakota has made great strides in community-based mental health care. Challenges do remain, however. Transition from the children's mental health system to the adult system can be a daunting task. In an attempt to address issues such as these and maximize community-based services, North Dakota is exploring various evidence-based practices. The Director of the Division of Mental Health and Substance Abuse Services held monthly teleconferences with staff from the regional human service centers to discuss the specifics of evidence based practices and the feasibility of implementing them. Topics included Programs of Assertive Community Treatment, Illness Management and Recovery, and Peer Support. Also, the annual Clinical Forum on Mental Health conference held in May of 2008 focused on evidence-based practice, mental health recovery, and mental health transformation.

In the children's mental health system of care; children, youth and families have access to Wraparound case management (promising practice) and therapeutic foster care (EBP). The Division has initiated two EBP for children and families. The first training was on Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) that occurred in June of 2007. The training was sponsored and conducted by the Neuropsychiatric Research Institute in Fargo along with the UND School of Medicine and Health Sciences. Sixteen clinicians from the 8 Regional Human Service Centers participated in the training with six months of follow-up supervision. The second EBP training was on Trauma Focused Cognitive Behavioral Therapy (TF-CBT) in February of 2008 with the same 16 clinicians with another 6 months of follow up supervision. The supervision is occurring two times per month for each clinician for one-hour sessions. TF-CBT is for children and adolescents of both genders from 3-18 years of age with a diagnosis of post-traumatic stress disorder (PTSD). SPARCS is used for children exposed to events, such as, traumatic loss of a loved one, physical abuse, domestic and community violence, motor vehicle accidents, fires, tornadoes, hurricanes, industrial accidents, terrorist attacks, sexual abuse and other traumatic events/experiences. TF-CBT has been used in individual, family and group therapy settings and in office based and school-based settings. This initiative is in collaboration with Steve Wonderlich, from the UND Medical School Neuroscience Department. The Children and Family Services Division and the Division of Mental Health and Substance Abuse Services have made a commitment to support the continued implementation of evidence-based practices in both child welfare and children's mental health system for the next three years.

The Children's Mental Health Administrator has been working on a catalog of Evidence-Based Practices across all disciplines; Juvenile Justice, Mental Health, Child Welfare, Education. Efforts continue to complete the catalog. The Children's Mental Health Administrator participated in the NASMHPD conference calls regarding a website application program for EBP's that Minnesota is piloting and will be having further discussion with the Division of MHSA to develop a program for ND.

TRANSITIONAL SERVICES: The 2006 Census estimates revealed that approximately 109,000 individuals in North Dakota were between the ages of 15 and 24. Although the children's population is declining, the complexity of their needs is increasing. There are recruitment and retention efforts – spearheaded by the Governor's Office – to maintain the young people in North Dakota. Despite efforts to offer incentives for North Dakotans to return to the state, the population continues to age.

- The transition from adolescence to adulthood can be a difficult time for some. For those individuals who received services under the children's mental health system of care, attempting to navigate into the adult system can be a trying, daunting task. At times people find that services they received in the children's system are not available in the adult system or they simply no longer meet the eligibility criteria. In order to ensure that a full array of appropriate services are available during this critical time of transition, the Division will be working with consumers and family members, providers, advocates, and other stakeholders to identify gaps and develop and implement solutions to address this issue. The Adult and Children's Mental Health Administrators conducted statewide on-site meetings at all 8 Regional Human Services Centers in 2006-2007 to gather feedback and solutions to meet the needs of transitioning youth A statewide interactive video meeting was held on September 17, 2007. This meeting was an open forum for discussing youth transitioning from children's to adult MH services and also those youth aging out of foster care. Transformation Activities across the state, strengths and gaps in the MH system of care along with an update on Evidence-Based Practices was discussed. Participants

included county regional representatives, Division of Juvenile Services, Independent Living Coordinators, tribal entities, county child welfare, and program administrators from the Division of Mental Health and Substance Abuse Services.

A legislative Interim Committee study was chosen to explore the needs of transition-aged youth in all systems: mental health, education, child welfare, juvenile justice, vocational rehabilitation and developmental disabilities. A collaborative effort among the systems has occurred to provide testimony and information to the committee. The Children's MH Administrator is also involved with a national transition aged youth workgroup, exploring areas such as, housing, employment, involvement in policy building and testimony. The Department also has a Transition Steering Council that has been working on this area.

DUAL DIAGNOSIS (MI/SED/DD) SERVICES: The North Dakota Department of Human Services met with residential treatment providers and identified a gap in services for children with lower cognitive functioning who have emotional disturbances. This private provider will provide services to that population in another part of the state who have both SED/DD diagnoses. The reason for this geographic change is due to a decrease in referrals to the original private provider site, in that during the past year they have run 50 percent or less occupancy. The private provider has submitted a transition plan to the Department outlining the steps they have taken to ensure that the current residents receive appropriate discharge planning and services. The Department has approved this transition plan. The private provider also provides step-down services for youth in the PRTF level of care to their residential childcare facilities.

The Department was also working with Minot State University in submitting a 360-Planning Grant to identify additional methods to better serve this population. A task force was formed from the Institutional stakeholder meetings and the State Review team's trend observations. The State Review Team supported the philosophy of the Single Point of Entry into Services, however a lack of resources prevented its fruition. Another area that is being addressed are young adults who are in the foster care system after the age of 18, have both developmental and mental health diagnoses and are in need of continued treatment. The Children and Family Services and the Developmental Disabilities Divisions are holding strategic planning meetings with various system partners to discuss viable solutions for these young adults transitioning from the foster care system into the adult system of care, which will lead to successful transitions. The Adult and Children's Mental Health Administrators met with the DD Coordinators to discuss transitioning concerns between the Children's and Adult Systems of Care.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Developmental Disabilities Programs. This position is responsible for planning, policy development and implementation, and program oversight of the SMI/SED/DD system of care across North Dakota.

DUAL DIAGNOSIS (SED/SA) SERVICES: The North Dakota Department of Human Services provides service to individuals who are dually diagnosed with a serious emotional disorder and a substance abuse disorder. The regional human service centers offer dual diagnosis programs ranging from group therapy to intensive case management.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Substance Abuse

Programs. This position is responsible for planning, policy development and implementation, and program oversight of the MI/SA system of care across North Dakota.

MENTAL HEALTH TRANSFORMATION: Mental health transformation takes many forms in North Dakota. The process uses a multifaceted transition approach that infuses the recovery concepts within the services delivery while initiating targeted evidence based practice initiatives within regional human service centers that have displayed readiness for implementation. At the same time, consistent message, work force development, contracted initiatives, and technical assistance covering a variety of transformation areas take place. The next step is to create and promote readiness in additional centers for future expansion efforts.

The Division of Mental Health and Substance Abuse Services is leading the community-based public mental health system and its partners in implementing various mental health transformation activities. These include Trauma-Focused Cognitive Behavioral Therapy, SPARCS, Mental Health Recovery, collaboration with the University System concerning Science to Services, implementation of the Mental Health Consumer and Family Network, Early Childhood Screening Collaborative, planning for SAMHSA's model of Supported Employment to be piloted at Southeast Human Service Center in Fargo, Workforce Development in conjunction with WICHE, and development of a prevention framework.

POLICY ACADEMY: In response to the growing concern on a national level regarding the number of youth with some degree of mental health issues in the juvenile justice system, the Center for Mental Health Services granted funding to the National Center for Mental Health and Juvenile Justice in September 2003 to expand the knowledge base regarding services and programs that effectively respond to the needs of youth in juvenile justice with mental health and co-occurring substance abuse issues.

The goal was to share information with federal, state, and local officials across the country and encourage the implementation of integrated services to those youth, both on the front end of the system as well as those youth reintegrating into their home communities.

The Policy Academy announcement was made in early 2004. The ND Division of Juvenile Services and the ND Department of Human Services, Division of Mental Health and Substance Abuse, received invitations to submit an application. The directors of these divisions were supportive of the idea. The application provided the opportunity to describe the efforts of system change in North Dakota around the issue of mental health and co-occurring substance abuse needs of youth, systems collaboration, and outlined the strengths and challenges we continue to face as we attempt to meet the needs of youth in the most appropriate, least restrictive environment. The application addressed the needs of youth that enter the system as well as those who are reintegrating into their home communities. Lastly, the application outlined the efforts that North Dakota wanted to take to continue to improve services to youth and their families.

An additional requirement of the application was to assemble a local team that would represent the various systems in North Dakota at the Policy Academy as well as to commit to continue to work together to implement a plan to continue to improve services to youth and their families. We received notification in March 2004 that our application was one of eight that was selected to participate in the Policy Academy in Bethesda, Maryland in June of 2004. During the policy Academy, the team worked with two facilitators to develop a strategic plan as well as to learn about promising practices across the country and to obtain information from nationally recognized experts in the area of mental health, substance abuse, and juvenile justice.

The strategic plan developed identified a mission statement, number of strengths and challenges we face in North Dakota, and goals. Following is the North Dakota Policy Academy Mission Statement:

> To effectively serve youth with mental health and co-occurring substance abuse issues in the juvenile justice system at the community level through early identification and screening with the emphasis on least restrictive, most appropriate levels of care. We will attempt to accomplish this through consistent identification and screening at the probation level, strengthened family involvement, and engaging the educational system in North Dakota.

The Policy Academy had new leadership and has met on one occasion to review the Parent Opinion Survey in regard to services provided by system partners; Law Enforcement, Juvenile Justice, Private-non-Profit Youth Services Agency. The MAYSI-2 Outcome tool is now implemented and used with youth statewide in the Juvenile Court system. The Policy Academy has not met since the submission of the last block grant application.

YOUTH ADVISORY COUNCIL: DMHSAS is leading the task of developing a statewide Youth Advisory Council. The Council will be representative of youth from all systems as well as youth who are not involved in any system. Youth will have the opportunity to discuss issues they face and advise the DHS and other system partners on those issues most pressing to them. The goal of the Council is to provide youth with an active voice in effecting policy and program change in ND.

AUTISM: The Department recognizes the need to explore and examine the growing concerns regarding children with Autism and Autism spectrum disorders in North Dakota. The Department did hold a stakeholders' meeting in May of 2008 to gather statewide feedback on trends, issues, services, and solutions to address the needs of these children. The Department will be reviewing this feedback to determine next steps. The Department will be pursuing a Medicaid waiver pursuant to legislative appropriation. Minot State University was awarded a grant to provide education and services targeting rural areas of the state. The program is called Great Plains Autism Spectrum Disorders Treatment Program. The program includes service, information, research and training.

THE NORTH DAKOTA CHILDREN'S SOCIAL, EMOTIONAL AND DEVELOPMENTAL ALLIANCE: The North Dakota Children's Social, Emotional and Developmental Alliance (NDSEDA) formerly known as the Children's Screening Coordination Committee is now a statewide committee with over 30 members from a variety of disciplines to include; medical, human services, juvenile justice, tribal communities, child protective services, etc. A sub-committee of the NDSEDA has been formed to include representation from Child Welfare, Mental Health, Medical Services, Head Start and Developmental Disabilities to review the statewide implementation of the two EBP mental health screening tools (MH Screening Tool Kit through the development of a Memorandum of Agreement).

The mission statement of the Statewide NDSEDA was expanded to include "families language" as reflected below. "A Collaborative Effort with system partners to promote an awareness and understanding of health social and emotional well being of individuals birth to 21 and their families". The committee has met on 3 occasions, to begin the strategic planning process in regard to the prioritized areas below, which included developing action steps with persons responsible and projected completion dates. The NDSEDA will continue to meet on a quarterly basis to complete the strategic planning process and strengthen on-going collaboration efforts. The NDSEDA is working to develop a strategic plan to address the Healthy North Dakota Early Childhood Alliance goal of development of a statewide multi-system, family inclusive training.

Prioritized Areas:

- Develop a statewide, multi-system, family inclusive training initiative regarding direct screening administration and/or referral, targeted to key audiences (HNDECA)

- Parents guide to children's mental health including milestones, checklists that parents and others who work with children (South Dakota Guide was sent around to committee members for review).

- Earlier intervention-child welfare, use parent resource centers, family preservation services, services "recommended cases" Services for children who slip between the cracks, children do not qualify for services as their diagnoses are "not severe enough"

- Pre-service and In-service personnel development

- Lack of small community "resources", (mentoring, medical, therapy, mental health needs). Small communities face many more barriers than large communities; affected by funding cuts

HEALTHY NORTH DAKOTA EARLY CHILDHOOD ALLIANCE: The Program Administrator for the Children's Mental Health Services Programs and the Head Start-State Collaboration Administrator did attend a National conference that focused on the collaborative efforts between system partners to concentrate on Children's Mental Health and Family Participation for the HNDECA strategic plan.

North Dakota

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

AVAILABLE SERVICES - CHILDREN

North Dakota is a rural, frontier state with an area of 72,000 square miles and an approximate population of 635,867. The largest city in the State is Fargo, which has a metropolitan statistical area population of 132,525 persons. Thirty-six of fifty-three counties are designated frontier areas, having less than seven persons per square mile. In 1982, to better serve the citizens of this rural state, the community mental health centers were merged with the area social service centers. This action created the regional human service centers and developed a one-stop system of care. The eight regional human service centers, listed below with their locations, provide public mental health programs to service areas ranging from three to ten counties.

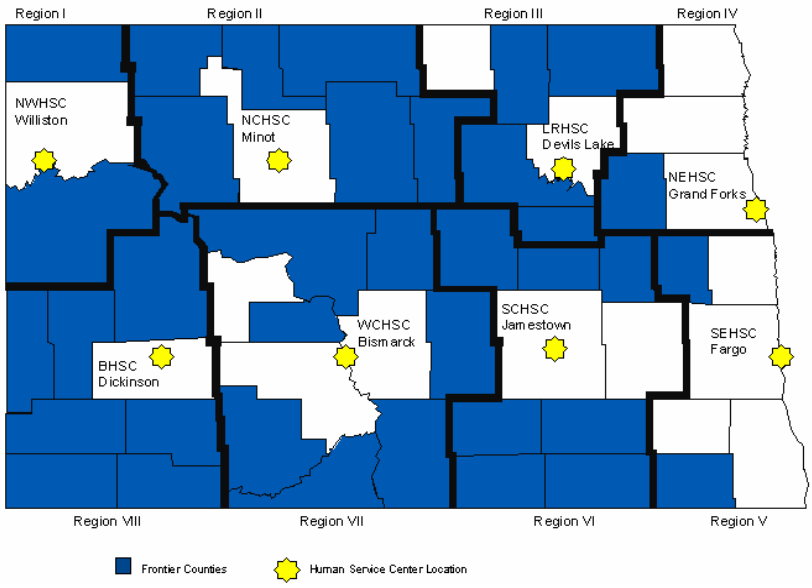
Northwest Human Service Center	Williston	Region I
North Central Human Service Center	Minot	Region II
Lake Region Human Service Center	Devils Lake	Region III
Northeast Human Service Center	Grand Forks	Region IV
Southeast Human Service Center	Fargo	Region V
South Central Human Service Center	Jamestown	Region VI
West Central Human Service Center	Bismarck	Region VII
Badlands Human Service Center	Dickinson	Region VIII

Adolescents and children are served in the community through a variety of rehabilitation services including:

- crisis stabilization and resolution;
- inpatient services;
- psychiatric/medical management including medication management and other health services;
- social services;
- residential services and supports;
- vocational and educational services and supported employment;
- social and leisure activities;
- evidence-based practices of Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Services at the regional human service centers are provided to all children regardless of the child's race, color, religion, national origin, sex, age, political beliefs, or disability in accordance with Title VI of the Civil Rights Act of 1984, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act, the Americans with Disabilities Act of 1990 and the North Dakota Human Rights Act (NDCC Chapter 14-02.4). All services are provided to Native Americans living on or off the reservations.

Figure 1: Regional human service center locations and frontier counties in North Dakota



Regional Intervention Service

The Regional Intervention Service (RIS) provides 24-hour, seven days per week crisis assistance enabling the consumer, family, and significant others to cope with emergencies while maintaining the consumer in the community. With an interdisciplinary team that may include a psychologist, masters-degreed social worker, masters-degreed human relations counselor, psychiatric nurse, psychiatrist, and/or a licensed addiction counselor, Regional Intervention Service is able to provide the consumer with the best suited crisis intervention including short-term crisis residential placement and immediate access to a range of housing, medical, and counseling services within the community.

In addition, the Regional Intervention Service team has the responsibility of evaluating consumers who may need referral to the North Dakota State Hospital, ensuring that consumers are provided with the least restrictive treatment environment. The Aftercare Coordinator, a member of the Regional Intervention Service team, coordinates discharge planning with North Dakota State Hospital staff providing a smoother transition and greater community linkage to the consumer upon return to their region.

Medical and Dental Services

Medical services at the human service centers include the delivery of medication monitoring, medication administration, psychiatric evaluation, and psychotherapy/treatment by a licensed psychiatrist. Some services are delivered by a licensed psychiatric nurse or licensed nurse practitioner under the supervision of a physician.

With some workforce categories, such as nursing, we have current, fairly comprehensive information. In other areas such as radiology and clinical lab technologists, we have very little data about supply and demand, other than anecdotal information that suggests that we may have an emerging short supply or at least a misdistribution of these providers.

North Dakota had 1,461 licensed physicians in 2004. Of the state's 328 practicing *family*

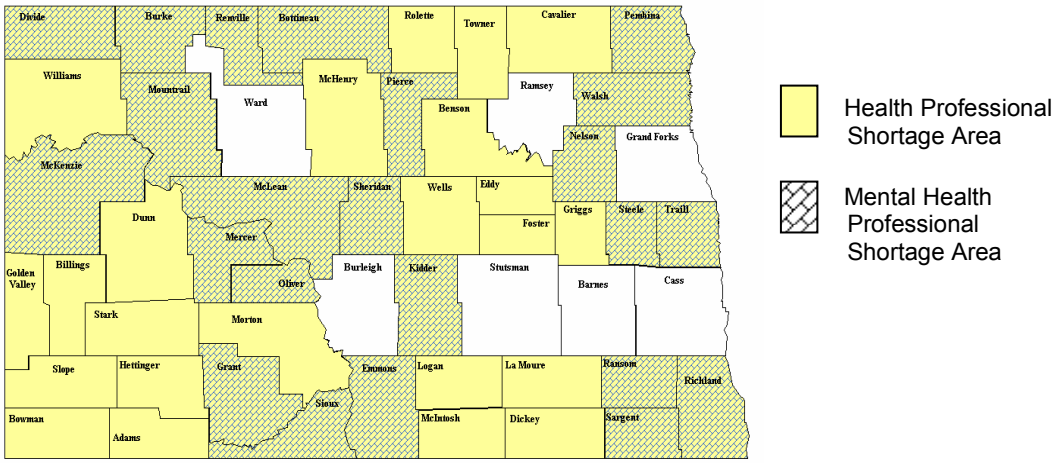
medicine physicians, 68 percent (222/328) graduated from the University of North Dakota, with a medical degree, or residency training, or both. Nationally, 11 percent of U.S. physicians practice in rural areas as compared to 32 percent in North Dakota (Rural Health Facts: Primary Care Providers, Center for Rural Health, UNDSMHS, Summer, 2005). Family medicine physicians provide the majority of patient care in rural areas. Similar to the rest of the United States, North Dakota is experiencing a decline in the number of medical graduates choosing a residency in Family Medicine.

One measure related to the demand for health care professionals is the number of unfilled positions or vacancies. In 2004, 92 physician vacancies were reported. Of those, 34 were reported in rural communities and 58 reported in three of the four state's urban cities. Vacancies in rural areas remain fairly stable with an average of 18 openings reported for Family Medicine each quarter from 1992-2005. Family Medicine constitutes the highest number of rural vacancies while subspecialty vacancies dominate in urban areas (North Dakota Physician Survey, Center for Rural Health, UNDSMHS, 2004). Vacancies across rural areas of North Dakota increased slightly between 2004 and 2005 (rural defined as communities other than Minot, Bismarck, Grand Forks, Bismarck/Mandan, Fargo, and Jamestown).

Another measure of type of physician availability is Health Professional Shortage Areas (HPSA), a federal measure that tracks physician shortages. HPSAs measure physician to population ratios (e.g., the physician to population ratio of 1:3500 or greater). Eighty-one percent of the state is designated (43/53 counties) as partial or full county HPSAs. Many federal programs use HPSA designations as a means to target federal resources.

As depicted in the following map, 94 percent of the state's counties have a Mental Health Shortage Designation calculated as one psychiatrist to 30,000 people. There are eight regional mental health centers and one state inpatient mental health facility. Vacancy rates for other mental health providers (for example psychologists, counselors, social workers) are unknown although in community dialogues the Center has conducted across the state, limited availability of mental health services is frequently identified as a very high priority concern for many rural communities.

Figure 2. North Dakota Health and Mental Health Professional Shortage Areas



The high incidence of suicide in North Dakota may be due, in part, to the lack of access to mental health services. The most recent data ranks North Dakota 13th in the nation for suicides for all ages, 2nd in the nation in suicides for 10-14 year olds, and 6th in the nation for 15-19 year olds. For the Native American population of the state, the Aberdeen Area of Indian Health Service is 2nd only to Alaska in the rate of suicide. Please note that the Aberdeen Area includes states other than North Dakota. Between 1994 and 2003, there were 797 reported suicides in the state, 700 whites, 89 Native Americans and 8 other ethnic minorities. Another indicator of the pervasiveness of mental health problems is the fact that the most frequently prescribed medications in the state are antidepressants, prescribed primarily by primary care physicians.

Children and adolescents diagnosed with serious emotional disturbances who receive services from the public mental health system in North Dakota have access to medical and dental services provided by local private physicians and local general hospitals. Services are paid for by the parent/guardian, insurance, or medical assistance. Care coordination staff in the human service centers work closely with children and adolescents and their families to ensure that their medical and dental needs are met.

For fiscal year 2007, there were 44,470 children age 0-21 that were eligible for a Health Tracks screening. 26,620 have had at least one screening with 62% of children having received a Health Tracks screening.

Health Tracks is a preventive health program that is free for children age 0 to 21 who are eligible for Medicaid. Health Tracks funds screenings, diagnosis, and treatment services to assist in the prevention and intervention of emotional/health as well as orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling, and other important health services. Health Tracks staff assist families with the scheduling of appointments for services, as well, as assist with finding transportation to the services. Health Tracks utilizes the Pediatric Symptom Checklist to assess for emotional/developmental and behavioral risk factors.

Health Tracks, Developmental Disabilities, Head Start, Child Welfare and Mental Health have initiated a work group to examine early prevention, intervention, screening and systemic points of entry for children and families. The work group, the North Dakota Children's Social, Emotional, Developmental Alliance, meets to discuss the need for all children in ND to be screened for emotional, behavioral, developmental, physical and educational risk factors. A decision-making tree was created to assist families and system partners in negotiation and understanding of the various systems program criterion in North Dakota that assist in meeting the needs of children and families.

A Mental Health Screening Tool Kit training and materials/videos are available to all system partners. A state form was developed known as the Preliminary Questions for Social/Emotional/Developmental/Screening that is used by the various systems. This form assists the staff from the various systems in discovering if the family has had prior mental health screening(s) or involvement in mental health services.

Healthy Steps, North Dakota's SCHIP, currently serves 4,087children. According to the 2007 Annual EPSDT (Health Tracks) report, 11,148 individuals from birth to 21 years of age received a dental service, 6,984 a preventive dental service and 5,069 received dental treatment services.

Access to dental care continues to be an issue in North Dakota. According to the University of North Dakota's Center for Rural Health, 30% of the state's 53 counties are designated as Dental

Health Professional Shortage Areas (as of 9-2007). Fifty-seven percent of North Dakota's population lives in Ward, Grand Forks, Cass and Burleigh counties, as do an overwhelming proportion of the state's dentists. As a result of growing concerns about a nation-wide shortage of dentists, and the number of designated dental HPSAs in North Dakota, the Center conducted a state-wide dental workforce survey to examine the demographics, practice profiles, and patient profile information of the state's 316 licensed dentists. North Dakota does not have a dental school, and over half of our dentists were trained at the University of Minnesota. Results from our 2004 survey indicate: just over half were born in ND, 73% practice general dentistry, the average age of North Dakota dentists is 52 years and 60% of dentists plan to retire in the next 15 years. In 2002 a state dental loan repayment program was established to attract dentists to areas of need across the state. There have been eight recipients of the loan program who located in 6 different communities (Minot, Fargo, New Rockford, Grand Forks, Bismarck, and West Fargo).

The Center for Rural Health also noted that between seven and twenty-five percent of dentists in North Dakota accept any and all Medicaid patients that present for treatment. Rural dentists tend to accept more Medicaid patients than do urban dentists. Care coordinators work closely with children and families to assist with accessing dental care. At times care coordinators have needed to transport children and their families hundreds of miles (roundtrip) to access dental care from a provider that accepts Medicaid patients.

In an attempt to address this issue, the Dakota Medical Foundation created the Dental Care Access Program (DCAP). DCAP is working to increase access to oral health care for the uninsured and underinsured of our communities. Under the direction of the dental coordinator, DCAP is networking with the North Dakota State Oral Health Department, Bismarck; Red River Valley Dental Access Project, Fargo; Bridging the Dental Gap Clinic, Bismarck; Dental Access Committee, Grand Forks; and federally qualified healthcare centers in Fargo, Northwood/Larimore, and Turtle Lake/Rolette/McCluskey.

Access to preventive care remains a problem for some segments of the population, specifically low-income, minority individuals. Individual knowledge of how oral health relates to general health is limited, and the mouth is frequently fragmented from the rest of the body. Workforce issues remain despite the state's legislation enacting a dental loan repayment program.

Healthy People 2010 Oral Health State Plan Statistics

During the 2004-2005 school year, the North Dakota Department of Health (NDDoH) conducted a statewide Oral Health Survey of third-grade children enrolled in public, state or Bureau of Indian Affairs elementary schools in the state. This survey found that 56 percent had cavities and/or fillings (decay experience) – substantially higher than the *Healthy People 2010* objective of 42 percent. Seventeen percent had untreated dental decay (cavities) compared to the *Healthy People 2010* objective of 21 percent. Compared to white non- Hispanic children in North Dakota, a significantly higher proportion of minority children have decay experience, untreated decay and urgent dental needs.

The Oral Health program has 5 oral health consultants located around the state. The consultants provide oral health education and oral health screenings. The consultants also provide technical assistance to schools participating in the fluoride mouth rinse and tablet schools programs. Within that plan, delivery systems such as a stand alone dental clinics, mobile dental vans, urgent care centers, dental clinics affiliated with hospitals and clinics and others will be analyzed and recommendations made for best practice.

Community Resource Coordinators (CRCs) located throughout the state have worked to ensure that whenever possible, oral health care is accessed by their clients. Through a program called Dental 1/90, case management is provided to uninsured clients. Dentists are fully reimbursed for charges incurred in the care of these patients while agreeing to see 1 new Medicaid patient every 90 days.

Psychological Services

These services, under the direction of a full-time licensed psychologist, include psychological evaluations, psychotherapy, and case and program consultation. Psychologists assist in developing treatment plans and diagnosing persons with mental illnesses.

Acute Treatment

Acute treatment, provided by a range of mental health professionals including social workers, psychologists, and case managers, refers to individual, group, and family therapy that is generally short-term in nature. Therapists use varied approaches to therapy including cognitive-behavioral, Gestalt, and psychodynamic techniques. When appropriate and with permission of the consumer, family members and/or significant others are involved in therapy to enhance the process.

Outreach

The service areas for eight regional human service centers range from three to ten counties. Each center has staff traveling to outlying rural communities and Native American reservations to provide mental health services.

Educational Opportunities

Consumers are offered a variety of educational opportunities by Department staff, either through staff presentations or via arranged speakers. These can include presentations concerning Social Security, community programs. Consumers who desire to further their education – whether by obtaining their high school diploma/GED, college degree, or other opportunity – may be assisted by human service center staff with accessing appropriate programs. This may include referral to Vocational Rehabilitation for assessment and assistance or accessing information from an educational institution.

Vocational Rehabilitation

Vocational Rehabilitation provides and/or purchases services that result in competitive employment of eligible individuals with physical or mental impairments. Vocational Rehabilitation services include, but are not limited to, diagnosis and evaluation, vocational counseling and planning, information and referral, adaptive equipment, vocational training, job placement and follow-up.

Alcohol and Drug Addiction Services

These services, provided to adults and adolescents, include addiction evaluation; intensive outpatient programs; day treatment; individual, group, & family therapy; pre-treatment programs;

and the treatment recidivist program which includes social detoxification, short-term residential, and a case manager aide program.

CHILDREN'S MENTAL HEALTH SYSTEM OF CARE

In 1994, the Division of Mental Health Services applied for a comprehensive community mental health services grant from the Center for Mental Health Services targeting children and adolescents diagnosed with serious emotional disturbances. This $16.8 million grant provided the impetus for a formalized system of care for children and was implemented statewide. Services developed or enhanced through the grant include care coordination, respite care, non-hospital crisis, school-based day treatment, and intensive in-home therapy, all using the wraparound process. North Dakota was able to sustain core services developed through the grant effort and approximately 2,751 children with serious emotional/behavioral disturbances have received services through the Partnership program through June 2008.

Key to the children's mental health system of care is a strong partnership with families and integrating services across systems. Parents are actively involved in the design and implementation of the programming, serve on the local and state advisory boards and provide on-going support to parents negotiating services for their children. The wraparound process, which uses a strength-based approach to service delivery, is used in this program and is a method shown to improve the functioning of children who have complex needs. The process is used to help communities develop individualized plans of care.

Working with the family, formal and natural supports (the child and family team) are wrapped around the family to provide them with the services/supports required to meet their needs. The wraparound process includes a set of core elements: 1) individualized plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting.

It is recognized that all children that come into contact with service systems can benefit from being served using the tenants of the wraparound process. The mental health system collaborated in developing a certification process with child welfare and juvenile justice. A training curriculum was developed with staff from the three systems plus parent representatives and private providers. This training curriculum formed the framework for case management/care coordination for all three systems. Each system provided the time and expertise of their staff as they formed the trainer group with a lead trainer.

It is noted that Wraparound training and certification began in the spring of 2003. The training efforts have expanded to include other private organizations, such as, the Professional Association of Treatment Homes (PATH), Village Family Service Center staff, Lutheran Social Service Center Staff, Head start case managers and Residential Treatment Center staff. Training has also been provided to Turtle Mountain Tribal staff, Spirit Lake Tribal staff, and Three Affiliated Tribal staff on the Wraparound Process for Foster Care Child and Family Team meetings formerly known as permanency planning meetings and the Single Plan Of Care (SPOC). There are over 450 child welfare and system partners certified in the Wraparound Process. A re-certification process has also been initiated, allowing for the continued practice of the Wraparound Process. Regional Human Service Center Supervisors have had two trainings in regard to the policy and philosophy of Wraparound including the demonstration and development of the Single Plan of Care (computer system). A three-level delivery system was developed to better adapt the process across systems defining family and team elements to

guide the intensity of coordination. This certification and collaborative process has propelled us closer to the realization of having a single plan of care. Wraparound Certification Training continues to be a collaborative effort with the Division of Juvenile Services, Children's Mental Health, Federation of Families and PATH. The wraparound case management process is week two of the four-week child welfare certification training. Forty-three participants completed Wraparound Certification Training this past year. The Training Center facilitated one additional Wraparound certification training and several re-certification trainings offered at the following statewide conferences; NDFBSA annual conference, the CFS annual conference, and the annual ICWA conference. The training focused on the Wraparound philosophy and other child welfare, mental health and juvenile justice issues.

An executive-level committee met in May of 2006 with the intent to begin an analysis of the concerns expressed by the County Directors and County Child Welfare staff. This analysis led to the development of a collaborative effort to design a new front-end system. The front-end system analysis with CFS started in November 2006. A project charter and project plan was developed and completed in February 2007. The first statewide systems analysis meetings to discuss and describe the Child Welfare business workflow processes began on February 20, 2007 and continued to meet every other week until May 31, 2007. In June 2007, an analysis of the information collected on the business workflow processes was discussed with the project sponsors- CFS Director and Information Technology Services Director to plan next steps. Further analysis of the project continued for the next few months and a small workgroup was developed to begin exploring and discussing the "design phase" of the front-end system. This group will be presenting a pre-liminary prototype of the new system to the original large group who were involved in the analysis phase of the project. The first meeting will be held on May 27-29, 2008 and continue to meet every other week until the design phase is completed.

Below is the array of services provided through the **Partnerships Program** within the children's mental health system of care:

- **Care Coordination:** Care coordination assists children with serious emotional disturbances and their parents with accessing the various services they need and helps them make informed choices about opportunities and services in the community. The care coordinator helps ensure the child and parents receive timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services enabling the child and parents to meet their own goals.

- **Case Aide**: This service is designed to provide behavioral management assistance and role modeling. Certified Mental Health Technicians help individuals stabilize, reduce, and eliminate undesirable behaviors that put them at risk of being served in restrictive settings. Certified Mental Health Technicians also help individuals observe and learn appropriate behavioral responses to situations that trigger their symptoms.

- **Flexible Funding**: This service is available when no other resources are available to meet specific needs and threaten the child's ability to remain in the least restrictive setting.

- **Crisis Residential Services**: This service provides a short-term, safe place to stabilize behaviors in a 24-hour supervised setting. The goal is to promote rapid stabilization and return to the home or community.

- **Substance Abuse/Dual Diagnosis Services**: When a child diagnosed with a severe emotional disturbance requires substance abuse treatment, a substance abuse provider becomes involved in the team process. With enhanced services made available through the SAPT Block Grant funding for adolescent services, service choices for the teams to consider are increased.

Other supports/services available within the children's mental health system of care:

- Inpatient Psychiatric Facility: This service component provides a short-term episode of care in a hospital setting for the purpose of crisis stabilization that cannot be managed in a non-medical setting, and for comprehensive assessment. The use of this service is reserved for extreme situations for youth who are showing serious acute disturbances or who have particularly perplexing behavior problems.
- Psychiatric Residential Treatment Facilities: A facility or a distinct part of a facility that provides to children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own home, in another home, or in a less restrictive setting.
- Voluntary Out-of-Home Treatment Program: Is administered by the N.D. Department of Human Services through collaboration between the Division of Mental Health and Substance Abuse Services and the Children and Family Services Division. The program is an option for parents to access out-of-home treatment for their children without relinquishing legal custody when the child's circumstances fall within the intent of this program. The child must be covered by Medicaid program and the application be approved by the Division.
- Therapeutic Foster Care: Specially trained and supported foster parents who provide a home for generally one child at a time. The child may remain in the foster home indefinitely. Intensive training for the foster parents is provided, along with on-going intensive support and back-up by mental health professionals and care coordinators.
- Parent-to-parent support: This service includes coaching and assisting families with increasing their knowledge of their child's needs, the process of choosing service providers, explanation and interpretation of policies and procedures, and training to assist parents in accessing mental health services for their children. The Division of Mental Health and Substance Abuse awarded the contract for the 2005-2007 biennium to the North Dakota Federation of Families for Children's Mental Health to provide the parent-to-parent support services effective July 1, 2005.
- Residential child care facilities: a less intensive service setting than a residential treatment center that provides 24-hour care.
- Employment Assistance: Children of working age in the system of care can receive employment assistance through the IEP process at their school. Once they have left the school system, Vocational Rehabilitation services are available. Partnership staff assist the child and family with accessing these services when needed.
- Other supportive Services: Acute, Psychological Services, and psychiatric services are available through the regional human service centers.
- Respite/Parent Support: Respite services provide families of children diagnosed with serious emotional disturbances with periodic relief or back-up assistance. These services may be on a planned or emergency basis and can be provided either in the family's home or in another setting.
- Intensive In-home Therapy: This service component provides crisis resolution and family therapy oriented services on an outreach basis to work intensively with children and families

in their homes. Families that receive these services have a child who is at risk for out of home placement. The services are intensive with 24-hour availability. Services include (but not limited to) skills training and counseling.

State Review Team: A consumer specific review process incorporating the involved systems and agencies to address challenges, barriers, and gaps preventing appropriate care, services and/or education.

The team looks at items ranging from clinical/education reports, placement options/attempts, housing options, and funding streams. It works toward braiding together possible options in the best interest of the individual discussed. The state review team (SRT) is a problem solving, creative options think tank that addresses not only individual cases but also explores systemic issues. It is not a forum to resolve disputes or appeal system decisions or replace local team responsibilities.

The agencies represented on the State Review Team are:

Division of Juvenile Services
Adult Corrections
Department of Public Instruction/Special Education
Children & Family Services Division-DHS
Medical Services-DHS
Mental Health and Substance Abuse-DHS
Developmental Disabilities/Vocational Rehabilitation-DHS
Aging Services Division – DHS
Institutions – State Hospital and Developmental Center
Regional Human Service Centers

Consumers for whom all known options have been exhausted by local teams may request a pre-screening conference by contacting the discipline leads who administer their respective programs for children, adults and individuals with disabilities.

The process for pre-screening conference is as follows: The discipline lead will review with the referral source the pertinent case information, options that have been utilized, explore the treatment process, inquire of team membership, funding streams.

Process for review at the State Review Team for discipline leads is as follows: Discipline leads will contact the coordinator of the SRT 12 days prior to the next State Review Team meeting date if there are cases to review. The discipline lead will provide the appropriate information to the coordinator to be distributed to the State Review Team.

IDEA Workgroup: A Collaborative effort exists between school systems, the Department of Public Instruction, the Department of Human Services, and families who have a child(ren)diagnosed with serious emotional disturbance. Issues concerning education and the Individuals with Disabilities Education Act are addressed as they impact functioning. Partnership Program staff work with all parties to achieve quality education and supports for children diagnosed with a serious emotional disturbance. A strengths assessment is completed based on life domains. Life domains impacted are addressed through the single plan of care, IEP and the child and family team process. Teachers are often and routinely members of these teams. Therapists routinely collaborate with education staff. Department staff and members of the Mental Health Planning Council are members of the State Advisory Committee on the

Education of Disabled Children. In fact, the Chair of that committee is a Planning Council member. This committee was organized to make recommendations and to advise the Department of Public Instruction concerning the administration of, preparation of general regulations for, and evaluation of Special Education programs in the state. The chair and Division staff are involved with the Department of Public Instruction in the development of education standards for educators. The ED Guidance Task Force has completed its task of the development of the Guidance For Working With Children, Youth And Young Adults With Emotional Disabilities document. The final draft was reviewed by task force members before final dissemination. The document was developed to provide guidance to the North Dakota system of care that supports children and youth birth to 21 years of age, with or at risk of developing emotional or mental health disorders and their families. The intent of the document is to increase understanding or requirements and practices among system partners that will lead to greater continuity and move closer to a true comprehensive system of care, clarify various laws, regulations or policies, especially where they impact eligibility decisions, strive for greater consistency in practice among school districts and provide information about best practice and strategies for intervention and support. In the end, the document was developed from a desire to ensure children and youth with behavioral and emotional needs are able to receive services that effectively address these needs.

Training for the ED Guidelines occurred statewide in three locations in April of 2007. A Power Point presentation was developed, along with group exercises for the training event. The intended outcomes of the training are 1. A better understanding of eligibility criteria and available services in the systems of care; 2. Awareness of similiatries and difference between partner providers; 3. Awareness of the benefits of working together to address the needs of families with children and young adults with emotional disabilities; 4. Information about additional resources and how to access new information and ; 5. Recognition of other providers to invite as team members and a beginning relationship between partners within a region.

This document is now accessible on the Department's website for easy access by parents, guardians, professionals, and youth.

NORTH DAKOTA STATE HOSPITAL

The North Dakota State Hospital, Jamestown, was established in 1883. The only state hospital in North Dakota, it is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified. The North Dakota State Hospital is utilized only when it has been determined by the regional human service center to be the most appropriate option. The North Dakota State Hospital provides total care consisting of physical, medical, psychological, rehabilitative, social, educational, recreational and spiritual services through a variety of clinical and non-clinical staff. The goal of the treatment process is to implement appropriate therapeutic modalities at the earliest time so that the period of hospitalization can be reduced to a minimum. This requires integration with a system of aftercare services in the community. North Dakota State Hospital staff work closely with community agencies on both a programmatic and an individualized basis to maintain continuity of care and treatment.

THE COUNTY SOCIAL SERVICE BOARDS OR DISTRICTS

There are fifty-three local county social service boards or districts. The county social service board delivery system is county-administered and state-supervised. The staff of county social

service boards provide social support services primarily to the following target populations: children, adults and families, older adults, and those individuals with a physical disability.

In addition, county social service boards provide supportive services such as: home and community-based services; information and referral to individuals who are chemically dependent, mentally ill, developmentally disabled, physically disabled, as well as other targeted population groups; parent aide and family preservation services – such as wraparound case management, Family Group Decision Making process/meetings, Kinship Care Program and intensive in-home service contracts – through the State.

Economic assistance programs administered by the county social service boards are financed through a combination of Federal, State, and local funds.

PROTECTION AND ADVOCACY SERVICES

Protection and advocacy, a vital service in North Dakota, ensures the quality of services provided to consumers. Protection and advocacy services to individuals with mental illness and serious emotional disturbances are provided by the North Dakota Protection and Advocacy Project, an independent State agency. The Protection and Advocacy Project employs full-time mental health advocates who are located across the state providing services at no cost to individuals with a mental illness and serious emotional disturbances. Services include information/referral, case advocacy, legal counsel, and protective services.

Advocacy services are easily available to ensure the protection of consumer rights and to help provide access to entitled services. Advocates ensure that grievance procedures and other mechanisms to protect the rights of consumers are in place and utilized in mental health and residential facilities. Legal services are available to protect consumer rights, to obtain entitled services, and to represent consumers in administrative and judicial proceedings.

North Dakota

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Table 3: Estimates of Prevalence, Need, and Numbers Served for Adults with Serious Mental Illness at the Human Service Centers (2007 Census)

REGION	Population >17 (2007 Census)	Population with a Serious Mental Illness (1)	Population with a Serious Mental Illness in Need of Services (2)	Actual Number Served at the Human Service Center (FY 2007) (3)	Actual Number Served at the Human Service Center (FY 2008) (3)	Estimated Number to be Served at the Human Service Center (FY 2009) (4)
I	21,308	1,151	426	350	463	472
II	62,214	3,360	1,244	595	817	833
III	29,462	1,591	589	379	513	523
IV	70,146	3,788	1,403	1,274	989	1,009
V	134,600	7,268	2,692	2,223	1,718	1,752
VI	44,849	2,422	897	659	833	850
VII	105,393	5,691	2,108	1,205	1,095	1,117
VIII	28,934	1,562	579	387	567	578
TOTAL	496,906	26,833	9,938	7,072	6,995	7,135

Table 4: Estimates of Prevalence, Need, and Numbers Served for Children with Serious Emotional Disturbance at the Human Service Centers (2007 Census)

REGION	Population <18 (2007 Census)	Population with a Serious Emotional Disturbance (5)	Population with a Serious Emotional Disturbance in Need of Services (6)	Actual Number Served at the Human Service Center (FY 2007) (7)	Actual Number Served at the Human Service Center (FY 2008) (7)	Estimated Number to be Served at the Human Service Center (FY 2009) (4)
I	5,853	240	117	97	89	91
II	20,106	824	402	111	204	208
III	10,996	451	220	51	71	72
IV	18,596	762	372	280	220	224
V	39,181	1,606	784	312	304	310
VI	10,744	441	215	188	167	170
VII	29,724	1,219	594	260	263	268
VIII	7,609	312	152	218	131	134
TOTAL	142,809	5,855	2,856	1,517	1,449	1,478

(1) & (2) Estimation based on 5.4% and 2%, respectively, of total State Adult Population as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)

(3) From ROAP adults with a completed SMI Form, and Program Enrollment Codes for Medication Only, Extended Care, and Acute Outpatient Services with no SMI Form.

(4) Estimation based on anticipated 2% growth.

(5) & (6) Estimation based on 4.1% and 2%, respectively, of total State Population under age 18 as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)

(7) From ROAP children and adolescents with a completed SED Form.

North Dakota

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

QUANTITATIVE TARGETS – ADULTS AND CHILDREN

MHSIP PROGRAM: The Nation is at a time where there is an increasing demand for accountability in the delivery of mental health services. Federal agencies, the State Legislature, consumers, and other stakeholders are demanding outcome data to justify funding levels for mental health services. The Mental Health Services Researcher is charged with the oversight and refinement of the data gathering and analysis projects for the community-based mental health system. North Dakota has a number of data collections systems that are used to derive mental health statistics: Regional Office Automation Program, State Hospital Patient Care System, the Single Plan of Care (SPOC), and the Mental Health Statistics Improvement Program.

The North Dakota Department of Human Services implemented an electronic financial and clinical data collection system. Referred to as the Regional Office Automation Program (ROAP), this system allows the Mental Health Services Researcher to have total access to the data gathered through the system and allows for the creation of detailed reports concerning the mental health services delivered at the regional humans service centers.

The North Dakota State Hospital has its own data collection system, the State Hospital Patient Care System, which is operated independently of the ROAP System. It does, however, collect data on patient admission, discharge, length of stay, demographic information, etc.

The Division of Mental Health & Substance Abuse Services continues to refine its performance outcomes measurement system. The MHSIP Outcomes Project has moved to an annual survey approach. This will allow the Division to measure the impact that the mental health services provided are having on consumer recovery and quality of life including access to care, quality/appropriateness, satisfaction, and outcome while minimizing the data collection burden for the clinician. Similarly, the Partnership Program now uses a web-based application. Using tools such as Access, Excel, and SPSS, the Mental Health Services Researcher is able to compile data from these different systems leading to an overall enhanced planning and reporting process. In the Single Plan of Care (SPOC), outcomes are directly entered into a web-based system by human service center staff. This has streamlined the outcome reporting process.

North Dakota participates in the Western States Decision Support Group of the Western Interstate Commission for Higher Education's Mental Health Program. This group, made up of fifteen western states, meets three times per year to discuss and work on state and regional mental health data collection and research projects. The Mental Health Services Researcher is the Division's liaison to this group.

TARGET POPULATION: The Federal Register, Volume 62, No. 60 dated Friday, March 28, 1997, defines serious mental illness and the Federal Register, Volume 64, No. 121 dated Thursday, June 24, 1999 estimates that North Dakota has 25,024 individuals with serious mental illnesses. In SFY 2008, the estimate for adults with serious mental illness (26,833) and children and adolescents (5,855) is 32,688.

Definition of Adults with Serious Mental Illnesses

Pursuant to Section 1912 (c) of the Public Health Service Act, as amended by Public Law 102-321 "adults with a serious mental illness" are persons:

- age 18 and over
- who currently, or at any time during the past year
  - have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specific within DSM-IV
  - that has resulted in functional impairment which substantially interferes with or limits one or more major life activities

These disorders include any mental disorders (including those of biological etiology) listed in DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders and developmental disorders which are excluded unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts.

Definition of Children with Severe Emotional Disturbance (SED)

Children with Severe Emotional Disturbances (SED) meet the following eligibility criteria:

- Age 18 or less
- Diagnosed with an emotional, behavioral, or mental disorder
- Placed out-of-home, are at imminent risk of out-of-home placement, or have a Global Assessment of Functioning score (GAF) of 50 or below
- Have service needs involving two or more community agencies such as mental health, substance abuse, education, juvenile justice, health, or child welfare
- Must have or be expected to have the disorder for one year or more

ESTIMATE OF PREVALENCE: Because North Dakota has not engaged in any formal estimate of prevalence studies for mental health services, the Division used estimate of prevalence information for adults with serious mental illness developed by the Substance Abuse and Mental Health Services Administration and presented in the Thursday, June 24, 1999 Federal Register (Vol. 64, No.121). Based on this documentation, a prevalence rate for serious mental illness of 5.4% of the total state population was used. For SFY 2006, estimates of prevalence are based on U.S. Census 2004 county and state population estimates. It is anticipated that approximately 2% of the total state population has a serious mental illness and is in need of mental health services. Not all persons in the priority population will seek services from the Department of Human Services. In general, individuals who can afford it tend to seek care from private providers. Some eligible persons do not seek services, engage in activities that place them in other settings such as the criminal justice system, or are assisted by family or non-traditional caregivers. At this time, the Division does not have a mechanism in place to determine how many consumers are receiving formal or informal mental health services outside of the public system.

The Division used a similar method as the one mentioned above to determine the estimate of prevalence for children with a serious emotional disturbance. Because no formal estimate of

prevalence studies have been conducted for children's mental health services, the Division used estimate of prevalence information developed by the Substance Abuse and Mental Health Services Administration and presented in the Friday, July 17, 1998 Federal Register (Vol. 63, No. 137). Not all children will seek services from the Department of Human Services. In general, individuals who can afford services tend to seek care from private providers. Some eligible children and their parents do not seek services or are assisted by other family outside the household or non-traditional caregivers. At this time, the Division does not have a mechanism in place to determine how many children/consumers are receiving formal or informal mental health services outside of the public system.

Please refer to the estimate of prevalence table for the latest prevalence information and the performance indicators for the targets for the upcoming year.

North Dakota

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

SYSTEM OF INTEGRATED SERVICES - CHILDREN

The public mental health delivery system is a coordinated, interagency effort made up of a variety of human services agencies and programs. Due to the complexity of needs that youth with serious emotional disturbances present, systems linkage is especially critical. For example, North Dakota currently has:

- Eight regional human service centers providing individual, family, and group therapy along with some intensive in-home and therapeutic foster care,
- Fifty-three counties responsible for the coordination and/or development and implementation of: parent-aide services, Family Group Decision Making, Kinship Care program, intensive in-home services, therapeutic foster care and Wraparound case management services to those children who are under the custody of their county,
- Thirty-one special education districts that cut across regional and county lines,
- Four Native American reservations and one Indian Service Area
- Eight Division of Juvenile Services offices, which correspond to the human service regions
- Thirteen juvenile court districts.

Because North Dakota does have a complex system of care available to children, care coordination services are vital. Presently there are approximately 56 care coordinators employed through the Partnerships Program. The care coordinators serve as facilitators, crisis responders, service brokers, interagency coordinators, and liaisons forming a therapeutic alliance with families and children. Partnerships Program staff meets with the Administrator of Children's Mental Health at least 4 times per year, to discuss trends and methods to further meet the needs of children and families. The major initiative this past year has been the development of a Statewide Care Coordination Manual.

In an effort to enhance coordination and integrate multiple systems into the children's mental health system of care, the Administrator of Children' Mental Health Services was out posted from the Division of Mental Health and Substance Abuse Services to the Division of Children and Family Services. This arrangement has proven to be advantageous by helping to improve communication and collaboration efforts between the child welfare, juvenile justice, tribal communities and other private/public mental health systems.

In 1994, the Division of Mental Health Services applied for a comprehensive community mental health services grant from the Center for Mental Health Services targeting children and adolescents diagnosed with serious emotional disturbances. This $16.8 million grant provided the impetus for a formalized system of care for children and was implemented statewide. Services developed or enhanced through the grant include care coordination, respite care, non-hospital crisis, school-based day treatment, and intensive in-home therapy, all using the wraparound process. North Dakota was able to sustain core services developed through the grant effort and approximately 2,751 children with serious emotional/behavioral disturbances have received services through the Partnership Program through June 2008.

Key to the children's mental health system of care is a strong partnership with families and integrating services across systems. Parents are actively involved in the design and implementation of the programming, serve on the local and state advisory boards and provide on-going support to parents negotiating services for their children. The Wraparound process, which uses a strength-based approach to service delivery, is used in this program and is a

method shown to improve the functioning of children who have complex needs. The process is used to help communities develop individualized plans of care.

Working with the family, formal and natural supports (the child and family team) are wrapped around the family to provide them with the services/supports required to meet their needs. The wraparound process includes a set of core elements: 1) individualized plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, and 5) least restrictive setting.

It is recognized that all children that come into contact with service systems can benefit from being served using the tenants of the Wraparound process. The mental health system collaborated in developing a certification process with child welfare and juvenile justice. A training curriculum was developed with staff from the three systems plus parent representatives and private providers. This training curriculum forms the framework for case management/care coordination fundamentals for all three systems. Each system has provided the time and expertise of their staff as they formed the trainer group with a lead trainer.

Wraparound training and certification began in the spring of 2003. The training efforts have expanded to include other private organizations, such as, the Professional Association of Treatment Homes (PATH), Village Family Service Center staff, Lutheran Social Service Center Staff, Head start case managers and Residential Treatment Center staff. Training has also been provided to Turtle Mountain Tribal staff, Spirit Lake Tribal staff, and Three Affiliated Tribal staff on the Wraparound Process for Foster Care Child and Family Team meetings formerly known as permanency planning meetings and the Single Plan Of Care (SPOC). There are over 490 child welfare and system partners certified in the Wraparound Process. 43 individuals were certified in the Wraparound Process this past year.

A re-certification process has also been initiated, allowing for the continued practice of the Wraparound Process. The re-certification process is due every other year for those who wish to remain certified in the Wraparound process. Various workshops, topics and training events are offered throughout the year, stipends are provided to HSC staff for attendance at conferences that qualify re-certification. The training is offered at the following statewide conferences; North Dakota Family Based Services Association annual conference, the Children and Family Services annual conference, and the annual Indian Child Welfare Act conference

A three-level delivery system was developed to better adapt the process across systems defining family and team elements to guide the intensity of coordination. This certification and collaborative process has propelled us closer to the realization of having a single plan of care.

The Single Plan of Care (SPOC) electronic treatment plan was developed and was implemented in June of 2003. The goal of the SPOC is to strive for the creation of the families plan that supports cross system planning, while reducing duplication of information that families need to provide to the numerous agencies involved in providing services for their child/children. The SPOC is used by juvenile corrections, child welfare, and mental health systems. To date, there are over 1500 plans on the system, which demonstrates an increased use of technology to support a process that acknowledges and uses a family's strengths to address their needs and challenges.

Currently, there is an analysis of the Department of Human Services computer systems, this analysis will provide input on what type of system is possible for all divisions in the Department

and what is fiscally feasible to implement. Therefore, a CCWIPS/SPOC Executive Level Committee was developed to address the concerns from County Directors in regard to duplication of efforts in the CCWIPS system, SPOC system and the amount and duplication of required paperwork in Child Welfare, including foster care and eligibility paperwork. This Committee met on one occasion in May 2006 with the intent to begin an analysis of the concerns expressed by the County Directors and County Child Welfare staff. This analysis led to the development of a collaborative effort to design a new front-end system.

The front-end system discussion with CFS began in November 2006. A project charter and plan was developed and completed in February 2007. The first statewide systems analysis meetings to discuss and describe the Child Welfare business workflow processes began on February 20, 2007 and will continue to meet every other week until May 31, 2007. In June 2007, an analysis of the information collected on the business workflow processes was discussed with the project sponsors, CFS Director and Information Technology Services Director, to plan next steps. The project was approved and the design phase of the project started in May 2008 to be completed in August 2008. The next phase would be testing, with completion set for August 2009.

Below is the array of services provided through the **Partnerships Program** within the children's mental health system of care:

- **Care Coordination:** Care coordination assists children with serious emotional disturbances and their parents with accessing the various services they need and helps them make informed choices about opportunities and services in the community. The care coordinator helps ensure the child and parents receive timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services enabling the child and parents to meet their own goals.

- **Mental Health Technicians:** This service is designed to provide behavioral management assistance and role modeling. Case aides help individuals stabilize, reduce, and eliminate undesirable behaviors that put them at risk of being served in restrictive settings. Case aides also help individuals observe and learn appropriate behavioral responses to situations that trigger their symptoms

- **Flexible Funding**: This service is available when no other resources are available to meet specific needs and threaten the child's ability to remain in the least restrictive setting.

- **Crisis Residential Services**: This service provides a short-term, safe place to stabilize behaviors in a 24-hour supervised setting. The goal is to promote rapid stabilization and return to the home or community.

- **Substance Abuse/Dual Diagnosis Services**: When a child diagnosed with a severe emotional disturbance requires substance abuse treatment, a substance abuse provider becomes involved in the team process. With enhanced services made available through the SAPT Block Grant funding for adolescent services, service choices for the teams to consider are increased.

Other supports/services available within the children's mental health system of care:

- Inpatient Psychiatric Facility: This service component provides a short-term episode of care in a hospital setting for the purpose of crisis stabilization that cannot be managed in a non-medical setting, and for comprehensive assessment. The use of this service is reserved for extreme situations for youth who are showing serious acute disturbances or who have particularly perplexing behavior problems.
- Psychiatric Residential Treatment Facilities: A facility or a distinct part of a facility that provides to children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own home, in another home, or in a less restrictive setting.
- Voluntary Out-of-Home Treatment Program: Is administered by the N.D. Department of Human Services through collaboration between the Division of Mental Health and Substance Abuse Services and the Children and Family Services Division. The program is an option for parents to access out-of-home treatment for their children without relinquishing legal custody when the child's circumstances fall within the intent of this program. The child must be covered by Medicaid program and the application be approved by the Division.
- Therapeutic Foster Care: Specially trained and supported foster parents who provide a home for generally one child at a time. The child may remain in the foster home indefinitely. Intensive training for the foster parents is provided, along with on-going intensive support and back-up by mental health professionals and care coordinators.
- Parent-to-Parent Support: This service includes coaching and assisting families with increasing their knowledge of their child's needs, the process of choosing service providers, explanation and interpretation of policies and procedures, and training to assist parents in accessing mental health services for their children.
- Residential Child Care Facilities: a less intensive service setting than a residential treatment center that provides 24-hour care.
- Employment Assistance: Children of working age in the system of care can receive employment assistance through the IEP process at their school. Once they have left the school system, Vocational Rehabilitation services are available. Partnership staff assist the child and family with accessing these services when needed.
- Other Supportive Services: Acute, psychological services, and psychiatric services are available through the regional human service centers.
- Respite/Parent Support: Respite services provide families of children diagnosed with serious emotional disturbances with periodic relief or back-up assistance. These services may be on a planned or emergency basis and can be provided either in the family's home or in another setting.
- Intensive In-home Therapy: This service component provides crisis resolution and family therapy oriented services on an outreach basis to work intensively with children and families in their homes. Families that receive these services have a child who is at risk for out of home placement. The services are intensive with 24-hour availability. Services include (but not limited to) skills training and counseling.

- State Review Team: A consumer specific review process incorporating the involved systems and agencies to address challenges, barriers, and gaps preventing appropriate care, services and/or education.

The state review team is a problem solving, creative options think tank that addresses not only individual cases but also explores systemic issues. It is not a forum to resolve disputes or appeal system decisions or replace local team responsibilities. The group looks at issues

ranging from clinical/education reports, placement options/attempts, housing options, and funding streams. The goal is to braid together possible options in the best interest of the individual discussed.

The agencies represented on the State Review Team are:

Division of Juvenile Services
Adult Corrections
Department of Public Instruction/Special Education
Children & Family Services Division-DHS
Medical Services-DHS
Mental Health and Substance Abuse-DHS
Developmental Disabilities/Vocational Rehabilitation-DHS
Aging Services Division – DHS
Institutions – State Hospital and Developmental Center
Regional Human Service Centers

The process for pre-screening conference is as follows: The discipline lead will review with the referral source the pertinent case information, options that have been utilized, explore the treatment process, inquire of team membership, funding streams, etc.

IDEA Workgroup: A Collaborative effort exists between school systems, the Department of Public Instruction, the Department of Human Services, and families who have a child(ren)diagnosed with serious emotional disturbance. Issues concerning education and the Individuals with Disabilities Education Act are addressed as they impact functioning. Partnership Program staff work with all parties to achieve quality education and supports for children diagnosed with a serious emotional disturbance. A strengths assessment is completed based on life domains. Life domains impacted are addressed through the single plan of care, IEP and the child and family team process. Teachers are often and routinely members of these teams. Therapists routinely collaborate with education staff. Department staff and members of the Mental Health Planning Council are members of the State Advisory Committee on the Education of Disabled Children. In fact, the Chair of that committee is a Planning Council member. This committee was organized to make recommendations and to advise the Department of Public Instruction concerning the administration of, preparation of general regulations for, and evaluation of Special Education programs in the state. The chair and Division staff are involved with the Department of Public Instruction in the development of education standards for educators. The ED Guidance Task Force has completed its task of the development of the Guidance For Working With Children, Youth And Young Adults With Emotional Disabilities document. The final draft was reviewed by task force members before final dissemination. The document was developed to provide guidance to the North Dakota system of care that supports children and youth birth to 21 years of age, with or at risk of developing emotional or mental health disorders and their families. The intent of the document is to increase understanding or requirements and practices among system partners that will lead to greater continuity and move closer to a true comprehensive system of care, clarify various laws, regulations or policies, especially where they impact eligibility decisions, strive for greater consistency in practice among school districts and provide information about best practice and strategies for intervention and support. In the end, the document was developed from a desire to ensure children and youth with behavioral and emotional needs are able to receive services that effectively address these needs.

Training for the ED Guidelines occurred statewide in three locations in April of 2007. A Power Point presentation was developed, along with group exercises for the training event. The intended outcomes of the training are 1. A better understanding of eligibility criteria and available services in the systems of care; 2. Awareness of similiatries and difference between partner providers; 3. Awareness of the benefits of working together to address the needs of families with children and young adults with emotional disabilities; 4. Information about additional resources and how to access new information and ; 5. Recognition of other providers to invite as team members and a beginning relationship between partners within a region.

This document is now accessible on the Department's website for easy access by parents, guardians, professionals, and youth.

Each human service center uses the Child and Adolescent Functional Assessment Scale (CAFAS) for all children diagnosed with a serious emotional disorder who are receiving services through the Partnerships Program. Staff receive booster training every two years on the tool. This is coordinated through the Division of Mental Health and Substance Abuse Services.

Staff from the Division of Mental Health and Substance Abuse Services meet with Clinical Forum, a group of clinician administrators from the human service centers counseling, psychology, and children's services units, on a quarterly basis. Topics discussed have included MHSIP rollout in each region, evidence based practices, single plan of care, alignment between Centers, Data Infrastructure Grant details, and training needs. Participation in these meetings assists Division staff monitor for challenges to the service system and any adjustments that may be needed to better serve children and families.

The regional human service centers provide assessment, diagnostic and treatment services for children with serious emotional disturbances and their families, upon referral from the nineteen shelters or runaway youth programs in the state. During SFY 2007, PATH Coordinators saw 46 youth seventeen years of age and under-Lauren through the Projects for Assistance in Transition from Homelessness grant program. Our current data systems, however, are unable to identify the total number of homeless youth who have a serious emotional disturbance.

NORTH DAKOTA STATE HOSPITAL

The North Dakota State Hospital, Jamestown, was established in 1883. The only state hospital in North Dakota, it is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified. The North Dakota State Hospital is utilized only when it has been determined by the regional human service center to be the most appropriate option. The North Dakota State Hospital provides total care consisting of physical, medical, psychological, rehabilitative, social, educational, recreational and spiritual services through a variety of clinical and non-clinical staff. The goal of the treatment process is to implement appropriate therapeutic modalities at the earliest time so that the period of hospitalization can be reduced to a minimum. This requires integration with a system of aftercare services in the community. North Dakota State Hospital staff work closely with community agencies on both a programmatic and an individualized basis to maintain continuity of care and treatment.

THE COUNTY SOCIAL SERVICE BOARDS OR DISTRICTS

There are fifty-three local county social service boards or districts. The county social service board delivery system is county-administered and state-supervised. The staff of county social

service boards provide social support services primarily to the following target populations: children, adults and families, older adults, and those individuals with a physical disability.

In addition, county social service boards provide supportive services such as: home and community-based services; information and referral to individuals who are chemically dependent, mentally ill, developmentally disabled, physically disabled, as well as other targeted population groups; parent aide and family preservation services – such as Wraparound case management, Family Group Decision Making process/meetings, Kinship Care Program and intensive in-home service contracts – through the State.

Economic assistance programs administered by the county social service boards are financed through a combination of Federal, State, and local funds.

PROTECTION AND ADVOCACY SERVICES

Protection and advocacy, a vital service in North Dakota, ensures the quality of services provided to consumers. Protection and advocacy services to individuals with mental illness and serious emotional disturbances are provided by the North Dakota Protection and Advocacy Project, an independent State agency. The Protection and Advocacy Project employs full-time mental health advocates who are located across the state providing services at no cost to individuals with a mental illness and serious emotional disturbances. Services include information/referral, case advocacy, legal counsel, and protective services.

Advocacy services are easily available to ensure the protection of consumer rights and to help provide access to entitled services. Advocates ensure that grievance procedures and other mechanisms to protect the rights of consumers are in place and utilized in mental health and residential facilities. Legal services are available to protect consumer rights, to obtain entitled services, and to represent consumers in administrative and judicial proceedings.

North Dakota

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

CHILD - GEOGRAPHIC AREA DEFINITION

North Dakota is a rural, frontier state with an area of 72,000 square miles and an approximate population of 635,867. The largest city in the State is Fargo, which has a metropolitan statistical area population of 132,525 persons. Thirty-six of fifty-three counties are designated frontier areas, having less than seven persons per square mile. In 1982, to better serve the citizens of this rural state, the community mental health centers were merged with the area social service centers. This action created the regional human service centers and developed a one-stop system of care. The eight regional human service centers, listed below with their locations, provide public mental health programs to service areas ranging from three to ten counties.

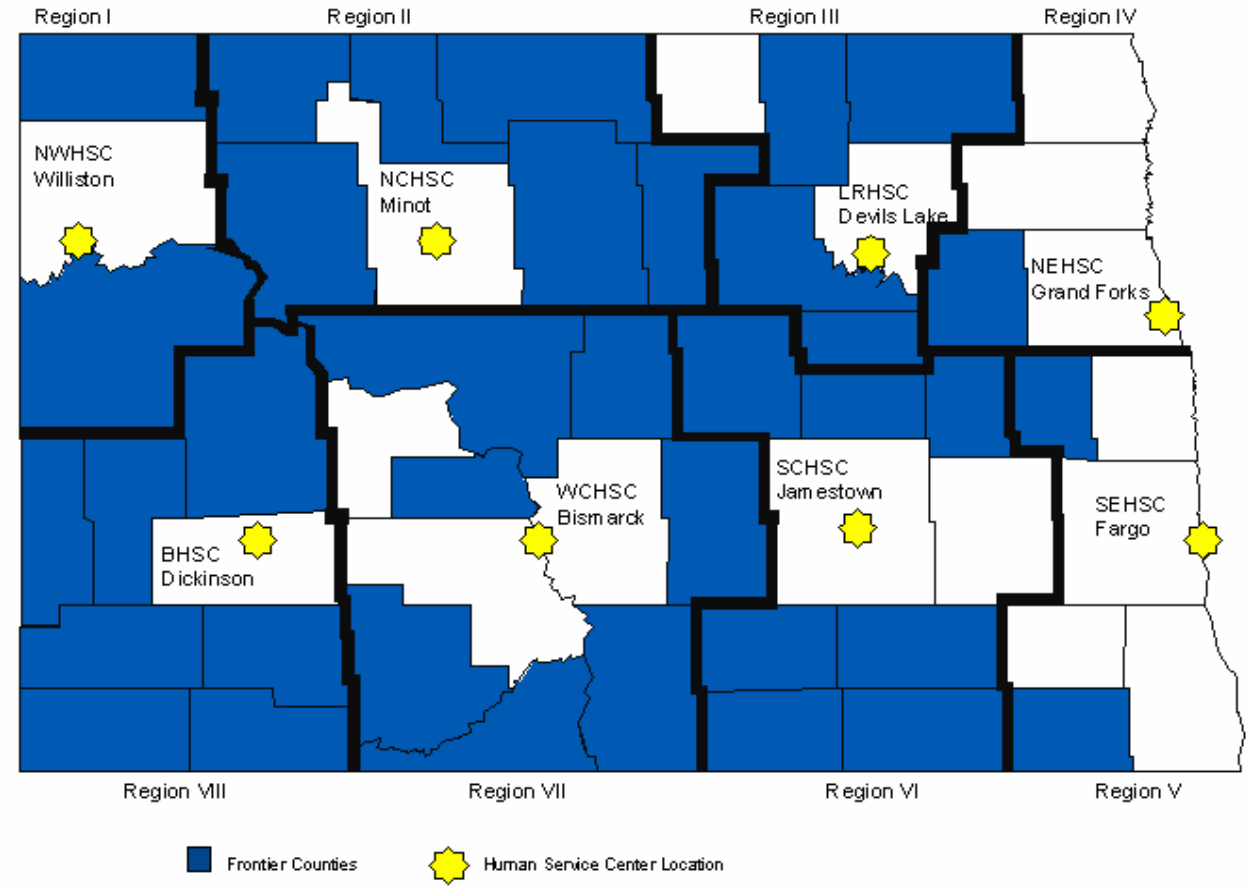
Northwest Human Service Center	Williston	Region I
North Central Human Service Center	Minot	Region II
Lake Region Human Service Center	Devils Lake	Region III
Northeast Human Service Center	Grand Forks	Region IV
Southeast Human Service Center	Fargo	Region V
South Central Human Service Center	Jamestown	Region VI
West Central Human Service Center	Bismarck	Region VII
Badlands Human Service Center	Dickinson	Region VIII

Adolescents and children are served in the community through a variety of rehabilitation services including:

- crisis stabilization and resolution;
- inpatient services;
- psychiatric/medical management including medication management and other health services;
- social services;
- residential services and supports;
- vocational and educational services and supported employment;
- social and leisure activities;
- evidence-based practices of Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Services at the regional human service centers are provided to all children regardless of the child's race, color, religion, national origin, sex, age, political beliefs, or disability in accordance with Title VI of the Civil Rights Act of 1984, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act, the Americans with Disabilities Act of 1990 and the North Dakota Human Rights Act (NDCC Chapter 14-02.4). All services are provided to Native Americans living on or off the reservations.

Figure 1: Regional human service center locations and frontier counties in North Dakota



North Dakota

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

OUTREACH TO HOMELESS –CHILDREN

Statistics for the education of children and youth under the McKinney-Vento Act were collected from all public school districts in the state of North Dakota for the 2006-2007 school year. The McKinney-Vento program is a sub-program of Title I, Department of Public Instruction.

Grade Levels
A total of 1,209 students, from school districts throughout the state, were reported as experiencing homelessness. Statistics listed below provide a breakdown by grade levels.

• 24% or 294 in pre-k and kindergarten
• 34% or 409 in grades one through five
• 17% or 199 in grades six through eight
• 25% or 307 in grades nine through twelve

Living Conditions
Living conditions of children and youth experiencing homelessness vary greatly. Some are living in shelters and others are living in unsheltered areas, i.e. car, tent, park. Statistics listed below provide living conditions of those identified as experiencing homelessness.

• 41 % or 492 children and/or youth lived in shelters
• 45% or 541 lived with friends or relatives, also recognized as “doubled-up”
• 10% or 126 lived in hotels/motels
• 4% or 50 children were reported as being unsheltered

Barriers
Barriers reported by school districts that may inhibit the education of children and youth experiencing homelessness include:

• Domestic violence
• Lack of adequate housing
• Lack of transportation
• Lack of adequate support system (family and friends)

Concerns
Concerns regarding the welfare and education of these children are many. The list below provides those most evident when addressing homelessness.

• Need for special services for children (i.e., special education and/or tutoring)
• Lack of parental involvement in the education process
• Need for counseling
• Need for collaboration between agencies
Please Note: Interpretation of the numbers of children and youth reported as experiencing homelessness should be looked at with consideration. The number may be much greater in some areas than what was reported due to the difference in the definition of homelessness being used by different entities in the identification process.

Homelessness continues to be an issue in North Dakota. The state lacks sufficient affordable housing, especially for low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is much more limited. In North Dakota

there is a willingness to tolerate chronic homelessness as an “acceptable” situation. In part, this belief is fostered by people’s lack of direct experience with chronically homeless individuals. It is difficult to feel a sense of urgency about an issue with which one has little knowledge or first hand experience. The people of this state have a fundamental belief in “self-sufficiency.” This belief often leads people to believe that the chronically homeless do not deserve help because they are not working hard enough to help themselves. Again, the belief itself is an obstacle to building support for the creation of housing options that specifically serve this population. At times, consumers have difficulty accessing available housing resources because of poor rental and credit histories and criminal backgrounds. In addition, very low or no income and an inability to afford rent, whether it is because they are unable to find a job where the pay is sufficient to cover housing costs or because they are unable to keep a job because of a disability.

The most recent formal needs assessment (2004) noted that approximately one of every four homeless individuals is below the age of 17 in North Dakota. A U.S. household sample of nearly 6,500 youth, ages 12 to 17 -- as part of the Youth Risk Behavior Survey (YRBS) -- found that approximately 7.6 percent had been homeless for at least one night during the past 12 months ((Ringwalt, C. L., Greene, J. M., Robertson, M., & McPheeters, M. (1998). The prevalence of homelessness among adolescents in the United States. American *Journal of Public Health, 88*, 1325-1329.). This would translate into approximately 1.6 million homeless youth each year nationwide or as high as 12,741 youth in North Dakota.

The most recent Point-In-Time Survey found 832 homeless persons in North Dakota including 556 adults, 248 children and 28 persons for whom age was unknown. Of these, 177 people or 21% were long-term homeless.

Table 6. Homelessness in North Dakota by Region (January 30, 2008)

	Adults	Children	Age Missing	Total Individuals	Chronically Homeless	Long-Term Homeless	Mental Illness	Substance Abuse
Region I	18	0	1	19	0	7	9	12
Region II	19	16	0	35	0	5	10	5
Region III	28	13	2	43	0	11	5	7
Region IV	102	36	3	141	15	25	17	19
Region V	191	56	18	265	24	91	68	87
Region VI	24	0	0	24	0	8	21	17
Region VII	159	113	3	275	7	30	44	50
Region VIII	15	14	1	30	0	0	7	4
Total - ND	556	248	28	832	51	177	181	201

The North Dakota Coalition for Homeless People, Inc. is the lead entity in the state working to decrease homelessness in North Dakota. Comprised of over sixty organizations (including the North Dakota Department of Human Services), the Coalition is committed to reducing the incidence of homelessness in North Dakota communities, assisting homeless individuals and families to move to self-sufficiency and permanent housing as quickly as possible, and ending chronic homelessness in North Dakota. The Coalition is also the lead entity for the statewide Continuum of Care process.

Through the Continuum of Care process, North Dakota received just over $1.3 million to fund housing and homeless assistance projects throughout the state. These include:

- Ruth Meiers Hospitality House - $119,998
- Fargo Housing & Redevelopment Authority - Shelter Plus Care $188,460
- Share House Inc. - Permanent Supportive Housing $150,000
- YWCA Cass Clay - Transitional Housing $441,365
- Prairie Harvest Human Services Foundation - $85,000
- Abused Adult Resource Center - $78,682
- Society of St. Vincent de Paul - Transitional Housing $15,277
- Community Violence Intervention Center - Transitional Housing $94,772
- Women's Alliance, Inc. Domestic Violence and Rape Crisis Center - Transitional Housing $37,600
- ND Department of Commerce, Division of Community Services - Homeless Management Information System $124,248

In addition to these projects, partnerships between local stakeholders have increased housing options for individuals diagnosed with serious mental illness in many regions. For instance, North Central Human Service Center, in partnership with other public and private stakeholders, is developing Harmony Heights, a four-apartment housing program located above the psychosocial rehabilitation center in Minot. With a case manager located on site, residents will have greater access to services, helping them remain in the community.

The Center for Persons with Disabilities out of Minot State University has facilitated two task forces created to enhance housing for persons with disabilities. The Visitability Task Force is working to advance visitability efforts in North Dakota and reviewing efforts in other states where visitability laws have already been passed. Passage of a visitability law would significantly impact the amount of accessible homes available for purchase by people with disabilities. The Section 8 Housing Task Force is working to get more Public Housing Authorities to sign on and use the public assistance program, which allows for Section 8 vouchers to be used toward home ownership. This program would significantly assist people with disabilities and minorities in purchasing homes by allowing them to use their Section 8 voucher as a mortgage payment.

The past few years have been pivotal for engaging both local and state elected officials in the NDC's work toward the goal of ending chronic homelessness. The Governor of North Dakota met with Coalition members in August 2004 to discuss developing a 10-year plan for ending chronic homelessness. Working with Coalition members, the Governor committed to having a plan in place by 2007, and -- by Executive Order -- established a 19-member North Dakota Interagency Council on Homelessness (NDICH) to develop the plan. The NDICH reports to the Governor and the North Dakota Legislature, which assembles biannually. In addition to state agency directors and NDC members, elected officials included on the NDICH are Dr. Wayne Sanstead, Superintendent of Public Instruction and Mayors Warford, Walaker, and Brown of the cities of Bismarck, Fargo, and Grand Forks respectively. Mayor Warford, in addition to serving on the NDICH and helping to develop the state's 10-year plan to end chronic homelessness, has committed to a 10-year plan for his jurisdiction of Bismarck. A 10-year plan has also been developed for the cities of Bismarck, Fargo, Grand Forks, Minot, Jamestown, Williston, Dickinson, and Devils Lake. In February 2005 the NDICH held its inaugural meeting at the State Capitol. The Director of the Division of Mental Health and Substance Abuse Services is a member of this council.

North Dakota

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

RURAL AREA SERVICES – ADULTS AND CHILDREN

North Dakota is a rural state with two-thirds of its counties designated as frontier areas. Nearly 40% of the state's population resides in the two eastern regions that lie on the border with Minnesota. In contrast, only ten percent of the population resides in the two regions that lie on the western border with Montana. In fact, the western half of the state has a sparse population density from 0.9 to 10.7 persons per square mile. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel. Round-trips of 200 miles or more to obtain services are not uncommon.

The eight regional human service centers serve catchment areas ranging from three to ten counties. In attempts to address the difficulty rural residents have with accessing needed services, each center has staff traveling to outlying rural communities to provide mental health services, e.g., diagnostic screening, evaluations, follow-up counseling, information and referral. Services are delivered to outreach sites as follows:

Region I	Permanent full-time outreach to two sites; other communities when needed or requested
Region II	Permanent full-time outreach divided between two sites, weekly outreach to two sites, other communities or individuals when needed or requested
Region III	Permanent full-time outreach to one site, biweekly outreach to ten sites, weekly outreach to two sites, other communities when needed or requested
Region IV	Permanent full-time satellite offices in one site; weekly outreach to one other site; other communities when needed or requested
Region V	Weekly or biweekly outreach to five sites, other communities when needed or requested
Region VI	Biweekly outreach to three sites, one site three times per week, other communities when needed or requested
Region VII	Biweekly outreach to six sites; one permanent site with outreach to four counties; other communities when needed or requested
Region VIII	Permanent part-time outreach to one site; biweekly outreach to four sites; other communities when needed or requested

The delivery of services to persons residing in rural areas has been and continues to be a major concern of the North Dakota Mental Health Planning Council. The mental health delivery system in the future will need to depend more on the assistance of other professionals who work and live in rural communities. County/city public health nurses and county social workers will need training to work with persons with serious mental illnesses and serious emotional disorders residing in rural North Dakota. Paraprofessionals will need to be trained to deliver quality care to this population.

In addition to the outreach sites listed above, case managers and care coordinators travel throughout the regions making home visits when appropriate and needed. Case management occurs in the environment of the person's choice such as their home, a public place, or in the human service center. When appropriate and with the individual's permission, family members are involved in support and planning, this is especially true for care coordination through the child and family team process.

North Dakota

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

RESOURCES FOR PROVIDERS – ADULTS AND CHILDREN

BUDGETING FOR MENTAL HEALTH SERVICES: Mental health services in North Dakota are provided by State funds, Federal funds, third party payer, and other specialty funds. The Division of Mental Health and Substance Abuse Services prepares a budget one year ahead of the legislative session. North Dakota's legislature meets every other year, therefore, the budgets are developed for a biennium. The Division develops a budget for its operation, which includes contracting with private providers for training, consultation, education, extended services, and homeless programs. Each human service center as well as the North Dakota State Hospital prepares its own budget. All budgets are then presented to the Executive and Fiscal division of the Department of Human Services for approval. Once approved, the budgets are reviewed by the Office of Management and Budget as well as the Governor's Office. When final approval has been granted by the Governor's Office, the budgets are presented to the Legislature for approval. During the legislative session, consumers, families, and other advocates appear before the legislative committees to testify on behalf of all mental health programs in the state.

BLOCK GRANT FUNDING: Funding has been broken into the block grant function categories as: Carrying out the Plan; and Planning, Administration and Evaluation. Descriptions of initiatives can be found in the criteria narratives while a brief description is found below.

- Supported Employment Pilot: Pilot program at Southeast Human Service Center in Fargo to explore the feasibility of implementing SAMHSA's model of Supported Employment in North Dakota.
- Aging Mental Health Services: Mental health and aging education targeted to mental health clinicians.
- IDDT Pilot: Continued implementation of Integrated Dual Disorders Treatment program at Southeast Human Service Center in Fargo.
- Mental Health Recovery: Continued implementation of the Mental Health Recovery Model throughout the state.
- Suicide Prevention: Support for suicide prevention efforts throughout the state.
- Consumer Network: Support for the North Dakota Mental Health Consumer and Family Network.
- Parent-to-Parent Support: Continued support of program matching experienced parents of children with SED to those with newly diagnosed children.
- Voluntary Out-of-Home Treatment Program for Children with Severe Emotional Disturbances: Continued support of program giving parents the option to access out-of-home treatment for their children without relinquishing legal custody.
- Anti-Stigma: Support for statewide media campaign to fight stigma associated with mental illness.
- MH Clinical Forum: Annual conference for providers focusing on evidence-based practice, recovery, transformation and other mental health topics.
- Evidence-Based Practice Training: Support for ongoing training for clinicians on evidence-based practices.
- Wraparound Training: Support for training of direct service staff on the fundamentals of Wraparound.
- Emergency Services Training/Primary Care: Training of first responders in mental health issues.

- Planning Council: Travel, per diem, printing, training opportunities, and other expenses associated with operation of the Council including full Council meetings and separate committee meetings.
- Carrying Out the Plan: Expenses associated with carrying out and administering the programs mentioned.
- Evaluating the Plan: Expenses associated with evaluating the community-based public mental health system.
- HSC-Partnerships: Continued delivery of the Partnerships Program in all eight regions.
- Extended Services: Enhancement of job placement and job coaching services for individuals diagnosed with a serious mental illness assisting them with obtaining and maintaining employment.

STAFFING: The regional human service centers employ approximately 830 FTE's. These include licensed clinical psychologists, licensed professional counselors, licensed addiction counselors, licensed certified/independent clinical social workers, occupational therapists, early childhood specialists, marriage and family therapists, vocational specialists, case managers, psychiatrists, and nurses. In addition, the Division of Mental Health and Substance Abuse Services employs twenty staff to oversee the mental health and substance abuse service system in North Dakota.

TRAINING: Mental health block grant dollars are also used to provide training to mental health professionals through the State concerning issues and innovations in the field. For instance, block grant dollars are used to fund the Clinical Forum on Mental Health Conference, Wraparound certification training, evidence-based practices training, and supports the annual Family-Based Services Conference, and the Indian Child Welfare Act Conference.

As required by block grant law, training will also focus on the recognition of psychiatric symptoms and strategies for dealing with situations resulting from psychiatric symptomology specifically targeted towards emergency personnel including emergency medical technicians, physicians, and law enforcement. The Division will collaborate with the North Dakota Law Enforcement Training Academy to train first responders.

North Dakota

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

EMERGENCY SERVICES PROVIDER TRAINING
ADULTS AND CHILDREN

As required by block grant law, training will also focus on the recognition of psychiatric symptoms and strategies for dealing with situations resulting from psychiatric symptomology specifically targeted towards emergency personnel including emergency medical technicians, physicians, and law enforcement. The Division will collaborate with the North Dakota Law Enforcement Training Academy to train first responders.

Mental health block grant dollars are also used to provide training to mental health professionals through the State concerning issues and innovations in the field. For instance, block grant dollars are used to fund the Clinical Forum on Mental Health Conference, Wraparound certification training, evidence-based practices training, and supports the annual Family-Based Services Conference, and the Indian Child Welfare Act Conference.

North Dakota

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Mental Health Block Grant 2008 Budget
October 2008 - September 2009

	TOTAL BUDGET		POPULATION BREAKOUT	
			Child	Adult
Transformation Activities		**$ 337,500.00**		
Supported Employment Pilot	$ 7,500.00		$ -	$ 7,500.00
Aging Mental Health	$ 30,000.00		$ -	$ 30,000.00
IDDT Pilot	$ 25,000.00		$ -	$ 25,000.00
Mental Health Recovery	$ 15,000.00		$ 7,500.00	$ 7,500.00
Suicide Prevention	$ 5,000.00		$ 2,500.00	$ 2,500.00
Consumer Network	$ 60,000.00		$ -	$ 60,000.00
Parent to Parent Support	$ 75,000.00		$ 75,000.00	
Voluntary Treatment	$ 75,000.00		$ 75,000.00	
Trauma-Focused EBP	$ 40,000.00		$ 20,000.00	$ 20,000.00
Anti Stigma	$ 5,000.00		$ 2,500.00	$ 2,500.00
Training		**$ 84,104.00**		
MH Clinical Forum	$ 50,000.00		$ 25,000.00	$ 25,000.00
EBP Training	$ 23,104.00		$ 11,552.00	$ 11,552.00
Wraparound Training	$ 6,000.00		$ 6,000.00	$ -
Emergency Services Training/Primary Care	$ 5,000.00		$ 2,500.00	$ 2,500.00
Planning Council	$ 20,000.00	**$ 20,000.00**	$ 10,000.00	$ 10,000.00
Carry Out the Plan	$ 33,317.00	**$ 33,317.00**	$ 16,658.50	$ 16,658.50
Evaluating the Plan	$ 17,800.00	**$ 17,800.00**	$ 8,900.00	$ 8,900.00
HSC Partnerships	$ 216,503.00	**$ 216,503.00**	$ 216,503.00	
Extended Services	$ 70,000.00	**$ 70,000.00**		$ 70,000.00
Total	**$ 779,224.00**	**$ 779,224.00**	**$ 479,613.50**	**$ 299,610.50**

North Dakota

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

John Hoeven, Governor

Randy Solem, Vice Chair

August 25, 2008

Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20850

Dear Ms. Orlando:

On July 31st and August 1st of 2008, the MHPC met to review and discuss the 2009 Community Mental Health Services Block Grant application. The application was drafted, prior to the meeting, by the staff of the Department of Human Services' (DHS) Division of Mental Health and Substance Abuse.

As you are aware, in July of this year North Dakota participated in a CMHS Mental Health Block Grant site review. A written report has not yet been made available but Division staff reported that reviewer feedback at the exit conference on July 24th was very positive. While areas of strength as well opportunities were provided by the reviewers, it was relayed that "exceptional areas of note" included:

- The Division's collaboration with other stakeholders is exceptional;
- The use of blended funding to provide services is good;
- The use of electronic records is exceptional;
- The use of tele-health to provide services in rural areas is good;
- Planning and outreach to tribal areas and veterans is good;
- The implementation of evidence-based practices is very good;
- The continued development of the Planning Council is good;
- There is a comprehensive array of services at the human service centers;
- Workforce planning and cultural competence efforts are good;
- Plans to include youth on the planning council are exceptional;
- Recovery and related philosophy is seen in consumers.

In addition to the positive attributes listed above, the MHPC is impressed with many other aspects of the system of the delivery mental health services. Of significant importance is the decrease in the number of admissions to the N.D. State Hospital. The annual Mental Clinical Forum is also a highlight. This year the concept and format for writing Mental Health Advance Directives was introduces to individuals with mental

c/o 1070 Enterprise Ave #5 – Dickinson ND 58601
701-260-3427 (Phone) * E-mail: irving@pop.ctctel.com

illness, case managers, and mental health professionals. It received a positive response and support for its use.

The Continuum of Care project has been a creative endeavor of the Division of Mental Health and Substance Abuse Services. It was established to analyze and enhance the system of care for adults with serious mental illness with an emphasis on community-based care. It consisted of two phases: the distribution of a statewide community needs assessment and a series of planning meetings with a group of stakeholders representing consumers of mental health services, agency partners, DHS staff, and MHPC members. The top priorities identified and being pursued are: 1) housing/supervised housing options; 2) peer support, socialization, & recreation; and 3) enhancement of community-based options, crisis/mobile services, & advance directives. The MHPC is excited with the work as well as the future outcomes that are expected from this project.

The MHPC recognizes the significant needs for mental health outreach to the State's largest minority population, American Indians, and specifically to those on the reservations which are in rural settings. At one of its meetings, the MHPC had a presentation on the mental health services available on each reservation in North Dakota. Discussion was focused on the overwhelming needs on Standing Rock reservation where there is a big void in mental health intervention services and a high suicide rate. The MHPC is advocating for funding to support internships for psychologists on the reservation. This could be done in partnership with West Central Human Service Center (which also serves Standing Rock) and Indian Health Services. There are existing partnerships with these entities but not in terms of shared funding. Financial support for internships is a good investment in terms of the return in services. A single intern will yield 2,000 hours of work in a calendar year at a cost of $25,000. This can also be a practical tool for potentially recruiting psychologists to stay and work in North Dakota as well as training them to be culturally competent in the delivery of mental health services.

The MHPC believes that more resources need to be provided for children's mental health services along with advocacy and family-to-family support. This was discussed at length during a recent meeting. The model in place for service delivery is effective but insufficiently funded to meet the needs.

In our rural and sparsely populated State, problems with transportation continue. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel. Round-trips of 200-300 miles or more to obtain services are not uncommon. More people are moving from the rural areas to the urban areas to be closer to needed services. There are several state-wide initiatives to study this

problem. The MHPC remains hopeful that some answers will be forthcoming and practical solutions implemented.

There is a new model for housing that includes support services, which was recently been put into place in Williston. This is a community with high unmet needs for housing as it's at the center of oil activity. The project was developed specifically for adults with mental illness. Each resident has their own apartment along with shared space for socialization and some of the meals. It is a unique model for North Dakota and may be an answer to unmet housing needs in other communities while, at the same time through the support services, helping individuals to stay out of the hospital.

The MHPC appreciates the work of the Division of Mental Health and Substance Abuse in drafting the block grant application as well as its facilitation of the review, discussion, and recommended revisions. Following these activities, the MHPC approved the 2009 Community Mental Health Services Block Grant application. The MHPC will continue to work collaboratively with the Division in pursuit of creative solutions to best meet the needs to individuals with mental illness of all ages.

If you have questions, please feel free to contact me at 701-260-3427. Thank you.

Sincerely,

Randy Solem

Randy Solem
Vice Chair
North Dakota Mental Health Planning Council

North Dakota

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.