

North Dakota

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/31/2015 4.01.26 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 802743534

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name North Dakota Department of Human Services

Organizational Unit Division of Mental Health and Substance Abuse Services

Mailing Address 1237 West Divide Avenue, Suite 1C

City Bismarck

Zip Code 58501

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Pamela

Last Name Sagness

Agency Name North Dakota Department of Human Services - Behavioral Health Division

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 58501

Telephone 701-328-8824

Fax 701-328-8969

Email Address psagness@nd.gov

State CMHS DUNS Number

Number 802743534

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name North Dakota Department of Human Services

Organizational Unit Behavioral Health Division

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 50501

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Pamela

Last Name Sagness

Agency Name ND Dept. of Human Services - Behavioral Health Division

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 58503

Telephone 701-328-8824

Fax 701-328-8969

Email Address psagness@nd.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Lauren

Last Name Sauer

Telephone 701-328-8733

Fax 701-328-8969

Email Address lsauer@nd.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
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Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 Coastal 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Maggie D. Anderson

Signature of CEO or Designee¹: _____

Title: Executive Director - ND Dept. of Human Services

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.



— State of —
North Dakota
Office of the Governor
Jack Dalrymple
Governor

July 1, 2013

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As Governor of North Dakota, I hereby designate Maggie D. Anderson, Executive Director of the North Dakota Department of Human Services, to make any and all assurances required by the Public Health Services Act for the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance in Transition from Homelessness Grant. This designation shall remain in effect as long as I am Governor of North Dakota and Ms. Anderson is the Executive Director of the North Dakota Department of Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to the Director of the department's Division of Mental Health and Substance Abuse Services, 1237 West Divide Avenue, Suite 1C, Bismarck, ND 58501-1208.

Sincerely,


Jack Dalrymple
Governor

37:63:71

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
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 and
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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.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Maggie D. Anderson

Signature of CEO or Designee¹: Maggie D. Anderson

Title: Executive Director - ND Dept. of Human Services

Date Signed: 7/28/2015
mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



— State of —
North Dakota
Office of the Governor
Jack Dalrymple
Governor

July 1, 2013

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As Governor of North Dakota, I hereby designate Maggie D. Anderson, Executive Director of the North Dakota Department of Human Services, to make any and all assurances required by the Public Health Services Act for the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance in Transition from Homelessness Grant. This designation shall remain in effect as long as I am Governor of North Dakota and Ms. Anderson is the Executive Director of the North Dakota Department of Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to the Director of the department's Division of Mental Health and Substance Abuse Services, 1237 West Divide Avenue, Suite 1C, Bismarck, ND 58501-1208.

Sincerely,


Jack Dalrymple
Governor

37:63:71

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Signature of CEO or Designee¹: Maggie D. Anderson

Title: Executive Director - ND Dept. of Human Services

Date Signed: 7/28/2015
mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
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 as required by
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Signature of CEO or Designee¹: _____

Title: Executive Director - ND Dept. of Human Services

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— State of —
North Dakota
Office of the Governor
Jack Dalrymple
Governor

July 1, 2013

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As Governor of North Dakota, I hereby designate Maggie D. Anderson, Executive Director of the North Dakota Department of Human Services, to make any and all assurances required by the Public Health Services Act for the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance in Transition from Homelessness Grant. This designation shall remain in effect as long as I am Governor of North Dakota and Ms. Anderson is the Executive Director of the North Dakota Department of Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to the Director of the department's Division of Mental Health and Substance Abuse Services, 1237 West Divide Avenue, Suite 1C, Bismarck, ND 58501-1208.

Sincerely,


Jack Dalrymple
Governor

37:63:71

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

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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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Maggie D. Anderson

Signature of CEO or Designee¹: Maggie Anderson

Title: Executive Director - ND Dept. of Human Services

Date Signed: 7/28/2015
mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



— State of —
North Dakota
Office of the Governor
Jack Dalrymple
Governor

July 1, 2013

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As Governor of North Dakota, I hereby designate Maggie D. Anderson, Executive Director of the North Dakota Department of Human Services, to make any and all assurances required by the Public Health Services Act for the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance in Transition from Homelessness Grant. This designation shall remain in effect as long as I am Governor of North Dakota and Ms. Anderson is the Executive Director of the North Dakota Department of Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to the Director of the department's Division of Mental Health and Substance Abuse Services, 1237 West Divide Avenue, Suite 1C, Bismarck, ND 58501-1208.

Sincerely,


Jack Dalrymple
Governor

37:63:71

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 Coastal 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

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Name of Chief Executive Officer (CEO) or Designee: Maggie D. Anderson

Signature of CEO or Designee¹: Maggie Anderson

Title: Executive Director - ND Dept. of Human Services

Date Signed: 7/28/2015
mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

STEP 1: ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS.

The following information provides an overview of North Dakota's behavioral health prevention, early identification, treatment, and recovery support systems. It gives a general overview of the state's demographics, the structure of the system of care, and initiatives that have been developed to strengthen services.

GENERAL STATE DEMOGRAPHICS

North Dakota is a rural, frontier state with an area of 72,000 square miles and a population of 689,781 (U.S. Census Bureau, 2009-2013 American Community Survey 5 Year Estimates). The largest city in the state is Fargo, which has an estimated population of 108,371 persons. The majority of North Dakotans (53 percent) reside in the top four populated counties (Cass, Burleigh, Grand Forks, and Ward). The Red River Valley area along the North Dakota-Minnesota border encompasses roughly one-third of the State. In fact, nearly two thirds of the State's population resides in this narrow corridor. In comparison, the western half of the State has a population density from 0.9 to 10.7 persons per square mile. Thirty-six of fifty-three counties are designated frontier areas, having less than seven persons per square mile. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel.

Persons 60 years of age and older comprise 20% (138,105) of North Dakota's population (689,781) based on the U.S. Census Bureau, 2009-2013 American Community Survey 5 Year Estimates. The Department's publication "Aging Is Everyone's Business," December 2010, predicts that a population shift of persons 60 years of age and older from rural to urban North Dakota communities is expected from 2000 to 2030. In 2000, persons 60 years and older living in rural areas was 74,706 (63 percent) as compared to persons 60 years and older living in urban areas at 44,279 (37 percent). By 2030, there is a population shift in this age group where 45 percent will be living in rural communities and 55 percent will live in urban communities. Growth is expected in the older population through 2050 with the first Baby Boomer reaching age 65 (Baby Boomers include anyone born between 1946 and 1964) in 2011; in 2030, all Baby Boomers will be between ages 65 and 84 and the population 65 and older will comprise about 25 percent of North Dakota's total population and by 2050, Baby Boomers will be age 85 and older. Additional information from the 2012 Statewide Housing Needs Assessment Briefing Points indicates in 2025, residents ages 65 and older are projected to be 18 percent of the total population, up from 14 percent in 2010.

American Indians represent the largest minority population in North Dakota (5.3% or 36,659 race alone). It is projected that the American Indian population (one race only) in North Dakota will be 59,000 in 2025. According to the North Dakota Indian Affairs Commission, "...almost 60 percent (of the current population) lives on reservations and over 40 percent of these American Indians are under the age of 20."

There are four federally recognized Indian tribes represented in the state: Mandan, Hidatsa, & Arikara Nation (Three Affiliated Tribes) consisting of six segments with a total population of 6,341 on Fort Berthold Reservation; Spirit Lake Sioux Tribe consisting of four districts with a total population of 4,238 on Spirit Lake Reservation; Standing Rock Sioux Tribe (bestrides North Dakota and South Dakota) consisting of eight districts with a total population of 8,217 on Standing Rock Reservation (4,153 ND side only); and Turtle Mountain Band of Chippewa Indians consisting of four districts with a total population of 8,656 residing on the Turtle Mountain Reservation. ⁱ

The western half of North Dakota consists of many small communities spread across thousands of acres of farmland, with farming as one of the main sources of income. A “Virginia-sized”, 24,000 square mile, oil reserve of an estimated 4.3 billion barrels lies 10,000 feet below the surface of western North Dakota creating an “oil boom.” Production rates of ND oil began to rise in 2004, but increased dramatically in 2007 with advancements in technology and higher oil prices. With all the royalties from the produced oil, it is calculated by the University of North Dakota that two millionaires are made each day. According to Job Service North Dakota, the state employment agency, the annual salary of employees in ten oil-patch counties has increased to an average of \$73,934.

The Bakken/Three Forks oil field has impacted North Dakota. While the 2010 Census lists the North Dakota population as 672,591, the Bureau estimated the 2014 population to be 739,482. According to a Hodur and Bangsrund (2013), just over 18,000 people resided in the Williston area in 2010. It is predicted that this will increase to nearly 54,000 people by 2017. The rapid growth has resulted in increased cost of living. According to the Associated Press (2014), Williston had the highest average rent in the U.S., at nearly \$2,400 a month for a one-bedroom apartment, which is higher than New York City's and Los Angeles' average rates. Individuals are moving to North Dakota looking for high paying oil field work only to find that affordable housing does not exist. Homelessness is often a result. According to Reuters (2015), though the fall in oil prices has led to a decline in housing demand and rental costs, the demand for housing still outpaces the supply in western North Dakota.

There are 56,770 veterans in North Dakota, comprising approximately 11% of the adult population.¹ North Dakota has two Air Force Bases which consist of 8,206 active duty and civilian personnel.² As of May 2012, a total of 10,095 North Dakotans have been deployed since the 2001 terrorist attacks on America.³

¹U.S. Census Bureau 2012 American Community Survey 1-Year Estimates

²2009-2013 American Community Survey 5-Year Estimates

³U.S. Department of Defense, Department of Manpower Data Center. (Dependent Data as of August 2012) (Deployment Data as of May 2012)

STRUCTURE OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

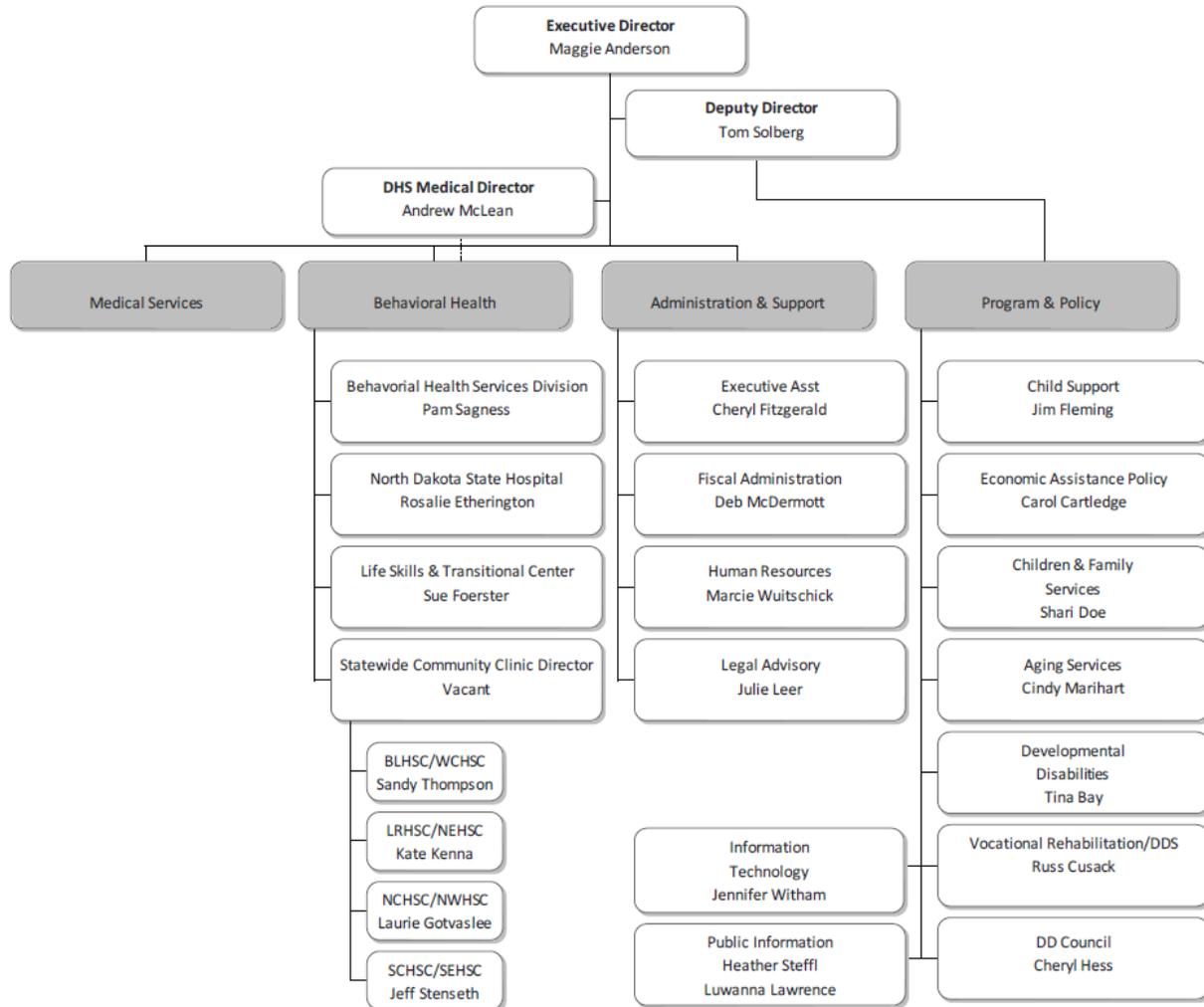
The North Dakota Department of Human Services: The Department of Human Services is the State governmental administrative agency that provides services to assist vulnerable North Dakotans of all ages maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional 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 2,200 employees, the Department of Human Services is organized into four major subdivisions consisting of Medical Services, Behavioral Health, Administration & Support, and Program & Policy. 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 Department, through the ND State Hospital, Life Skills and Transition Center and Statewide Community Clinics (Human Service

Centers), is also a direct provider of human services and the state institution for individuals needing inpatient psychiatric services.

Please see the Department’s Organizational Chart below.

North Dakota Department of Human Services

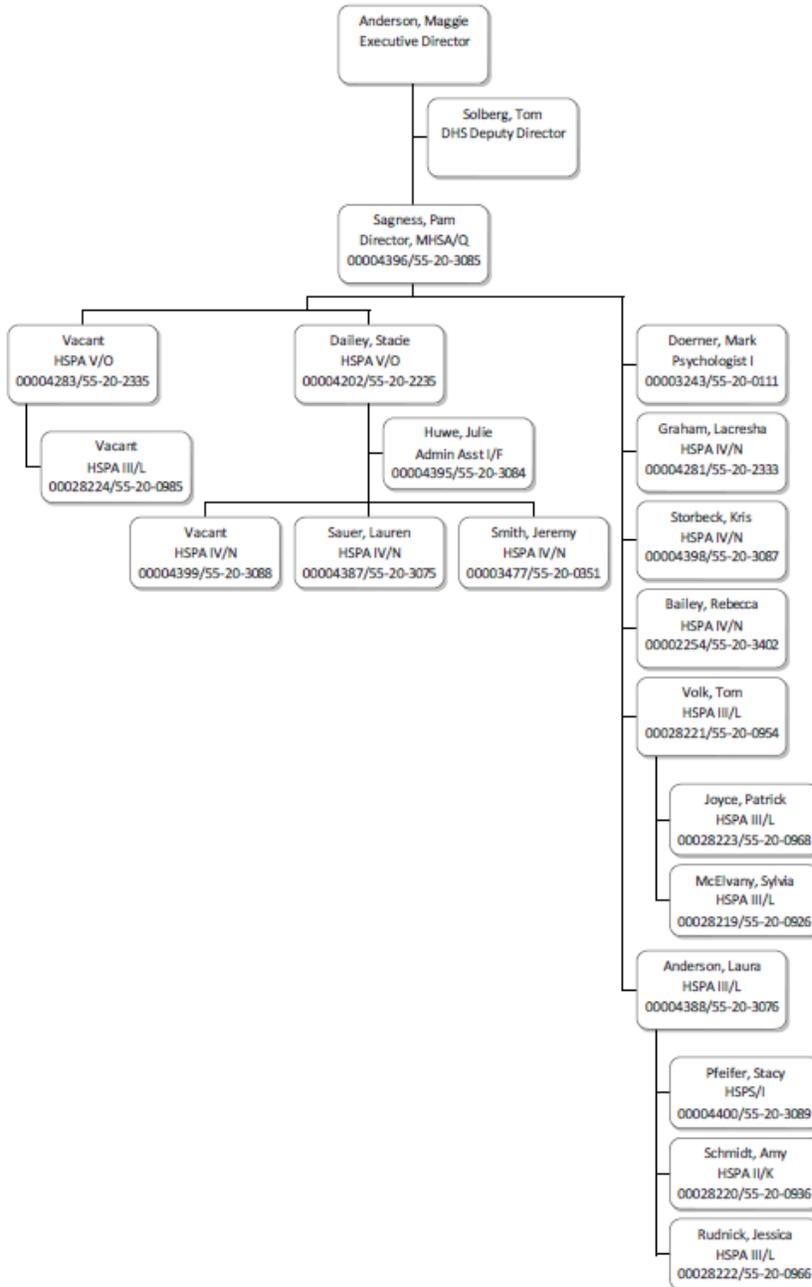


Effective Date: 06-01-2015

The Behavioral Health Division: The Behavioral Health Division (see organizational chart below) is a part of the Behavioral Health subdivision of the Department of Human Services. The Division serves as the State Mental Health Authority, State Substance Abuse Authority, and the State Opioid Treatment Authority. It provides leadership to the field in substance abuse prevention and in developing systems and models of care for mental illness and substance abuse, including dual diagnosis (mental health/substance abuse). The role of the Division is to ensure health and safety, access to services, and that the available services are quality. 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.

North Dakota Department of Human Services
Behavioral Health Division



More specially, the Division's core functions are:

- Regulation: The Behavioral Health Division is responsible for licensing all substance abuse treatment programs in North Dakota, the regional human service centers, opioid treatment programs, DUI seminar programs, and all psychiatric residential treatment facilities for children.
- Administration: The Division develops behavioral health policies for the State of North Dakota and oversees the implementation of behavioral health programs. Implementation of these programs and policies is often a function of the service delivery arm of the Department (ND State Hospital and Community Clinics [Human Service Centers]). The Division also serves as a liaison between the Federal government, state/local entities, and the citizens of North Dakota. The Division administers such programs as TBI services, First Episode Psychosis services, problem gambling, and recovery events. As the SSA, the Division acts as the primary organization to administer funding related to substance abuse prevention. This includes the administration of the SAPT BG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The Division also administers the SPF SIG and will be administering the SPF-PFS.
- Workforce Development: The Division provides training, technical assistance and consultation concerning best practice behavioral health prevention, intervention and treatment services to North Dakota citizens, behavioral health professionals, and behavioral health organizations (both public and private). The Division funds and assists in the planning for the semi-annual Behavioral Health Conferences, each of which are attended by over 300 behavioral health stakeholders. The Division is also in the process of training two staff to provide the Substance Abuse Prevention Skills Training (SAPST) on a regular basis to individuals working in community-level prevention across the state. Through the SPF SIG (and continuing through the SAPT BG), the prevention system's training and technical assistance staff has enhanced their capacity to provide trainings and technical assistance on the Strategic Prevention Framework and evidence-based strategies..
- Behavioral Health Promotion and Prevention: The Division encourages the creation of environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Because of the state's rural/frontier population, communication efforts can easily and effectively be implemented across the state. The ND Prevention Resource and Media Center (PRMC) acts as the primary vehicle which delivers messages supporting substance abuse prevention, and with the recent focus on shared risk and protective factors, overall behavioral health. Communication efforts center on altering the community norms to be less accepting of high-risk behaviors, including underage drinking, adult binge drinking and prescription drug abuse. One example of a key behavioral health promotion and prevention initiative is the Parents LEAD program. Parents LEAD (Listen, Educate, Ask, Discuss) is a ND, evidence-based underage drinking prevention program, founded on risk and protective factors, targeting parents through statewide, web-based communication. Also, prescription drug abuse prevention communication efforts funnel through this function. The Division has collaborated with the Attorney General's office and the ND Board of Realtors to enhance communication of reducing access to prescription drugs. This work will continue throughout this upcoming SAPT BG planning period.
- Partnerships: The Behavioral Health Division works closely with a number of entities to ensure that quality, efficient, and effective behavioral health services are available statewide. These include (but not limited to) the Behavioral Health Planning Council, TBI Advisory Group, and the Problem Gambling Advisory Council. The ND Substance Abuse Prevention System leads and is a participant in

many state-level partnerships in an effort to eliminate duplication of services and streamline goals. These partnerships include all levels, from department directors (Governor’s Prevention Advisory Council), to program administrators (Prevention Expert Partners Workgroup), to data analysts (State Epidemiological Outcomes Workgroup). Other partners include the ND Cares Coalition, the Non-Medical Use of Pharmaceuticals Task Force, Healthy ND, ND Board of Realtors, Indian Affairs Commission, Injury Prevention coalition, and the State Suicide Taskforce.

■ **The Regional Human Service Centers:** The North Dakota Department of Human Services operates eight regional human service centers, listed below. Each serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services, and other human services.

The Regional Human Service Centers are the access point for State Hospital admissions. Human service center employees also provide direction and oversight for services offered through county social service offices and other providers. Crisis lines are answered 24 hours a day, seven days a week. Contact information, including the counties served, is provided below.

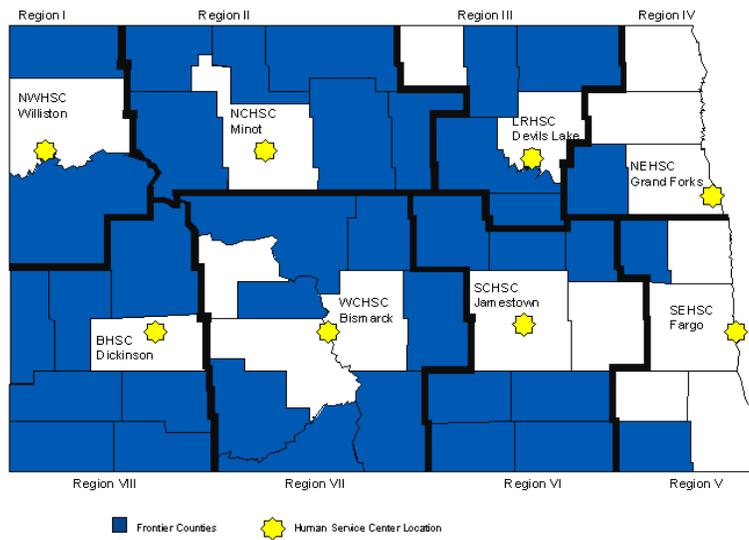
Delivering human services involves a partnership between the Department, counties, tribes, and service providers. In addition to providing direct services themselves, the regional human service centers also contract with private non-profit providers for crisis residential services, most residential services, as well as the Recovery Centers.

Regional Human Service Center Contact Information

<p>Region I: Northwest Human Service Center - Williston 316 2nd Ave W, PO Box 1266, Williston, ND 58802-1266</p> <p><i>Counties served for human service programs: Divide, McKenzie, and Williams.</i></p>	<p>701-774-4600 Fax: 701-774-4620 Toll Free (ND only): 1-800-231-7724 Crisis Line: 701-572-9111 TTY: 701-774-4692 E-mail: dhsnwpsc@nd.gov</p>
<p>Region II: North Central Human Service Center - Minot 1015 S. Broadway, Suite 18, Minot, ND 58701</p> <p><i>Counties served for human service programs: Bottineau, Burke, McHenry, Mountrail, Pierce, Renville and Ward.</i></p>	<p>701-857-8500 Fax 701-857-8555 TTY: 701-857-8666 Crisis Line: 701-857-8500 OR Toll Free 1-888-470-6968 E-mail: dhsncpsc@nd.gov</p>
<p>Region III: Lake Region Human Service Center - Devils Lake 200 Hwy 2 SW, Devils Lake, ND 58301</p> <p><i>Counties served for human service programs: Benson, Cavalier, Eddy, Ramsey, Rolette, and Towner.</i></p>	<p>701-665-2200 / Toll Free: 888-607-8610 Fax: 701-665-2300 TTY: 701-665-2211 Crisis Line: 701-662-5050 E-mail: dhsnrpsc@nd.gov</p>
<p>Outreach Office - Rolla 113 Main Ave. East, Rolla, ND 58367-0088</p>	<p>701-477-8272 Fax: 477-8281</p>

<p>Region IV: Northeast Human Service Center - Grand Forks 151 S 4th St Suite 401, Grand Forks, ND 58201-4735</p> <p><i>Counties served for human service programs: Grand Forks, Nelson, Pembina, and Walsh.</i></p>	<p>701-795-3000 Fax: 701-795-3050 TTY: 1-800-366-6889 Crisis Line: 701-775-0525 or -0526 OR 1-800-845-3731 E-mail: dhsnehsc@nd.gov</p>
<p>Outreach Office 5th & School Road, Grafton, ND 58237</p>	<p>701-352-4334 Toll Free: 888-845-2215</p>
<p>Region V: Southeast Human Service Center - Fargo 2624 9th Ave South, Fargo, ND 58103-2350</p> <p><i>Counties served for human service programs: Cass, Ransom, Richland, Sargent, Steele and Traill. Day care licensing services are provided to Barnes, Cass, Dickey, Eddy, Foster, Griggs, LaMoure, Logan, Ransom, Richland, Sargent, Steele, Traill, and Wells.</i></p>	<p>701-298-4500 Fax: 701-298-4400 Toll Free: 1-888-342-4900 Crisis Line: 701-298-4500 Suicide Prevention: 1-800-273-TALK (8255) E-mail: dhssehsc@nd.gov</p>
<p>Region VI: South Central Human Service Center - Jamestown 520 3rd St NW, Box 2055, Jamestown, ND 58402</p> <p><i>Counties served for human service programs: Barnes, Dickey, Foster, Griggs, LaMoure, Logan, McIntosh, Stutsman, and Wells.</i></p>	<p>701-253-6300 Fax: 701-253-6400 TTY: 701-253-6414 Crisis Line: 701-253-6304 Toll Free: 1-800-260-1310 E-mail: dhsschsc@nd.gov</p>
<p>Region VII: West Central Human Service Center - Bismarck 1237 W Divide Ave Suite 5 Bismarck, ND 58501-1208</p> <p><i>Counties served for human service programs: Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux.</i></p>	<p>701-328-8888 Toll Free: 1-888-328-2662 Fax: 701-328-8900 TTY:1-800-366-6888 (Relay ND) Crisis Line: 701-328-8899 OR Toll Free 1-888-328-2112 E-mail: dhschwchsc@nd.gov</p>
<p>Region VIII: Badlands Human Service Center - Dickinson 300 13th Ave W, Suite 1, Dickinson, ND 58601</p> <p><i>Counties served for human service programs: Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark.</i></p>	<p>701-227-7500 Fax: 701-227-7575 Toll Free: 1-888-227-7525 Crisis Line: 866-491-2472 OR 701-290-5719 TTY: 701-227-7574 E-mail: dhsblhsc@nd.gov</p>

Regional human service center locations and frontier counties in North Dakota



Services provided at the regional human service centers are detailed below. Variation does occur dependent upon other area providers. However, there is a core set of services provided by all regional human service centers including:

Acute Clinical Services: Provided by a range of mental health professionals including social workers, psychologists, and case managers, Acute Clinical Services refers to individual, group, and family therapy that are generally short-term in nature. Therapists use varied approaches to therapy including cognitive-behavioral, Dialectical Behavior Therapy, 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.

Aging Services: The Aging Services Division, within the Department, provides administration and oversight of Older Americans Act and other federally funded programs including congregate and home-delivered meals, legal services, assistive safety devices, options counseling, health maintenance services, family caregiver support services, senior companion, ombudsman services, vulnerable adult protective services, and senior community service employment program. The Aging Services Division also provides administration and oversight for state funded dementia care services, guardianship establishment and telecommunications services.

The focal point for information, referral, advocacy, education, training, and program monitoring of programs and services is the Regional Aging Service Program Administrator (RASPA). At the regional level the RASPA is the lead staff for the Aging and Disability Resource – LINK, which connects older adults and people with physical disabilities and their family members to care options that can help them live as independently as possible and maintain their quality of life. Using a person-centered approach, the Aging and Disability Resource – LINK provides information and awareness through public education and information on long-term support options; assistance through long-term support options counseling, referral, crisis intervention, planning for future needs, and comprehensive assessment and support in accessing choice of services based on need.

Other Aging Services Division staff located at the regional human services centers provide services and support to include: a) vulnerable adult protective services (receive reports regarding abuse,

neglect/self-neglect, or exploitation of a "vulnerable adult"). A new law passed by the 2013 Legislature provides for the mandatory reporting of abuse or neglect of a vulnerable adult by any medical or mental health professional or personnel, law enforcement officer, firefighter, member of the clergy, or caregiver. It provides that any individual who is required to report the abuse or neglect of a vulnerable adult but fails to do so is guilty of an infraction. b) Licensure of adult foster care providers; c) Family Caregiver Support services (supportive services provided to caregivers of persons 60 years of age or older or to persons with Alzheimer's Disease or a related dementia regardless of age or to a grandparent or relative caregiver who is 55 years of age or older and who provide care for children younger than 18 or to an adult child with a disability who is 19-59 years of age). d) Long Term Care Ombudsman Program works with residents of long-term care facilities (skilled nursing facility, basic care facility, assisted living facility or swing-bed hospital) to investigate and resolve complaints to protect their health, safety, welfare, and rights.

Child Welfare Services: Staff members at the regional human service centers supervise, monitor, and provide technical assistance for programs that are delivered by the County Social Services such as: foster care for children; licensing of family foster care and residential child care facilities; child protection services (child abuse and neglect); family preservation services including respite care (contracted) and wraparound/safety - permanency fund.

The Child and Family Services Reviews (CFSR) are conducted by the Children's Bureau, within the United States Department of Health and Human Services, to help States improve safety, permanency, and well-being outcomes for children and families who receive services through the child welfare system. The Child and Family Services Reviews monitor States' conformity with the requirements of title IV-B of the Social Security Act. The first round of Child and Family Services Reviews took place between 2000 and 2004 and all States were required to implement Program Improvement Plans (PIPs). The Child & Family Service Reviews (CFSRs) are held in each of the eight regions and in Cass County using the federal CFSR Instrument annually. The Children and Family Services Division staff, including at least one member of the Children and Family Services Management Team, attends each regional CFSR and serves as a member of the Quality Assurance team. At least one Regional Supervisor from the Human Service Centers participates on each Quality Assurance team as well. Team reviewers were previously trained on the Child and Family Services Reviews instrument/review process and highly experienced reviewers were designated as Team Leads.

Specifically, the Child and Family Services Reviews measure seven outcomes and seven systemic factors. The outcomes measured include whether children under the care of the State are protected from abuse and neglect; whether children have permanency and stability in their living conditions; whether the continuity of family relationships and connections is preserved for children; whether families have enhanced capacity to provide for their children's needs; and whether children receive adequate services to meet their physical and mental health needs. The systemic factors measured by the Child and Family Services Reviews include the effectiveness of the State's systems for child welfare information, case review, and quality assurance; training of child welfare staff, parents, and other stakeholders; the services that support children and families; the agency's responsiveness to the community; and foster and adoptive parent licensing, recruitment, and retention.

Children's Mental Health Services: Available to children who have serious emotional disorders, the Partnerships Program uses the wraparound process to coordinate and provide services for children and their families. Services include: care coordination (partially contracted); case aide (contracted); respite care (contracted); parent aide; safe beds (contracted); flexible funding (contracted).

Crisis/Emergency Response 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. They are also the point of contact for the Department of Corrections and Rehabilitation to assist prisoners in transitioning to the community.

Developmental Disabilities Services: Services for individuals diagnosed with a developmental disability include: program management services (information and referral, client assessment program planning, quality enhancement, financial support for authorized services); regional program planning and development; regional administration of the individualized supported living, family support, family subsidy, and extended employment programs.

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.

Extended Care (SMI) Services: Community-based services for individuals with a serious mental illness include: serious mental illness case management services, serious mental illness homeless case management services, psychiatric nursing services, aftercare services, supported employment and mental illness extended services, supportive living services, community-based residential services, and case aide services.

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. Regional human service centers utilize telepsychiatry to bring psychiatric services to psychiatric shortage areas. These include psychiatric evaluations and medication reviews. Also, telepharmacy has been implemented in all regional human service centers and the State Hospital. A pharmacist has been employed at the State Hospital to provide expertise and support to the human service centers, resulting in efficiencies at the centers.

All clients who receive services from the public behavioral health system, including adults diagnosed with serious mental illness, children diagnosed with serious emotional disturbances, and individuals in

need of substance abuse treatment, 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.

Outreach: The service areas for the 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 behavioral health services. Outreach for substance use disorders services are provided in rural counties when feasible.

Each of the regional human service centers employs licensed counseling staff to work either full-time in outreach areas or sends a licensed addiction counselor to outreach areas regularly, based on need for services. The regional human service centers promote awareness of services to outreach areas through communication with referring agencies, county courts, regional health units and county social service agencies. Services are also discussed through the local media, regional human service center brochures, speaking engagements, listed in the directory of all ND licensed substance abuse treatment programs (listed first by region, then by city), on the web (including priority status), and in the phone book.

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 or substance use disorders.

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

Vocational Rehabilitation: Vocational Rehabilitation assists eligible individuals with physical or mental disabilities with obtaining or maintaining competitive, integrated employment.

Services Specific to Block Grant Priority Populations (SMI, SED, SUD) at the Regional Human Service Centers

Serious Mental Illness: 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: The mission of case management is to improve the quality of life and dignity of individuals with serious mental illness, utilizing a recovery-focused approach to care. All individuals presenting for services at the regional human service centers are screened during the intake or multidisciplinary case staffing to determine if they have a serious mental illness and meet criteria for case management services. Clients meeting the diagnostic and additional criteria are offered case management services. If consumers are interested in receiving such services, a case manager is assigned to work with them. The case manager begins the process of completing the Daily Living Activities (DLA-20): Adult Mental Health, a functional assessment with the client. The assessment focuses on 20 daily living activities. The completion of this assessment determines what areas of daily living the client needs assistance with, level of case management service, assists with

determining which services and supports the client wants and needs, and assists with the development of the person-centered treatment plan.

Case management assists consumers with accessing those identified services and to make informed choices about opportunities in the community. The case manager helps ensure timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services. Case management is provided in the environment of the consumer's choice. Overall, services are provided to assist individuals to live as independently as possible while reducing the need for inpatient hospitalization and decreasing the risk of harm to self or others.

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 of care and coordination of service provision for 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 assisting them with accessing new opportunities, 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 with consumers
 - To assure all interventions are planned and carried out in a real partnership between the consumer and team members.
- 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 operating the facility. The human service center provides case management as requested.
 - Supported Housing - Independent living arrangement with staff and financial support from the agency operating the facility. 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. The program operates with minimal staff supervision and through peer support.
- Recovery Centers: There is a mental health recovery center located in each of the eight regions of North Dakota. Each regional human service center contracts with a private entity to administer the centers. The purpose of the recovery centers is to offer an environment of learning that promotes wellness and personal growth designed to empower individuals in recovery to live more meaningful lives in the community. Recovery centers are member-operated and promote recovery through peer support, socialization, education, and training. By working together, members pursue life goals, build better lives for themselves, gain employment, maintain independence and become a part of their communities. The Recovery centers offer groups, activities and resources that will empower the members to work, volunteer, attend school or further enrich their lives as they work towards recovery.
- Supported Employment and Extended Service: Case management staff work closely with Vocational Rehabilitation to offer employment support services to consumers who desire to work. Those who go through the traditional VR Supported Employment Program transition into Extended Services. 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. In addition, the Department has implemented the evidence-based practice of Supported Employment in conjunction with the IDDT program at three of the eight regional human service centers. This model emphasizes rapid job search, zero exclusion and time-unlimited supports and has been met with very positive results. Individuals involved in the EBP model of Supported Employment can transition to extended services
- 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.

Serious Emotional Disorders: The North Dakota Department of Human Services was the first cohort of the System of Change Grant for children diagnosed with a serious emotional disorder. 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 included care coordination, respite care, non-hospital crisis, school-based day treatment, and intensive in-home therapy, all using the wraparound process. North Dakota continues to sustain core services developed through the grant effort.

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.

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 with 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 Behavioral Health Division 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 the Medicaid program and the application be approved by the Division. There were a total of 17 youth placed through this program from July 1, 2011 – June 30, 2013
- 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.
- 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 Individual Educational Plan 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.
- Transition to Independence Program: The Transition to Independence Program (TIP) started on July 1, 2011 and provides transition to independence process – wraparound case management services to transition aged individuals who are at risk between the ages of 14-24, at all eight of the Departments Human Service Centers. The Transition to Independence Program also provides technical assistance to service providers and community partners who are working with transition aged individuals to assist in guiding youth successfully into adulthood. As of June 3, 2013 there were 66 youth enrolled in TIP.

Substance Use Disorder: Substance abuse treatment services offered in North Dakota follow a continuum of care as identified in North Dakota Administrative Code (NDAC) Chapter 75-09.1. The full continuum of care of North Dakota licensed treatment programs ranges from assessment and early intervention services (such as the DUI Seminar, American Society of Addiction Medicine, Inc. (ASAM) level 0.5), outpatient services - adult and adolescent ASAM level 1, intensive outpatient treatment - adult and adolescent ASAM level 2.1, partial hospitalization/day treatment - adult and adolescent ASAM level 2.5, clinically managed low-intensity residential care - adult and adolescent ASAM level 3I.1, clinically managed medium-intensity residential care - adolescent ASAM level III.5, clinically managed high – intensity residential care - adult ASAM level 3.5, medically monitored high-intensity inpatient treatment - adolescent ASAM level 3.7, medically monitored intensive inpatient treatment - adult ASAM level 37, and social detoxification - ASAM Level 3.2-D. Clients are seen for an assessment or through

emergency services and then referred to the appropriate level of care, based on admission criteria as outlined in NDAC Chapter 75-09.1 and current ASAM criteria. All levels of care and the admission criteria for levels of care are based on the American Society of Addiction Medicine Criteria (ASAM) a nationally recognized standard. DUI Seminar and inpatient treatment are provided throughout North Dakota, but SAPT Block Grant funds are not used for the provision of these services.

Allocations from the SAPT Block Grant base funds for treatment services are allocated by a formula among the eight regional human service centers. Based on need, each center provides or contracts for appropriate services, offering a continuum of care.

A statewide need was identified for adolescent residential services in a centralized location. Funding was allocated to West Central Human Service Center with services provided at Youth Residential Services (YRS) contracted through Pride, Inc.

Needs were identified by three regional human service centers (West Central Human Service Center, Lake Region Human Service Center, and North Central Human Service Center) for the specific funding focusing on Native American populations. North Central Human Service Center uses these funds via a contract to provide services to Native Americans on Ft. Berthold Reservation/Three Affiliated Tribes. Lake Region Human Service Center contracts for services for Native Americans on Spirit Lake Nation/Reservation and Turtle Mountain Band of Chippewa Indian Reservations.

Additional Resources in the Public Behavioral Health System of Care

North Dakota State Hospital: The North Dakota State Hospital, located in 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 provides service to individuals aged 18 year and older and is utilized only when it has been determined by the regional human service center to be the most appropriate option. It serves as the safety net for the public system in North Dakota. The North Dakota State Hospital provides total care consisting of physical, medical, psychological, substance abuse, 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. The North Dakota State Hospital is recovery focused. 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. 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 Support is also active within the facility. Meetings are held each week and consumers are assisted with transitioning to peer support services in the community upon discharge. 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.

Implementation of an inpatient adaptation of IDDT at the State Hospital continues. As implementation continues, this level of inpatient programming greatly enhances continuity of care and transition when clients return to their home communities. Staff from the regional human service centers and the hospital work in close collaboration with consumers they have in common.

The sister facility to the State Hospital – the Life Skills and Transition Center – serves individuals diagnosed with an intellectual disability. Located in Grafton, the Life Skills and Transition Center provides outreach services through the Clinical Assistance, Resource, and Evaluation Service (CARES) team and the CARES Clinic. Services are provided to prevent admissions and readmissions and to assist in transitioning people to the community. In addition, a team of applied behavioral analysts deliver behavioral assessment and intervention services to people with intellectual disabilities throughout North Dakota, including individuals dually diagnosed with mental illness and intellectual disabilities.

The County Social Service Boards: There are fifty-three local county social service boards. 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 – throughout 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 (P&A), a vital service in North Dakota, ensures the quality of services provided to consumers. P&A is an independent state agency established in 1977 to advance the human and legal rights of people with disabilities. P&A strives to create an inclusive society that values each individual.

People served include infants, children and adults of all ages. The majority of funds for program operations are from federal grants. Additional support is provided by the State of North Dakota.

There is no cost for services, however, P&A does implement general eligibility requirements, including that the individual must reside within the State of North Dakota. P&A has eight different advocacy programs that serve individuals with disabilities:

1. Developmental Disabilities Advocacy Program
2. Mental Health Advocacy Program
3. Protection & Advocacy Project for Individual Rights
4. Protection & Advocacy for Beneficiaries of Social Security
5. Assistive Technology Advocacy Program
6. Help America to Vote Program (HAVA)
7. Protection and Advocacy for Individuals with Traumatic Brain Injury
8. Client Assistance Program

P&A's staff comes from a wide variety of backgrounds. They are all trained to be knowledgeable about service delivery systems and the legal rights of people with disabilities.

The Behavioral Health Division's Substance Abuse Prevention System: The North Dakota Substance Abuse Prevention System is data-driven, science-based, and follows a public health approach. Prevention services in North Dakota are delivered both directly by the SSA and through community organizations/groups/coalitions supported by the SAPT BG and other funding sources. Examples of services delivered directly by the SSA include the Prevention Resource and Media Center (PRMC), local training and technical assistance. In recent years, both of these services have expanded and been increasingly formalized. Training and technical assistance provision has become a key function of the substance abuse prevention system and the Prevention Resource and Media Center (PRMC) is often the vehicle the assistance is delivered.

Examples of services delivered at the community-level, supported by the SAPT BG and SSA, include funding to tribal prevention programs and other forms of community-level support. The Division's Substance Abuse Prevention System plans to enhance the level to which SAPT BG funds can be invested to support implementation of community prevention efforts that can achieve population-level changes. Both state and community-based processes are guided by the Strategic Prevention Framework. Through the state's SEOW, ND reviews available data to ensure services address the needs of diverse racial, ethnic and sexual gender minorities.

The Behavioral Health Division allocates approximately 25% of the SAPT BG primary prevention funding to support community-level prevention efforts on the four federally-recognized Native American reservations in the state. These Tribal Prevention Programs are required to follow the Strategic Prevention Framework as they provide culturally-appropriate substance abuse prevention coordination and implementation of evidence based programs, practices and strategies. This work is one of the strengths of the ND Substance Abuse Prevention System – longstanding collaboration with the tribes in the state.

The ND Substance Abuse Prevention System leads and is a participant in many state-level partnerships in an effort to eliminate duplication of services and streamline goals. These partnerships include all levels, from department directors (Governor's Prevention Advisory Council), to program administrators (Prevention Expert Partners Workgroup), to data analysts (State Epidemiological Outcomes Workgroup). Other partners include the ND Cares Coalition, the Non-Medical Use of Pharmaceuticals Task Force,

Healthy ND, ND Board of Realtors, Indian Affairs Commission, Injury Prevention coalition, and the State Suicide Taskforce.

Through the SPF SIG, substance abuse prevention has been integrated into Local Public Health units across the state. This integration has been beneficial to the state's community-level substance abuse prevention system in building a sustainable infrastructure that can continue substance abuse prevention efforts post-SPF SIG, and through continued support by the SAPT BG.

A continuing need of the state's substance prevention system is the development and maintenance of the community-level substance abuse prevention infrastructure, even with the enhancements in recent years. Local substance abuse prevention in the state is relatively new to the use of evidence-based strategies. The rural and frontier culture also presents barriers due to limited access to trained workforce and long distances to resources. There are limited prevention training opportunities in ND, professional prevention workforce shortages, and no statewide prevention specialist certification process. One gain, within the past two-three years, was the first two Master's in Public Health programs became available in the state.

North Dakota does not currently have a statewide licensing or certification program for the substance abuse prevention workforce. Also, a formal community coalition network, registration, training or certification process does not exist in the state. The Division is currently receiving support from CAPT regarding the development of a statewide coalition network system. This system will ensure coalition coordination, provision of additional prevention trainings, and increase sustainability of SPF efforts.

INITIATIVES OF THE BEHAVIORAL HEALTH SYSTEM OF CARE

The Behavioral Health Division, regional human service centers, and community partners have implemented a number of programs to strengthen the behavioral health system of care statewide. The following narrative highlights these initiatives:

Collaboration with Military Support Organizations: Increased demand for mental health and substance abuse services available in the public system will emerge as military personnel and their families feel more comfortable to seek services and/or exhaust services offered by the VA or other support systems. The North Dakota Department of Human Services has participated on the Inter-Service Family Assistance Committee (ISFAC) for the past five years. The Inter-Service Family Assistance Committee is a multi-agency committee dedicated to collaboration around the needs of military servicemen and women and their families.

The North Dakota National Guard, Office of Veterans Affairs and the VA are active participants on the Traumatic Brain Injury Advisory Committee and Traumatic Brain Injury Systems Workgroup. This collaboration provides the opportunity to stay abreast of all the efforts across the state and to share information about agency resources and services.

In past years, a number of training opportunities have been provided to staff on military related issues such as military culture and reintegration. Alan Fehr, PhD, with the North Dakota National Guard, has developed a curriculum on military culture that offers training and certification to civilian behavioral healthcare providers. Training sessions began in the Spring of 2013. In March of 2013, North Dakota was invited by SAMHSA to participate in the Service Members, Veterans, and Family Members Policy Academy. Two program administrators from the division are part of the team. These efforts support

the third SAMHSA Initiative for military families with the goal of support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services and outcomes are successful.

In January of 2015, Governor Jack Dalrymple established the North Dakota Cares Coalition. The North Dakota Cares (ND Cares) Coalition includes a broad spectrum of more than 40 service providers and partners whose work touches the lives of Service Members, Veterans, Families and Survivors. Members share a common interest in strengthening an accessible network of support across the state, even though each entity retains authority over its own programs and services. The ND Cares coalition is dedicated to the strengthening of an accessible, seamless system of support for service members, veterans, families and survivors in the state. The coalition's priority is behavioral health, defined as a state of mental and emotional being and/or choices and actions that affect wellness. First Lady Betsy Dalrymple chairs the coalition, and Kathleen Wrigley and Connie Sprynczynatyk serve as co-chairs. The Behavioral Health Division staff is represented on this coalition as well as the executive committee. A military data booklet was developed through the assistance of Behavioral Health Division staff to enhance the sharing of data showing behavioral health needs of the military population.

Evidence-Based Practices: North Dakota has made great strides in community-based behavioral health care. A number of evidence-based practices have been implemented across North Dakota.

- **Evidence-Based Prevention Strategies:** The North Dakota Substance Abuse Prevention System and all services provided through the SAPT BG follows evidence-based processes (the Strategic Prevention Framework) and supports the implementation of evidence-based strategies. Also, the ND Substance Abuse Prevention System follows SAMHSA's criteria for evidence-based prevention strategies and encourages the determination of "best fit", as not all evidence-based approaches are right for all communities. Training and technical assistance materials and tools are developed following these evidence-based guidelines as well.
- **Integrated Dual Disorder Treatment:** For the past eight years, Southeast Human Service Center has been providing Integrated Dual Disorder Treatment (IDDT) programming with clients diagnosed with serious mental illness and co-occurring substance abuse disorders. Clients are served by two teams for those who meet criteria for Quadrant 4: severe and persistent mental illness and chronic substance abuse. Between the two teams, 75-80 consumers are receiving services at any given time. Annual fidelity reviews/consultation continues to be conducted by consultants from the Center for Evidence Based Practices at Case Western Reserve University. Southeast Human Service Center continues to achieve high ratings. The fidelity action plan is revised based on the results and recommendations of the review to reflect ongoing work towards continued fidelity-to-model. All human service centers are serving clients who meet criteria for Quadrant 4 as described above.

The Behavioral Health Division, the regional human service centers, and a consultant from the Center for Evidence Based Practices at Case Western Reserve University, continues to work together to plan annual training for program leaders of the Integrated Dual Disorder Treatment programs. The goal of the annual training is to provide a learning environment for program leaders to discuss the challenges of implementation, gain knowledge and learn new skills.

Implementation of an inpatient adaptation of Integrated Dual Disorder Treatment at the North Dakota State Hospital continues. The hospital updates their action plan based on the results and recommendations of the fidelity reviews/consultations to reflect ongoing work towards continued

fidelity-to-model. As implementation continues, this level of inpatient programming greatly enhances continuity of care and transition when clients return to their home communities. Staff from the regional human service centers and the hospital work in close collaboration with consumers they currently have in common now.

- Matrix: In 2005, Human Service Center Directors and the Behavioral Health Division (BHD) made a decision to begin training clinicians on evidence-based practices. North Dakota began with the Matrix training. BHD worked with Prairielands Addiction Technical Transfer Center (PATTTC) to facilitate with UCLA to provide a two-day training of clinical staff and supervisors in Bismarck in April 2006. A second two-day MATRIX training for 20 clinicians and supervisors was held in May 2007. North Dakota sent 17 (11 in 2006 and 6 in 2007) supervisors to attend Key Supervisor Training at the Matrix Institute on Addictions. A third two-day MATRIX training for 20 clinicians and 18 supervisors was held in Bismarck in October 2012. The process of MATRIX certification and fidelity continues. North Dakota currently has 7 Matrix Certified programs at Northwest Human Service Center, North Central Human Service Center, Lake Region Human Service Center, Northeast Human Service Center, Southeast Human Service Center, South Central Human Service Center, and West Central Human Service Center. The MATRIX model of treatment is now offered in each regional human service center. Field Services Division is working with the Matrix Institute for continued training, maintaining Matrix Certified programs, and fidelity reviews for the MATRIX model of treatment.
- Motivational Interviewing: North Dakota partnered with Prairielands Addiction Technology Transfer Center (Prairielands ATTC) to provide training on Motivational Interviewing (MI) for clinical supervisors and clinicians for both mental health and addiction staff from the regional human service centers across North Dakota. Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. This training was designed to introduce the spirit of Motivational Interviewing and develop techniques in manifesting the spirit. Field Services Division is planning ongoing training and fidelity monitoring for motivational interviewing.
- Treatment Collaborative for Traumatized Youth (TCTY): In 2007, the Division initiated Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) as the two EBPs for children and families. The TCTY initiative is in collaboration with Dr. Steve Wonderlich, from the University of North Dakota Medical School Neuroscience Department. The Behavioral Health Division along with the Children and Family Services Division have made a commitment to support the continued implementation of evidence-based practices in both children's mental health and child welfare systems for the next two years (2011-2013). The SPARCS & TF-CBT trainings are sponsored and conducted by the Neuropsychiatric Research Institute in Fargo along with the UND School of Medicine and Health Sciences. All Clinicians that are trained in SPARCS & TF-CBT receive direct clinical supervision that occurs for one hour, two times per month, as part of the six month learning collaborative.

October 2011 – September 2012 the Treatment Collaborative for Traumatized Youth in conjunction with Dr. David Kolko conducted a one year learning collaborative for 14 human service clinicians and 6 intensive in home therapist in the treatment method of Alternative for Families – Cognitive Behavioral (AF-CBT). AF-CBT is evidence based practice, family-centered treatment designed to address family conflict, coercion and hostility, emotional abuse, and child physical abuse. AF-CBT teaches individual and family skills to strengthen family relationships and safety routines using coordinated and structured training methods. The goals of AF-CBT are to help family members

improve their communication and problem-solving skills, help parents learn skills to effectively support and discipline their children, and help children manage difficult emotions and respond more positively to challenges. These training methods seek to help family members improve their communication and problem solving skills, help parents to effectively support and discipline their children, and help children manage difficult emotions and respond more competently to interpersonal challenges.

Guardianship Services: Provides funds for guardianship petitioning costs for those individuals that meet the definition of incapacity and have income at or below 100 percent of the federal poverty level, or who are Medicaid eligible. The program has grown from \$40,000 in 2005 to \$352,500 for the 2015-2017 biennium.

Healthy North Dakota Early Childhood Alliance: The Behavioral Health Division continues to work closely with Healthy North Dakota Early Childhood Alliance (HNDECA). The Alliance is comprised of over 50 agency, parent and advocacy organization representatives, developed as part of efforts to build a comprehensive plan for early childhood in the state of North Dakota. To support families and communities in their development of children that are healthy and ready to learn at school entry, collaborations and partnerships are being built through the Healthy North Dakota Early Childhood Alliance.

Funding for this initiative, called the Early Childhood Comprehensive Systems (ECCS) Grant, is from the federal Health Resources and Services Administration (HRSA). The goal of the ECCS grant is to develop and implement collaborations and partnerships to support families and communities in their development of children, ages 0 to 8, who are healthy and ready to learn at school entry. The role of HNDECA was to oversee the process, to assure that it met federal guidelines and to be good stewards of the planning funds.

The five essential areas in the planning phase of this initiative include Access to Health Insurance and Medical Home, Mental Health and Social/Emotional Development, Early Care and Education/Childcare, Family Support and Parent Education. Some of the key goals developed include:

- To establish critical pathways, including checks and balances, for (childcare) licensure standards and practices to assure uniformity of delivery statewide.
- To assure that all North Dakota communities will involve families in planning and implementation of children's mental health programs and services.
- To increase the number of health and dental care provider practices that incorporate the seven medical home core components (care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective).
- To assure that all parents, and persons in a parental role, of children aged birth through eight have access to parenting education.

Medication Assisted Treatment: The Behavioral Health Division is currently developing a strategic plan for ensuring access to a full continuum of care including quality medication assisted treatment. Continued efforts to partner with community stakeholders will be a key step in planning and the implementation of strategies. Considerations will include creating and updating informational briefs and handouts to be disseminated to specified audiences. Training needs will be addressed through the Behavioral Health Conference, agency presentations, webinars, and other training and technical assistance opportunities.

Considerations will include updating the North Dakota Administrative Rules for Substance Abuse Treatment Programs. Efforts to advocate for access to Opioid Treatment Programs (OTPs) will remain an important consideration in planning as North Dakota does not have an operating OTP at this time. When OTPs are operating, the BHD is authorized to conduct licensing reviews for compliance with rules and regulations. The State Opioid Treatment Authority will remain current on guidelines for operation of OTPs and will incorporate guidelines into Administrative Rules as necessary.

Mental Health First Aid: In collaboration with SAMHSA's Regional Representative, the Behavioral Health Division participated in Mental Health First Aid train-the-instructor education. Two Division staff members are certified instructors. North Dakota has 16 certified instructors for adult Mental Health First Aid located in various agencies across the state. The Department of Public Instruction held a Youth Mental Health First Aid Instructor Certification training March 2-5, 2015. Sixteen people were trained as YMHFA Instructors. This brings the total number of trained YMHFA instructors to 17.

Network for The Improvement of Addiction Treatment (NIATX): In 2006, Behavioral Health Division staff and staff from two regional human service centers attended a process improvement orientation workshop. In 2008, North Dakota partnered with Prairielands Addiction Technology Transfer Center (Prairielands ATTC) to bring the NIATx project to North Dakota. Three regional human service centers are participating in this project (Northeast Human Service Center - NEHSC, Lake Region Human Service Center - LRHSC and Southeast Human Service Center - SEHSC). These providers are examining their admission process and paperwork requirements. The rapid cycle change process is being used. The four aims from NIATx are increase admissions, increase continuation of services, reduce no-shows and reduce waiting times. Changes made to processes so far include eliminating a redundant admission form at NEHSC, resulting in 20-30 minute time savings for the client at admission, implementing a walk-in immediate care 'clinic' at SEHSC, resulting in clients being seen when they have the most need. These three centers are discussing other strategies for a reduction in no-shows. LRHSC is one of three HSCs that has established a NIATx change team and started to implement NIATx continuous improvement efforts toward successful consumer strategies and processes. The NIATx approach forms another core asset to the implementation of the "Pathways to Recovery" application. All centers participated in the paperwork reduction initiative. Some human service centers continue to use the NIATX model to practice improvement. In 2013, three additional centers participated in a full NIATX project: West Central Human Service Center in Bismarck, Badlands Human Service Center in Dickinson, and South Central Human Service Center in Jamestown. In 2014 North Central Human Service Center in Minot and Northwest Human Service Center in Williston joined the practice improvement process.

Olmstead: For the past six years, the Behavioral Health Division has received Olmstead stipends from SAMHSA. Funds have been used to leverage other funding sources to assist in the implementation of the evidence based practices of Integrated Dual Disorder Treatment and Supported Employment, to underwrite recovery events for consumers, and support transition-aged youth in their goals towards independence, including youth stipends for the second annual transition conference hosted by the North Dakota Federation of Families in July of 2011. Division staff continue to participate in the North Dakota Olmstead Committee and participate in the revision of the Olmstead Plan. In 2013, the state participated in the Olmstead Academy to develop a strategic framework for North Dakota. The plan established three priorities which include access to access to housing options, competitive employment, and access to peer supports. The Olmstead Commission is currently in the process of blending the Olmstead Plan with the Policy Academy Strategic Framework and identifying five to six priorities to focus

on for the year. Please refer to Item 17: Community Living and the Implementation of Olmstead in the Environmental Factors and Plan for additional information.

Outreach to Homeless: 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 are limited. Some zoning laws in the state contain provisions that make it difficult to construct 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. 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.

North Dakota is experiencing rapid growth. The oil industry presence in the western part of the state is expanding. According to a Hodur and Bangsrund (2013), just over 18,000 people resided in the Williston area in 2010. It is predicted that this will increase to nearly 54,000 people by 2017. The rapid growth has resulted in increased cost of living. According to the Associated Press (2014), Williston had the highest average rent in the U.S., at nearly \$2,400 a month for a one-bedroom apartment, which is higher than New York City's and Los Angeles' average rates. Individuals are moving to North Dakota looking for high paying oil field work only to find that affordable housing does not exist. Homelessness is often a result. According to Reuters (2015), though the fall in oil prices has led to a decline in housing demand and rental costs, the demand for housing still outpaces the supply in western North Dakota.

The most recent Point-In-Time Survey (for which data was available) found 2,310 homeless persons in North Dakota including 1,627 adults and 683 children. Of these, 157 people were veterans, 395 were chronically homeless, and 2 were long-term homeless. One hundred and eighty-eight individuals reported mental illness issues and 149 reported a history of substance abuse. Due to the limitations with the survey, it is believed this data underrepresents the true picture of homeless in North Dakota.

Homelessness in North Dakota by Region (January 23, 2014)

	Adults	Children	Veterans	Chronically Homeless	Long-Term Homeless	Severely Mentally Ill	Chronic Substance Abuse
Region I	333	36	25	0	1	0	6
Region II	34	6	6	11	0	2	5
Region III	546	415	0	0	0	0	0
Region IV	163	27	31	66	0	12	30
Region V	256	74	66	302	0	118	80
Region VI	3	0	0	0	0	0	2
Region VII	290	122	23	16	1	56	26
Region VIII	2	3	6	0	0	0	0
Total - ND	1627	683	157	395	2	188	149

Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness Grant provide persons who are homeless or at risk of homelessness and are mentally ill or have a co-occurring mental illness and substance use disorder 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.

Person-Centered Treatment Planning: The Department has trained all clinicians on Person-Centered Treatment Planning. This model 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. Consumers are active participant in their treatment planning and treatment goals are documented in the consumer's own words.

Training on stages of change and stages of treatment serves to compliment the work occurring on person-centered treatment planning. Recognizing the importance of meeting the consumer where they are at, developing an open trusting relationship, and engaging consumers in their own care is critical to successful outcomes for consumers. This has been implemented statewide. A four-hour session on the training was offered at the 2011 Clinical Forum on Mental Health Conference. Staff from the regional human service centers, State Hospital, and various community providers were in attendance at the session. Clinicians providing services at the regional human service centers are beginning to complete a more formal "staging" of consumers as they work closely with them to develop treatment plans.

NDAC 75-09.1 requires substance abuse treatment programs to include in client records evidence of the direct involvement of the client in the decision-making process related to the client's program.

Recovery: The concept of recovery is the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-run services that comprise the Behavioral Health Division's system of care. Services within this system identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment encourages hope and emphasizes individual dignity and respect. As one of its foremost priorities, the Division promotes a recovery-oriented service system for persons at risk of, or who have psychiatric or substance use disorders.

The Division continually strives to address the needs of people over time and across different levels of disability, and to apply recovery principles to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles are applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders.

In partnership with the recovery communities, the Division is making revisions to existing policies, procedures, programs, and services, and ensuring that all new initiatives are consistent with a recovery-oriented service system. Future strategic planning and resource development efforts will build upon existing strengths and continue to move the Division in the direction of promoting recovery as a core concept. By doing so, the language, spirit, and culture of recovery will be embedded throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.

The Division strives to ensure the service system is notable for its quality, marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects are sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, attention is focused on ensuring the recovery-oriented service system is age and gender appropriate, culturally competent, and attends to trauma and other factors known to impact on one's recovery. Whenever possible, services are provided within the person's own community setting, using the person's natural supports. The goal is to help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

Recovery initiatives include the following:

- Recovery Month Events: The Behavioral Health Division developed a Recovery Month Event Toolkit in 2010. The purpose of the Toolkit is to assist communities with planning and funding Recovery Events held throughout the state. Recovery Month events provide a platform to celebrate people in recovery and those who serve them and serves to educate the public on substance abuse as a national health crisis, that addiction is a treatable disease, and that recovery is possible. Educating the public reduces the stigma associated with addiction and treatment. Involving community in advocacy and recovery celebrations helps change public perceptions of recovery, promote effective public policy and demonstrate that recovery is a reality for millions of Americans.

The Behavioral Health Division offers stipends to eligible applicants to assist with funding these events and each year rallies, runs, walks, sober social events and other activities are held to educate people in our state about long-term recovery, engage children and families in community-wide events, and demonstrate the joy and new life that goes along with recovery.

- Recovery Readiness Survey: The North Dakota Organizational Self-Assessment for Recovery-Oriented Person-Centered Practices for Adults with Mental Illness a.k.a. *The Recovery Readiness Survey*. The Behavioral Health Division partnered with the North Dakota Center for Persons with Disabilities to conduct a set of surveys to gather information from adults receiving mental health services in North Dakota and professional who administer mental health services in North Dakota. The resulting survey data guides efforts to provide and promote recovery-oriented person-centered mental health services throughout the state. The information is used to develop ways to promote recovery and provide ongoing improvements in the way mental health services are provided in North Dakota. The survey data helps identify what is working well in the current North Dakota Mental Health service system and also identifies challenges of the current system. The data helped to determine the level of recovery readiness of mental health service providers and guides implementation of best practices. This information assists state agencies, policymakers, and advocates to build on the current system of mental health services in North Dakota.
- Pathways to Recovery Survey: In a separate survey, the Department attempted to establish a baseline of how ready the state is to support people in substance use recovery using different pathways; identify next steps to providing better opportunities to people seeking Recovery; and capture gaps in the system. Out of a total of 3,950 surveys mailed out, 830 surveys were returned by April 27, 2012, yielding a response rate of 21.0%. Of the responses, 246 were submitted online and 584 were submitted through a paper-based survey. Survey respondents were given ten statements and asked to select the response they believed to be the most correct. Of the respondents that answer the questions,

- Over 90% (ninety percent) indicated they strongly agreed or agree with family, friends, and social networks are important for people to sustain their recovery (98.4%),
 - Having a visible and active group of people in recovery is a good thing for the local community (96.4%),
 - Individuals who abuse alcohol and drugs can make a full recovery and go on to lead a fulfilling life (96.9%), and
 - Negative life events can lead to excessive alcohol or drug use (96.1%) (Table 6).
 - Over fifty percent of respondents disagreed or strongly disagreed with the statement that individuals can choose to stop excessive drinking when they want (75.4%),
 - People can only begin to recover when they have hit ‘rock bottom’ (87.7%),
 - Recovery from alcohol abuse is different from recovery than drug abuse (60.2%),
 - In order for a person to achieve recovery, a person must complete a traditional substance abuse treatment program (81.2%).
- Telephone Recovery Support: The “Recoveree Connection”, North Dakota’s Telephone Recovery Support Program, was implemented statewide in June, 2008. The Department of Human Services contracts with Rehab Services, a private agency located in Minot, North Dakota to administer the program. The Recoveree Connection is a non-clinical, volunteer based, support service whereby individuals in recovery from substance use disorders receive telephone calls from trained telephone recovery support specialists, most of whom are peers in the process of recovering themselves. Volunteers provide a “check-in” with the person in the early stages of recovery and help the individual to access community supports that further support the person’s recovery in the community. For the year ending June 30th, 2015 there were 9,860 calls made to 1,133 individuals in recovery.
 - Peer Support: Peer Support Programs are located at each of the 8 Regional Recovery Centers, as well as the North Dakota State Hospital. Peer Support Services are consumer-centered with rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Services are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. Because of their life experience, peers have expertise that professional training cannot replicate. Peer Specialists foster their peer’s ability to make informed, independent choices; help their peers recognize, and build on their strengths; and help their peers get the information and support they need from the community to make their goals a reality. Peer Specialists perform a wide range of tasks to assist peers in attaining their recovery goals. Peer Specialists undergo certification training and complete the certification process developed and recognized by the North Dakota Department of Human Services. The Behavioral Health Division employs an individual who provides training to the Peer Support programs.
 - Consumer Family Network: The Behavioral Health Division provides funding to Mental Health America of North Dakota to administer the North Dakota Consumer Family Network (CFN). The CFN is a collaboration consisting of individuals, family members, and advocacy organizations dedicated to education, support, advocacy, and empowerment in the interest of promoting mental health. Goals of the CFN include consumers being well-informed of their choices and possibilities beyond those presently available and for mental health care to be consumer and family driven. Mental Health America of North Dakota and the Consumer and Family Network are members of the North

Dakota Mental Health and Substance Abuse Planning Council and provide input into the planning of the behavioral health system of care.

- **Recovery Mini Grants:** The Behavioral Health Division provides funding to eligible organizations for Recovery Mini-Grant projects that promote recovery for adults with substance abuse addiction disorders. The Recovery Mini-Grant program aims to improve community support for recovery from substance use disorders. The goals of the program are to achieve abstinence and improve health, wellness, and quality of life for those with alcohol and other drug addictions. The program is part of a larger statewide effort to develop a recovery-oriented system of care, which is individualized and builds on the strengths and resiliencies of individuals, families, and communities. This grant program strives to increase non-traditional recovery support services in North Dakota, including employment assistance, child care, care management, educational sessions, community recovery events, support groups, mentoring, and housing support. Innovative and creative approaches to support recovery are highly encouraged in the written application. Resulting projects funded by the program focus on ways to build upon the strengths of persons in recovery, to increase opportunities to contribute to the recovery community, or find innovative ways to support persons in recovery. Organizations eligible to apply for the grants include non-profit organizations, community, county, regional, multi-county, or statewide organizations, non-tribal and tribal government entities, and faith-based organizations. A review committee evaluates qualifying proposals and awards funding to organizations who meet the criteria set by the division. Heartview Foundation's "H.E.A.R.T." program is funded by the Division of Mental Health and Substance Abuse Service's Recovery Mini-Grant Program. H.E.A.R.T. (Helping Achieve Recovery Today) is a strengths-based education and support program for family members and those in recovery. The program consists of a series of educational and support sessions and an on-line family recovery network. The program capitalizes on each participant's strengths and will assist participants to discover the tools they need to reach their full potential.

Services to Individuals Who Have Sustained a Traumatic Brain Injury: North Dakota continues to sustain the work accomplished by the TBI Implementation Grant and facilitate the statewide TBI Advisory Committee and TBI Systems Workgroup. The systems development meetings serve as a venue for open discussions not only about service coordination and collaboration but more importantly about unmet needs of individuals with TBI and their family members. The result of ongoing meetings has the potential to influence ongoing decisions about services and system development.

Funds were appropriated in the 2013 Legislative session and again in the 2015 session for the Department to provide resource facilitation services for individuals with TBI. This funding will greatly enhance the development of a system of care to include informal supports, peer mentoring, resource facilitation, social/recreational opportunities, and pre-vocational skills and mentoring.

A TBI screening tool continues to be administered during the intake process at the eight regional human service centers. The screening tool has been integrated into the intake process for all consumers except those who apply for developmental disability services only. 13,793 individuals were screened the first year of the project. Of those screened, 10% indicated a possible TBI, 18% a mild TBI, 5% a moderate TBI, and 2% a severe TBI. According to self-report, clients indicated that moving vehicle accidents were the most common cause of their injury, followed closely by falls as the second most common cause of injury. The results of the screenings continue to provide vital information to clinicians to better understand who they are providing services to, improve treatment outcomes for consumers, and to provide data to DHS to utilize in future service and budget planning.

State and Regional Review Teams: When barriers are encountered while attempting to meet the needs of children and adults who present with unique and complex needs, the Division of Mental Health and Substance Abuse will facilitate the use of the Regional Review Teams and/or State Review Team processes.

The Regional Review Team is a team of administrators representing multiple systems, serving as a resource to local teams by assuring active consideration and utilization of all available state-wide community options & resources when assisting the local team with planning for individuals with complex needs. The Regional Review Team shares knowledge of available resources, engages in problem solving, provides recommendations, and assists with access to difficult to obtain resources.

If the barrier is not overcome at the regional level, the situation is referred to the State Review Team for response.

The State Review Team is a team of administrators representing multiple systems, available to assist Regional Review Teams with situations where all available options have been exhausted, yet the consumer continues to have unmet needs. The State Review Team meets on a monthly basis and attempts to address the barriers and gaps brought forward by the Regional Review Team, through creative problem solving and braiding together possible options.

The State Review Team is not a forum to resolve disputes or appeal system decisions or replace agency and/or system responsibilities.

Substance Abuse Treatment Contingency Management – Motivational Incentive Program: In 2008, DHS issued a policy on Contingency Management – Motivational Incentive Program describing the program, including targeted behaviors, methodology and rewards, and the process for monitoring and accountability for the program. Full implementation was completed at each of the regional human service centers by January 2009. The primary objectives of utilizing a motivational incentive program are to increase: retention rates; the number of people attending treatment programming; the number of clients who participate in vocational, educational, and/or community support programs; the number of clients who achieve employment; and the number of clients who attain drug-free status. The targeted behaviors are to be individualized and each client who participates in this program will have an entry in their treatment plan. A clearly defined “fishbowl” method is used as described in the policy. Most regional human service centers continue to utilize contingency management as an engagement strategy for consumers within the Matrix program (intensive outpatient/outpatient treatment program).

Transition Services: According to the U.S. Census Bureau, 2009-2013 American Community Survey 5 Year Estimates, North Dakota has had an increase in both child and adult populations. The Survey estimates revealed that the transition-aged youth population between the ages of 15 and 24 is at 110,917, which is an increase of 1,917 from the 2006 Census estimate of 109,000. With the transition aged population on the rise, so does the complexity of their needs.

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.

The Transition to Independence Program provides wraparound case management services to transition aged individuals between the ages of 14-24 who are at risk and who do not qualify for other case management services within the eight regional human service centers. As of June 1, 2013 the Transition to Independence Program has assisted 267 youth transition into adulthood. To assure the Department stays informed on the needs of this population, the Department has eight regional Transitions to Independence Subcommittees that report quarterly to the Statewide Transition to Independence Interagency Advisory Council.

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. 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.

Treatment of Problem Gambling: Treatment for individuals with a gambling disorder and their family is provided via contract with Gamblers Choice, a program of Lutheran Social Services of North Dakota. Funding for the treatment program is allocated by the North Dakota Legislature utilizing state general funds and proceeds from the state lottery. The program is required to provide services statewide to individuals and their family utilizing nationally certified problem gambling counselors and conduct media efforts to address problem gambling prevention, awareness, crisis intervention, and treatment services.

ⁱ *The population estimates provided denotes the number of people residing on reservation lands not the total number of enrolled members. Source: 2010 Census Data, North Dakota Indian Affairs Commission (accessed at <http://www.nd.gov/indianaffairs/?id=37>).

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

UNMET NEEDS AND CRITICAL GAPS

The Behavioral Health Division and the North Dakota Mental Health and Substance Abuse Planning Council use a variety of data sources to identify needs within the behavioral health system and to develop plans to address those need areas. For instance, North Dakota substance use-related data is summarized in the Epidemiological Profile (compiled/created by the state's State Epidemiological Outcomes Workgroup [SEOW]). The Department of Human Services holds stakeholder meeting each biennium to gather input on needs and gaps. The North Dakota Legislature commissioned a study of the needs and gaps of the behavioral health system throughout the state. Below are needs and gaps of the behavioral health system that were identified by various groups.

UNMET NEEDS AND CRITICAL GAPS IDENTIFIED BY THE NORTH DAKOTA MENTAL HEALTH AND SUBSTANCE ABUSE PLANNING COUNCIL

Throughout the 2014-2015 planning cycle, the Planning Council discussed what gaps exist in the current behavioral health system. Items identified included:

- Stigma/fear of stigma prevents individuals from seeking help.
- North Dakota does not have integration between mental health and substance use services.
- There is a lack of understanding in primary care of existing behavioral health resources. Mental health services need to be more accessible.
- There needs to be improved integration of services across the board.
- Major depressive episodes among youth is frequently untreated.
- Crime rates in North Dakota are up and most jails do not have behavioral health providers or have little to no access to them.
- There are not mental health specialty courts in North Dakota. There are drug courts but no other specialty courts.
- Unmet need for substance use treatment: rates vary by data but approximate numbers suggest only 4-12% of youth needing treatment for substance use disorders actually receive.
- There needs to be more peer support services.
- Telehealth needs to be expanded to help provide services in rural/remote areas.
- There are no regulations in North Dakota preventing or at least governing seclusion and restraint in schools. Also, no data is collected by the Department of Public Instruction on the use of seclusion and restraint in schools.
- Wraparound services for children have lost fidelity to model.
- There are no intensive wraparound services for the adult population.
- Supportive housing, especially for transition-aged youth, is lacking.
- Veteran-specific programming is lacking.
- There has not been a comprehensive behavioral health needs assessment conducted in North Dakota.
- There needs to be formal peer to peer, parent to parent, and youth to youth support programs established.
- Discharge planning needs to be enhanced to ensure no one falls through the gaps.
- There is the need to develop more culturally appropriate service delivery.
- The use of warmlines needs to be expanded.

- There is a need for specialized treatment for families of those individuals receiving therapy.
- There needs to be an expanded trauma-informed system of care.
- There are no serious mental illness prevention services.
- There is rapidly increasing demand being placed on the behavioral health system due to the oil boom including increased drug trafficking, human trafficking, and organized crime.
- Lack of community-based services to address crisis issues.

UNMET NEEDS AND CRITICAL GAPS IDENTIFIED BY THE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES STATEWIDE STAKEHOLDER MEETINGS

The latest stakeholder meeting occurred in September of 2013. Another meeting will occur this year but has not yet been scheduled. Feedback from the group included:

- Workforce:
 - There is a need for more case management positions.
 - There is a need for additional vulnerable adult protective services workers.
 - There is a lack of psychiatrists and licensed addiction counselors, especially in the rural areas.
 - Staff turnover is an issue throughout DHS.
 - Housing, childcare, paperwork, and high caseloads are issues for field staff.
- Systems Issues:
 - There are complex client situations requiring specific expertise.
 - The internship requirements for addiction counselors create a disincentive to enter the program resulting in a shortage of counselors.
 - There is a lack of affordable housing for workers and clients.
 - Homelessness is increasing.
 - Transportation to services is an ongoing need.
- Regulatory/Administrative Issues:
 - There needs to be guidance on the use of electronic communications between consumers/clinicians.
 - More Home and Community-Based Services are needed.
 - Youth are being sent out of state for treatment.
 - There is a lack of awareness of DHS services.
- Capacity Challenges Exists within the following:
 - Adult residential treatment
 - Foster homes
 - Transitional living
 - Adolescent addiction
 - Intensive In-home services
 - Psychiatric
 - Long term residential
 - Addiction services

UNMET NEEDS AND CRITICAL GAPS IDENTIFIED BY THE FINAL NORTH DAKOTA BEHAVIORAL HEALTH PLANNING REPORT (SHULTE REPORT)

The North Dakota Legislature contracted with Shulte Consulting, LLC to study the behavioral health system in North Dakota and to create a plan to improve those services. Schulte Consulting, LLC, conducted over 35 face-to-face meetings with various groups and individuals. Five public hearings were conducted statewide. Bi-weekly public conference calls occurred. Over 414 separate people participated for a total of over 19,738 minutes logged by North Dakotans. Over 230 documents, not including email, were reviewed and considered for the report. Gaps identified included:

- Service Shortages:
 - Access to services.
 - Lack of case management.
 - Lack of crisis assessment options.
- Expand Workforce:
 - Professional licensing issues.
 - Lack of use of peers, family support peers, recovery coaches and other alternatively trained persons.
- Insurance Coverage Changes Needed:
 - Lack of funding options for services
 - Lack of coverage for providers
- Changes in DHS Structure and Responsibility
 - Lack of transparency and choice in services
 - Need for proposed structural changes
- Improve Communications
 - Lack of integrated physical and behavioral health treatment
 - Lack of record sharing and real time information
 - Lack of communication between HSCs and everyone else
- Data Collection and Research
 - Lack of data for providers outside the HSC system
 - Lack of data for services provided outside the HSC system
 - Lack of data driven services utilized for treatment

UNMET NEEDS AND CRITICAL GAPS IDENTIFIED IN THE SUBSTANCE ABUSE PREVENTION SYSTEM

North Dakota has an active State Epidemiological Outcomes Workgroup (SEOW), which was established in 2006. The ND SEOW's mission is to identify, analyze, and communicate key substance abuse and related behavioral health data to guide programs, policies, and practices. Administered by the Behavioral Health Division, the SEOW has built a broad representation of diverse partners and continues to provide leadership in identifying community data needs along with readiness to act for high need communities that will implement the evidence based prevention programming. The SEOW continues to collect, organize, analyze and develop data-sharing products (Epidemiological Profile, Data Book, Data Briefs, SUND website) with a continued look at expanding how alcohol and other drug abuse impacts other behavioral health issues.

North Dakota's SEOW identifies, collects and organizes a variety of data types, including consumption rates, consequence indicators, data describing community readiness and perceptions, and is starting to identify and collect more data describing intervening variables, including risk and protective factors. This data covers a variety of populations including, middle school, high school, youth ages 12 and over, college students, adults (ages 18-25 and 26 and over). Also, all data is available at the statewide level.

Some data is available at the regional levels and very limited data is available at the county or city level (because of the rural nature of the state).

The data sources utilized by the ND SEOW include the following (both national and state sources): National Survey on Drug Use and Health (NSDUH); Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Surveillance System (YRBS); Youth Tobacco Survey (YTS); Adult Tobacco Survey (ATS); Crime in ND reports; ND Department of Transportation Crash Report; ND Community Readiness Survey; ND CORE survey; and Treatment Episode Data Set (TEDS).

A comprehensive Epidemiological Profile is developed every other year. The data used in the Epidemiological Profile are at the aggregate state level, with limited sub-state analyses. A major challenge for the North Dakota SEOW is the limited availability of reliable and valid data at the local level. Limitation in the utility, reliability, and validity of data exist because of the state's small population. The challenge is even greater when considering epidemiological data from sub-state entities, such as counties and school districts. However the SEOW is continuously working to identify available sub-state data in order to enhance local needs assessment processes. The SEOW is currently developing a data sharing website, Substance Use North Dakota (SUND), modeled after Minnesota's SUMN.org in order to increase sharing of available data and support communities in applications for funding and data-driven planning.

The SEOW's deliberation and review of the data on substance use consumption patterns, consequences of use, perceptions, and intervening variables resulted in the identification of priority areas in which the SAPT BG primary prevention funds should be allocated: (1) Underage Drinking; (2) Adult Binge Drinking; and (3) Prescription Drug Abuse.

Also produced by the ND SEOW is the Substance Use in North Dakota data booklet, which overlays some of the key data indicators from the Epidemiological Profile in a story-telling manner. This booklet, along with the Data Briefs produced by the SEOW, is targeted to the general population with the goal of raising the awareness of substance use issues and guiding programming and policy decisions.

Within the past year, through the SEOW effort, Context Maps were developed. These Context Maps contain models visually depicting the root causes (intervening variables) and consequences of excessive alcohol use, tobacco consumption and illicit drug abuse in N.D. These models were developed with a small group of subject matter experts (SMEs), and subsequently validated by the SMEs and a targeted literature search. Each context map also features prioritized conditions, which are underlying conditions the SMEs believe should be targeted, given resource and time constraints. For example, the intervening variables that were prioritized for alcohol include, lack of alcohol law; limited enforcement of alcohol laws/policies; community norms supportive of alcohol use; social availability of alcohol; young age of initiation.

Also through this process, unmet service needs (i.e. all prioritized underlying conditions for which there are no activities) are being identified, which will lay the foundation for improving the effectiveness of the current primary prevention system.

Although the North Dakota substance abuse prevention system has many strengths, there are also identified gaps. A continuing need of the state's substance prevention system is the development and maintenance of the community-level substance abuse prevention infrastructure, even with the enhancements in recent years. Local substance abuse prevention in the state is relatively new to the use of evidence-based strategies. The rural and frontier culture also presents barriers due to limited

access to trained workforce and long distances to resources. There are limited prevention training opportunities in ND, professional prevention workforce shortages, and no statewide prevention specialist certification process. One gain, within the past two-three years, was the first two Master's in Public Health programs became available in the state.

North Dakota plans to continue development of this sustainable local-level infrastructure and the prevention workforce in the state. The Division is currently receiving technical assistance support from CAPT regarding the development of a statewide coalition network system. This system will ensure coalition coordination, provision of additional prevention trainings, and increase sustainability of SPF efforts. The Division will ensure that funds from the SPF SIG, SPF-PFS and the SAPT BG are leveraged and aligned to support building the capacity of the state and local prevention workforce.

Another identified gap is that the Division's substance abuse prevention system has developed many pieces of a strategic plan to guide substance abuse prevention; however, it has not all been put together into one comprehensive "strategic plan" document. For example, priority areas have been identified through the review of data through the SEOW and logic models for priority areas/efforts identify activities and process and outcome measures. The Division plans on pulling all of this information together in order to develop a comprehensive strategic plan to guide decisions about the use of the primary prevention set-aside of the SABG. This plan will also include information as to how the Division will leverage, redirect and align statewide funding streams and resources for prevention.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

The following unique IT systems are used in the behavioral health system in North Dakota.

ROAP- All eight regional human services centers use this electronic record. The electronic record has one unique client identifier used across all centers so that whatever center provides services to a client will have access to their entire EHR. This system, which is a NetSmart product, captures client specific-level data for both mental health and substance use services. The type, duration, and cost of services is captured. This is both a billing and a clinical record system. Services are captured by service area and service type. There is a ROAP code manual updated as needed. Data for the SUD program are captured on an episode of care, ASAM level, and National Outcome Measures basis. Mental health services are captured on a service specific and duration basis. For all behavioral health services, the system provides both claims data and encounter data. Each center has a national provider identifier and if a specific Medicaid service requires both the provider and the professional to be enrolled, both are completed. The system allows for unduplicated counts of clients within and across services. Services can be reported by clinician as well. Supervisory and clinician reports are generated routinely to provide administrative information. This system links with the state's Medicaid Management Information System.

This system complies with Federal data standards and uses CPT/HSPCS codes. This system is used to produce the annual URS table reports for mental health services and national outcomes measures for the SAPT block grant. This system can capture client-level data.

ROAP has reports generated routinely and are available on an electronic computer drive in aggregate. Specific unique reports are available through the Department's Decision Support Services Unit. The research analyst's from this unit meet with division staff routinely.

The One Center - Two Specialized Facilities are currently using AIMS software for managing client registration, client movement, fiscal operations, as well as clinical, such as doctors orders, treatment plans, progress notes and pharmaceutical activities. AIMS was purchased in 2001 by the vendor Netsmart Technologies . In 2001, the State of North Dakota opted to purchase the source code rather than upgrade to Netsmart Technologies replacement system. Since 2001, ND Information Technology Department has been maintaining and modifying the source code.

Field Services EHR Replacement: The Field Services Electronic Health Record Information System Replacement project will implement an electronic health record information system that is focused on behavioral health to support the services offered by the Department's Field Services Division. This project will replace the ROAP and AIMS systems mentioned above and should be completed during the 2015-2017 biennium. The replacement software will support both outpatient and psychiatric inpatient business functions and service delivery needs. It will support the State Hospital's continued Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation by modernizing the IT system architecture and outdated technology, which limits the ability to incorporate changing federal requirements. The Director of the Behavioral Health Division is a member of the team overseeing the project.

FRAME – FRAME is a web-based electronic record system that was implemented across systems in North Dakota, November 2009. FRAME has replaced the Single Plan of Care (SPOC) application. This web-based application captures case management activities along with data collection & outcome reporting across systems and the life of the case. Further, the information & data collected will be used for possible longitudinal studies that follow children through systems and to provide outcomes as they enter into adulthood.

Systems currently utilizing the FRAME Electronic Record system are Children & Family Services, Human Service Centers - Partnership Care Coordination & Regional Supervisors, County Social Services (Foster Care, Child Protection Services, and In-home Services), Criminal Back Ground Check Unit, Independent Living Coordinators, Decision Support Services, Child Support, and the Department of Juvenile Services. In an effort to expand cross system use of FRAME, Children & Family Services is currently piloting a project with their contracted private providers, who provide In-Homes Services to use FRAME. FRAME electronic record system now includes Child Protection Services (CPS) statewide. The information from CPS will be utilized to better track abuse and neglect - subjects and victims. FRAME will replace the current CPS index as this too will be integrated into the application.

CCWIPS or Comprehensive Child Welfare Information Program System will remain in operation keeping the payments process, foster home licensing and adoption.

Each case manager who has access to the client based information in FRAME has a security profile that is based on their level of need to access information within the electronic records system. The security profile is determined by their supervisor with a request submitted to administration, and then sent to Information Technology System (ITS) for final approval.

North Dakota will utilize FRAME to capture data for the NCANDS and AFCARS report out of FRAME. The information from FRAME will be transferred to COGNOS which is the data warehouse for FRAME. From this application, ND will be able to create reports in a variety of ways using the various fields from FRAME.

Substance Abuse Prevention Data Collection and Reporting Systems

The Division's substance abuse prevention system has developed an Access reporting database, titled the Daily Reporting System (DRS) for internal use in order to record state-level prevention activities and the provision of training and technical assistance to communities across the state. It is designed to capture the process data (numbers served, resources created, technical assistance activities, etc.) needed for SAPT BG reporting and the evaluation of prevention programs and efforts. Also, the Division is planning on leveraging some of the SPF-PFS funds to adopt and enhance the computer system, data infrastructure/management information systems (MIS) in order to improve community-level and statewide reporting of process and outcome measures. This will be aligned with SAPT BG reporting requirements.

All substance abuse prevention community grantees through the SAPT BG are required to submit reports on process data related to their work. These process measures include the following: number of materials disseminated, number of people served, number of media efforts (including reach), number of contacts with policy-makers, etc. The most recent

contracts for the Tribal Community Prevention Programs include more well-defined reporting requirements than past contracts. For example, the Tribal Community Prevention programs funded through the SAPT BG are required to submit a data-driven strategic plan within 60 days of the start of their contract. Each month throughout their contract, they are required to submit a monthly report which summarizes process data on implemented strategies. Every six months, the grantees are required to submit an evaluation report including a summary of implementation progress, list of identified action steps for the next six months, summary of any barriers impacting implementation and a list of identified action steps to address barriers. Community grantees are encouraged to review their monthly and bi-annual reports to monitor implementation. A final report is also required which includes a summary of outcome measures, list of notable achievements and list of any barriers that impacted implementation effectiveness.

This process data (both state and community-level) is reviewed at regular time periods (monthly, quarterly and annually) in order to ensure the implementation of prevention efforts is going as planned and to allow for adjustments in implementation to ensure success.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Community-Based Services
 Priority Type: SAT, MHS
 Population(s): SMI, SED, PWWDC, IVDUs, TB

Goal of the priority area:

Enhance the quality of and access to community-based services.

Objective:

Implement a data-driven system to enhance the quality of and access to community-based services

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Implementation of evidence-based wraparound model of case management for individuals diagnosed with a serious mental illness at the regional human service centers.
 Baseline Measurement: State has limited use of evidence-based wraparound models in case management for individuals diagnosed with a serious mental illness at the regional human service centers.
 First-year target/outcome measurement: Regional human service centers will research the feasibility of implementing an evidence-based wraparound model in case management for individuals diagnosed with a serious mental illness at the regional human service centers.
 Second-year target/outcome measurement: Pilot the chosen evidence-based wraparound model in case management for individuals diagnosed with a serious mental illness at one of the regional human service centers.

Data Source:

Reporting of progress made at the quarterly Extended Care Directors meeting.

Description of Data:

Qualitative Progress Reports

Data issues/caveats that affect outcome measures::

The nature of the data sources is not reliable and difficult to measure.

Indicator #: 2
 Indicator: The percentage of pregnant women and IV drugs abusers provided public substance abuse services are offered services within the appropriate time frame.
 Baseline Measurement: 92% compliance
 First-year target/outcome measurement: 100% compliance
 Second-year target/outcome measurement: 100% compliance

Data Source:

Electronic Health Record

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

All clients seeking alcohol and drug services at regional human service centers are screened (at initial contact) to determine if they are pregnant injecting drug users, pregnant substance abusers, or injecting drug users (within the past year). If identified as a priority population, they are given preference for admission and scheduled or offered an appointment within 48 hours to be evaluated and referred to the appropriate level of care. All regional human service centers and the Division have toll-free phone numbers. Preference for priority populations are advertised in regional human service center brochures and on the Division's web page (<http://www.nd.gov/dhs/services/mentalhealth/index.html>). All programs reported that they were able to provide admission and treatment to this population upon demand and therefore did not have a need to provide interim services. Reports are generated and reviewed by Division staff. Compliance with this regulation is reviewed at peer reviews, licensure reviews and Assurance of Compliance with Rules and Regulations are signed by HSC directors and included in HSC SA contracts

Indicator #: 3
Indicator: Increase/Retained Employment (percentage) Mental Health
Baseline Measurement: 36% of adults diagnosed with a serious mental illness who receive public mental health services were employed (2012)
First-year target/outcome measurement: Increase the percentage of adults diagnosed with a serious mental illness who receive public mental health services and are employed by 2%.
Second-year target/outcome measurement: Increase the percentage of adults diagnosed with a serious mental illness who receive public mental health services and are employed by 5%.

Data Source:

Regional Office Automation Program (ROAP) -- North Dakota's Electronic Health Record -- will be used to collect data.

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time.

Indicator #: 4
Indicator: Percentage of Adolescents engaged in SPARCS and TF-CBT that show a decrease in symptoms from admission to discharge in the treatment program.
Baseline Measurement: 65% show a decrease in symptoms from admission to discharge in the treatment program
First-year target/outcome measurement: 67% show a decrease in symptoms from admission to discharge in the treatment program
Second-year target/outcome measurement: 69% show a decrease in symptoms from admission to discharge in the treatment program

Data Source:

Trauma Symptom Checklist

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

Compliance issues with reporting.

Priority #: 2
Priority Area: Prevention Services
Priority Type: SAP

Population(s): PP

Goal of the priority area:

Decrease harms associated with substance use and abuse in North Dakota.

Objective:

Decrease underage drinking, adult binge drinking, and prescription drug abuse.

Strategies to attain the objective:

Following the Strategic Prevention Framework model and implement evidence-based strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decreased past month binge drinking rates among adults.

Baseline Measurement: Ages 18-25: 53.75%. Ages 26+: 27.94% (2012-2013 NSDUH)

First-year target/outcome measurement: Implementation of evidence-based adult binge drinking strategies.

Second-year target/outcome measurement: 2% decrease for Ages 18-25, 1% decrease for Ages 26+

Data Source:

The National Survey on Drug Use and Health (NSDUH) will be utilized to monitor adult consumption rates.

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time.

Indicator #: 2

Indicator: Decreased past month alcohol use among ND high school students.

Baseline Measurement: 335.3% ND High School students reported alcohol use in the past 30 days.

First-year target/outcome measurement: Continued implementation of evidence-based strategies targeting underage drinking.

Second-year target/outcome measurement: A 2% decrease in past 30 days alcohol usage among ND high school students.

Data Source:

North Dakota Youth Risk Behavior Survey (YRBS)

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time.

Indicator #: 3

Indicator: Decreased prescription drug abuse among ND high school students

Baseline Measurement: 17.6% ND high school students reported taking a prescription drug without a doctor's prescription in their lifetime.

First-year target/outcome measurement: Continued implementation of evidence-based strategies targeting prescription drug abuse.

Second-year target/outcome measurement: 1% decrease in lifetime prescription drug abuse among ND high school students.

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time

Priority #: 3

Priority Area: Military

Priority Type: SAP, SAT, MHS

Population(s): Other (Military Families)

Goal of the priority area:

Assure access to quality behavioral health services for military representatives, veterans, and families.

Objective:

Increase partnerships and collaboration with military agencies and preventions and treatment providers.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Maintain one combat veteran of the Iraq or Afganistan Conflicts and one family member of a combat veteran of the Iraq or Afganistan Conflicts on the North Dakota Mental Health and Substance Abuse Planning Council.

Baseline Measurement:

There is one Veteran representative but no family member of a veteran representative currently on the Council.

First-year target/outcome measurement:

One family member of a veteran representative will become a member of the Council

Second-year target/outcome measurement:

Twelve months of consistent membership from a veteran and a family member.

Data Source:

Planning Council Roster

Description of Data:

Inventory of the roster of the North Dakota Mental Health and Substance Abuse Planning Council will show if one combat veteran and one family member of a combat veteran are members of the Council. Attendance will be evidenced by sign-in at the quarterly Council meetings.

Data issues/caveats that affect outcome measures::

None identified at this time.

Priority #: 4

Priority Area: Behavioral Health Integration

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, TB

Goal of the priority area:

An integrated behavioral health system.

Objective:

Foster integration of substance use, prevention, mental health, and other services.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Integrated Strategic Plan
Baseline Measurement: No plan exists.
First-year target/outcome measurement: Complete a needs assessment to guide planning.
Second-year target/outcome measurement: Develop a strategic plan for behavioral health integration.

Data Source:

Completed assessment and plan

Description of Data:

Qualitative

Data issues/caveats that affect outcome measures::

None identified at this time.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$7,570,717		\$1,393,871	\$0	\$26,973,824	\$0	\$9,876,971
a. Pregnant Women and Women with Dependent Children*	\$585,000		\$0	\$0	\$415,584	\$0	\$0
b. All Other	\$6,985,717		\$1,393,871	\$0	\$26,558,240	\$0	\$9,876,971
2. Substance Abuse Primary Prevention	\$2,440,710		\$0	\$4,250,697	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$1,859,836		\$0	\$444,088	\$698,851	\$0	\$0
13. Total	\$11,871,263	\$0	\$1,393,871	\$4,694,785	\$27,672,675	\$0	\$9,876,971

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$5,072,156	\$0	\$1,087,709
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$432,708	\$20,861,884	\$10,629,153	\$61,146,625	\$0	\$8,049,979
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$79,697	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$1,081,537	\$0	\$232,579	\$4,611,282	\$0	\$0
13. Total	\$0	\$1,593,942	\$20,861,884	\$10,861,732	\$70,830,063	\$0	\$9,137,688

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$	\$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$	\$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$	\$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$	\$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$	\$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$	\$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$	\$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$	\$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$	\$
Total	\$0	\$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$4,609,703
2 . Substance Abuse Primary Prevention	\$1,229,254
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$307,314
6. Total	\$6,146,271

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
		SA Block Grant Award	
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		\$241,851
	Total		\$241,851
Education	Universal		
	Selective		
	Indicated		
	Unspecified		\$60,463
	Total		\$60,463
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		\$60,463
	Total		\$60,463
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		\$12,093
	Total		\$12,093

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	\$302,314
	Total	\$302,314
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	\$532,070
	Total	\$532,070
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	\$20,000
	Total	\$20,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$1,229,254
Total SABG Award*		\$6,146,271
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Column Total	\$0	
Total SABG Award*	\$0	
Planned Primary Prevention Percentage		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

Targeted Substances	
Alcohol	b
Tobacco	e
Marijuana	e
Prescription Drugs	b
Cocaine	e
Heroin	e
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	e
Military Families	b
LGBT	e
American Indians/Alaska Natives	b
African American	e
Hispanic	e
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	b
Underserved Racial and Ethnic Minorities	e

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$15,040	\$0	\$0	\$15,040
2. Quality Assurance	\$5,440	\$10,000	\$0	\$15,440
3. Training (Post-Employment)	\$10,240	\$40,000	\$0	\$50,240
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$98,800	\$0	\$0	\$98,800
6. Research and Evaluation	\$10,400	\$0	\$0	\$10,400
7. Information Systems	\$10,800	\$0	\$0	\$10,800
8. Total	\$150,720	\$50,000	\$0	\$200,720

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	\$195,000
MHA Planning Council Activities	\$20,000
MHA Administration	\$82,656
MHA Data Collection/Reporting	\$125,000
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$422,656
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

²⁷ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁸ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁹ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>: <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

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³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

⁴¹ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

⁴³ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴⁷ <http://www.nrepp.samhsa.gov/>

⁴⁸ Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

⁴⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁵⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. The Health Care System and Integration

The Behavioral Health Division is looking at ways to integrate behavioral health with other services such as primary care, corrections, and services specific to older adults.

In 2013, the North Dakota Mental Health and Substance Abuse Planning Council voted to change its structure to integrate mental health and substance abuse planning populations. The Council's composition was modified and new member positions were added to bring a voice to substance use disorder issues. The structure of the Council includes representatives of the service area population including the Indian Affairs Commission, the Aging Services Division, families of children with serious emotional disturbance, families of adults with serious mental illness, families of adults/children with substance use disorder, consumers, military veterans, and families of military veterans. The Council continues to look at its membership to ensure that it is an accurate representation of an integrated behavioral health system.

The Behavioral Health Division is an active member of the North Dakota Behavioral Health Stakeholders Group. This group consists of over 100 members representing many different organizations. The group convened in the fall of 2013 with the purpose of addressing unmet needs in behavioral health in North Dakota. Using a Substance Abuse and Mental Health Services Administration (SAMHSA) template of the components of a comprehensive system of behavioral health care, the group has identified needs in North Dakota and is working on solutions to meet those needs. Types of behavior health services addressed by this group include adult mental health, children's mental health, substance abuse, and workforce development.

The semi-annual Behavioral Health Conferences are funded and planned through the Behavioral Health Division. To ensure that the conferences focus on integrated behavioral health services, the planning committee was broadened to include the following partners: North Dakota Mental Health and Substance Abuse Planning Council, North Dakota Department of Correction and Rehabilitation, North Dakota Treatment Providers Coalition, North Dakota Addiction Counselors Association, Protection and Advocacy, Mental Health America of North Dakota, and the North Dakota Department of Human Services.

Based on a requirement in the substance abuse treatment program administrative rule, NDAC 75-09.1, all licensed programs are to conduct an adequate assessment in specific areas including tobacco. There is a requirement to substantiate or rule out a client's diagnosis and clearly describe the diagnostic impressions based on a five-axis assessment of the DSM and recommendations for treatment based on the American Society of Addiction Medicine patient placement criteria. Reviewers interpret this to include tobacco. Additionally, programs must implement a written policy for referral and recommendations for services not available through the program. Programs are to have a written policy that addresses the use of smoking products. In collaboration with the Department of Health, brochures regarding referrals and information on smoking cessation programs are available and provided to programs as needed. One such service is ND Quits, a program of the North Dakota Department of Health. Their mission is to improve and protect the health of North Dakotans by reducing the negative health and economic consequences of the state's number-one cause of preventable disease and death – tobacco use. This program is open to all citizens of North Dakota. Through their ND Quits Phone, anyone who enrolls in NDQuits phone counseling and is uninsured or does not have cessation medication coverage through their health plan can receive a free two month supply of the nicotine patch, nicotine gum or nicotine lozenges. The Division of Behavioral Health also partners with the Center

for Tobacco Policy and Control to integrate tobacco cessation into behavioral health treatment throughout the State.

All clients who receive services from the public behavioral health system, including adults diagnosed with serious mental illness, children diagnosed with serious emotional disturbances, and individuals in need of substance abuse treatment, 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.

Prevention staff members from the Behavioral Health Division write articles on prevention topics for publication in the quarterly North Dakota Physician's Magazine. They also partner with the Non-Medical Use of Pharmaceuticals Task Force to distribute prescription drug abuse materials through the North Dakota Pharmacy Association. Through the Strategic Prevention Framework State Incentive Grant, the Behavioral Health Division works closely with the local public health units.

North Dakota would welcome any technical assistance that would help us broaden our integrated behavioral health service system.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. Health Disparities

The Department of Human Services, through enrollment in services, will continue to collect client data on race, ethnicity, gender and age through the use of the assessment/outcome instrument in the electronic record. English is the primary language of most North Dakotans. The Department will continue to work to engage populations with varied language preferences and levels of literacy based on local need. The regional human service centers access interpreters, as needed, to ensure that language is not a barrier to accessing services, including services for the deaf. All services at the regional human service center are available to individuals regardless of race, ethnicity, gender, LGBTQ, and age.

Effective prevention services requires prevention programs be delivered with sensitivity to culture and language and aligned with the needs of the target population. Training and technical assistance is provided to community grantees on cultural competence, relating to all of these factors. Because of the historically homogeneous population and primary focus of environmental prevention, a data-driven quality improvement process for tracking and assessing sub-population disparities is new to the state. North Dakota's State Epidemiological Outcomes Workgroup will work to develop a data-driven process for assessing health disparities among various sub-populations in the state.

Training for providers regarding cultural competence and health disparities has been conducted at annual training events. For instance, Dr. Donald Warne from North Dakota State University presented on Historical Trauma during the Fall 2014 Behavioral Health Conference. Training needs will continue to be assessed to ensure cultural and linguistic competency in the behavioral health workforce.

The Division would welcome any technical assistance that would enhance our efforts in cultural and linguistic competency.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3. Use of Evidence in Purchasing Decisions

The Behavioral Health Division is working to increase the use of evidence when making purchasing decisions. Contracts are now written to be more outcome-based. The Division as a whole tracks and disseminates information on evidence-based and promising practices. The semi-annual Behavioral Health Conferences focus on topics of evidence-based and promising practices. The conferences are attended by over 300 system stakeholders.

The North Dakota Department of Human Services is in the process of replacing its electronic health record for Field Services. This will allow for the collection of more reliable performance data. Along with this, the Department of Human Services is implementing a new quality management process within Field Services to improve the overall performance of the community-based public behavioral health system. The Behavioral Health Division is conducting strategic planning. These endeavors will allow the Department of Human Services to better manage the quality and outcomes of the community-based public mental health system across North Dakota.

The North Dakota Substance Abuse Prevention system utilizes the Strategic Prevention Framework to guide the selection and implementation of evidence-based prevention strategies by assessing data, ensuring capacity, and consistent evaluation. The Division's Substance Abuse Prevention System ensures that services provided are evidence-based practices and puts a focus on environmental strategies. Also, evidence-based principles are followed and utilized to create technical assistance materials for local communities.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

4. Prevention for Serious Mental Illness

North Dakota has not implemented mental illness prevention programs. Efforts have focused on the prevention of substance use disorders. The substance abuse prevention system in North Dakota is a robust, data-driven system and will be used as an example when developing a system for mental illness prevention. The Behavioral Health Division, along with the Mental Health and Substance Abuse Planning Council and other stakeholders, will be exploring during the 2015-2017 biennium the feasibility of implementing mental illness prevention programs. The Division would welcome any technical assistance from SAMHSA to help with this process.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. Evidence-Based Practices for Early Intervention (5 Percent)

Heinssen, Goldstein, and Azrin (2014) noted that nearly 100,000 (or 3.3 per 1,000) adolescents and young adults in the United States experience first episode psychosis each year. Using this information, it is estimated that approximately 350 adolescents and young adults (between 15 and 25 years of age) experience first episode psychosis each year in North Dakota.

A number of studies, as referenced in Heinssen, Goldstein, and Azrin (2014), show that early intervention – including low doses of atypical antipsychotic medication, cognitive and behavioral therapy, family education and support, and educational and vocational rehabilitation – provides the best opportunity for symptom reduction and functional recovery. The best results are often found when intervention occurs within the first two years following the initial episode of psychosis.

There are many treatment programs available for a system to model. For instance, Coordinated Specialty Care has proven successful in Australia, the United Kingdom, Scandinavia, and Canada. Prevention and Recovery in Early Psychosis (PREP) has shown positive outcomes in the State of Massachusetts, and Early Psychosis and the Early Assessment and Support Alliance (EASA) is showing success in the State of Oregon. Care must be taken to choose a model that is appropriate for a rural/frontier state such as North Dakota.

North Dakota is using the 5% set-aside funds to build the infrastructure for first episode psychosis treatment services targeted toward individuals between 15 and 25 years of age. A consultant was hired to provide training to a key group of stakeholders concerning first episode psychosis and the various evidence-based practices available to serve the target population. The next step will be to develop a plan to implement a first episode psychosis treatment program in North Dakota. The set-aside funding during the planning period will be used for consultant services and meeting and training expenses.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

The North Dakota Department of Human Services has implemented a voucher system for substance use disorder treatment in areas where staff shortages are resulting in waiting lists for services. The vouchers allow individuals to access treatment services through a private addiction treatment professional of their choice.

In an effort to improve documentation of medical necessity and help move 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. All clinicians at the regional human service center utilize person-centered treatment planning.

North Dakota Administrative Code 75-09.1 requires substance abuse treatment programs to include in client records evidence of the direct involvement of the client in the decision-making process related to the client's program.

Administrative Code prescribes 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". Furthermore, "The professional staff member assigned to the consumer shall develop and review the individual plan with the consumer, shall document in the consumer's record the consumer's input in the development and review indicating the extent of the involvement in developing the individual plan, and shall have the consumer sign the treatment plan." 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 consumer, case manager, and case manager's supervisor shall review individual plans at least every six months, except when consumer circumstances necessitate a change to the treatment plan."

Training on stages of change and stages of treatment serves to compliment the work done on person-centered treatment planning. Recognizing the importance of meeting the consumer where they are at, developing an open trusting relationship, and engaging consumers in their own care is critical to successful outcomes for consumers. Clinicians providing services at the regional human service centers are using this process.

North Dakota would welcome any technical assistance that would enhance client participation in the treatment process.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity

A program integrity plan specific to the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Block Grant has not yet been developed. Through the contracting process, the program administrators responsible for the contract review the monthly requests for reimbursement submitted by the vendor for appropriate expenses. Performance requirements/indicators are built into the contracts and monitored by the program administrators. Onsite visits to the vendors are conducted, as needed. The Fiscal Administration Division also reviews reimbursement requests to ensure compliance with allowable program expenses and conducts audits when required.

The contracting process for the North Dakota Department of Human Services contain budget reviews, claims/payment adjudication, expenditure report analysis, compliance reviews, encounter/utilization/performance analysis, and audits. The Division ensures that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered by following state procurement guidelines.

The state assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through technical assistance. If this proves to be impossible, the contract will be revoked and new vendor will be selected.

The state ensures that the Block Grant funds and state dollars are used to pay for individuals who are uninsured and services are not covered by private insurance and/or Medicaid. The state enters into contracts specific to those services and will establish guidelines for vendors to follow. Contract monitoring will include the elements mentioned above. Irregularities will be corrected or, if needed, the contract will be terminated and a new vendor selected.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

8. Tribes

The Tribes in the state are represented on many state coalitions/task forces, which the Behavioral Health Division leads or participates in, including the State Epidemiological Outcomes Workgroup (SEOW), Prevention Expert Partners Workgroup (PEPW), the Governor's Prevention Advisory Council (GPAC), Problem Gambling Advisory Council, Mental Health and Substance Abuse Planning Council and Olmstead Commission.

The Behavioral Health Division allocates approximately 25% of the SAPT BG primary prevention funding to support community-level prevention efforts on the four federally-recognized Native American reservations in the state. These Tribal Prevention Programs are required to follow the Strategic Prevention Framework as they provide culturally-appropriate substance abuse prevention coordination and implementation of evidence based programs, practices and strategies. These community programs implement the following strategies: information dissemination, education, alternatives, community-based processes and environmental efforts. This work is one of the strengths of the North Dakota Substance Abuse Prevention System – longstanding collaboration with the tribes in the state.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

9. Primary Prevention for Substance Abuse

Overview of North Dakota's SEOW

North Dakota has an active State Epidemiological Outcomes Workgroup (SEOW), which was established in 2006. The ND SEOW's mission is to identify, analyze, and communicate key substance abuse and related behavioral health data to guide programs, policies, and practices. Administered by the Division, the SEOW has built a broad representation of diverse partners and continues to provide leadership in identifying data needs. The SEOW continues to collect, organize, analyze and develop data-sharing products (Epidemiological Profile, Data Book, Data Briefs, SUND website) with a continued look at expanding how alcohol and other drug abuse impacts other behavioral health issues.

North Dakota's SEOW identifies, collects and organizes a variety of data types, including consumption rates, consequence indicators, data describing community readiness and perceptions, and is starting to identify and collect more data describing intervening variables, including risk and protective factors. This data covers a variety of populations including: middle school, high school, youth ages 12 and over, college students and adults (ages 18-25 and 26 and over). Also, all data is available at the statewide level. Some data is available at the regional levels and very limited data is available at the county or city level (because of the small population and rural/frontier nature of the state).

The data sources utilized by the ND SEOW include the following (both national and state sources): National Survey on Drug Use and Health (NSDUH); Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Surveillance System (YRBS); Youth Tobacco Survey (YTS); Adult Tobacco Survey (ATS); Crime in ND reports; ND Department of Transportation Crash Report; ND Community Readiness Survey; ND CORE survey; and Treatment Episode Data Set (TEDS).

A comprehensive Epidemiological Profile is developed every other year. The SEOW is currently developing a data sharing website, Substance Use North Dakota (SUND), modeled after Minnesota's SUMN.org in order to increase sharing of available data and support communities in applications for funding and data-driven planning. Also produced by the ND SEOW is the Substance Use in North Dakota data booklet, which overlays some of the key data indicators from the Epidemiological Profile in a story-telling manner. This booklet, along with the shorter Data Briefs produced by the SEOW, is targeted to the general population with the goal of raising the awareness of substance use issues and guiding programming and policy decisions.

Needs Assessment Data Utilized in Allocation of Funding

North Dakota substance use-related data is summarized in the Epidemiological Profile (compiled/created by the state's State Epidemiological Outcomes Workgroup [SEOW]). The latest North Dakota Epidemiological Profile is available on the state's prevention website: <http://www.nd.gov/dhs/services/mentalhealth/prevention/pdf/2012-epi-profile.pdf>. An updated Epidemiological Profile is in the process of being finalized, with the goal of being completed by September 2015.

The data used in the Epidemiological Profile are at the aggregate state level, with limited sub-state analyses. A major challenge for the North Dakota SEOW is the limited availability of reliable and valid data at the local level. Limitation in the utility, reliability, and validity of data exist because of the state's small population. The challenge is even greater when considering epidemiological data from sub-state entities, such as counties and school districts. The SEOW is continuing to work on making local-level data available, including the development of sub-state epidemiological profiles/needs assessments.

The SEOW's deliberation and review of the data on substance use consumption patterns, consequences of use, perceptions, and intervening variables resulted in the identification of priority areas in which the SAPT BG primary prevention funds should be allocated:

1. Underage Drinking
2. Adult Binge Drinking
3. Prescription Drug Abuse

The Division's Substance Abuse Prevention System will continue investigating ways in which funding can be allocated to communities across the state who have a high need, supported with available data. Funding is allocated by following a Strategic Prevention Framework (SPF) data-driven process and targets the entire lifespan.

Building Capacity of the North Dakota Prevention System

Building capacity of both the state and community prevention systems is a priority for the Division's Substance Abuse Prevention System. Progress has been made in increasing the workforce's capacity (at both the state and community levels) through the SAPT BG and the recent implementation of the Strategic Prevention Framework State Incentive Grant (SPF SIG) in the state. Even with this progress in enhancing the capacity of the prevention workforce, there are still gaps that need to be addressed. The following have been identified as two gaps in the North Dakota prevention workforce: 1) limited trained workforce in evidence-based prevention; and 2) absence of a statewide community-based/coalition prevention infrastructure.

Local substance abuse prevention infrastructure in North Dakota is in its infancy. Partnership with Local Public Health Units through SPF SIG has begun to grow this infrastructure. Still, there are gaps to enhance in order to implement and sustain effective substance abuse prevention efforts in ND communities. Local substance abuse prevention in the state is relatively new to the use of evidence-based strategies. The rural and frontier culture also presents barriers due to limited access to trained workforce and long distances to resources. There are limited prevention training opportunities in ND, professional prevention workforce shortages, and no statewide prevention specialist certification process. One gain, within the past two-three years, was the first two Master's in Public Health programs became available in the state. The Division is pursuing a partnership with these programs in order to be listed as a practicum site for students, with the goal of introducing substance abuse prevention and the ND prevention system to students going into the Public Health field. Also, the Division is in the process of having a few state staff become trained as SAPST (Substance Abuse Prevention Skills Training) trainers in order to offer the training on a more regular basis to the state's prevention workforce.

The Division is planning to identify the core competencies needed among all levels of the prevention workforce (at both state and community levels). This will assist in creating consistency and a benchmark for competency expectations. Also, the Division plans to pursue an assessment of the current prevention workforce needs based on the competencies that are identified. Once this assessment is completed, a workforce development plan for the state can be developed in order to ensure training and technical assistance is targeted to the most pressing workforce needs. All of these activities may not occur within this current SAPT BG application period; however, this process will be initiated.

Community coalitions/task forces in rural/frontier areas of the state do exist; however, are typically difficult to maintain because of the limited resources, workforce and access to services. Through North Dakota's SAPT BG and SPF SIG, many communities have initiated community coalitions to guide, support, and implement the SPF locally.

Through the SAPT BG, the Division will continue to develop and maintain a comprehensive plan to build local community infrastructure and capacity to implement the Strategic Prevention Framework, support evidence-based programs, policies and practices and provide training and technical assistance. The Division's approach for building capacity includes both proactive and reactive methods. The proactive method for building capacity includes the continued compilation of technical assistance resources, tools and planning of coordinated trainings anticipating community needs. The reactive method for building capacity is being responsive and providing individualized assistance based on community requests and the needs identified through onsite technical assistance visits. The Division's training and technical assistance staff has expertise in the application of the Strategic Prevention Framework and is familiar with North Dakota communities, their efforts, capacity and culture.

North Dakota plans to continue development of this sustainable local-level infrastructure. The Division is currently receiving technical assistance support from CAPT regarding the development of a statewide coalition network system. This system will ensure coalition coordination, provision of additional prevention trainings, and increase sustainability of SPF efforts. The Division will ensure that funds from the SPF SIG, Strategic Prevention Framework Partnership for Success (SPFPFS) and the SAPT BG are leveraged and aligned to support building the capacity of the state and local prevention workforce.

North Dakota does not currently have a statewide licensing or certification program for the substance abuse prevention workforce. Also, a formal community coalition network, registration, training or certification process does not exist in the state. These activities may not be currently occurring; however, a process addressing these topics has been initiated and will be continued.

The Division has been developing its function as a training and technical assistance provider to all levels of the state's substance abuse prevention workforce. Through partnerships with CAPT, the Division has made efforts to formalize this TTA function through the development of resource documents and a logic model to guide efforts. However, the Division plans to continue formalizing this TTA provided through an assessment of prevention workforce needs (based on competencies), creation of a workforce development plan, and ensuring that the TTA delivered is targeting the most important workforce needs in the state. Also, the Division will continue to streamline the TTA processes and procedures.

A statewide Community Readiness Survey was conducted in 2008. Currently, ND is administering the statewide Community Readiness Survey again with results expected fall of 2015. The Division utilizes this information to guide the implementation of prevention strategies at the state-level, and encourages the utilization of this information for community-level implementation.

Use of Data to Identify Types of Primary Prevention Services Needed

As mentioned earlier, data guides the development of priority areas (underage drinking, adult binge drinking and prescription drug abuse). Within the past year, through the SEOW effort, Context Maps were developed. These Context Maps contain models visually depicting the root causes (intervening variables) and consequences of excessive alcohol use, tobacco consumption and illicit drug abuse in N.D. These models were developed with a small group of subject matter experts (SMEs), and subsequently validated by the SMEs and a targeted literature search. Each context map also features prioritized conditions, which are underlying conditions the SMEs believe should be targeted, given resource and time constraints. For example, the intervening variables that were prioritized for alcohol include, lack of alcohol law; limited enforcement of alcohol laws/policies; community norms supportive of alcohol use; social availability of alcohol; young age of initiation.

Also through this process, unmet service needs (i.e. all prioritized underlying conditions for which there are no activities) are being identified, which will lay the foundation for improving the effectiveness of the current primary prevention system.

Strategic Plan

The Division has developed many pieces of a strategic plan to guide substance abuse prevention; however, it has not all been put together into one comprehensive “strategic plan” document. For example, priority areas have been identified through the review of data through the SEOW and logic models for priority areas/efforts identify activities and process and outcome measures. The Division plans on pulling all of this information together in order to develop a comprehensive strategic plan to guide decisions about the use of the primary prevention set-aside of the SABG. This plan will also include information as to how the Division will leverage, redirect and align statewide funding streams and resources for prevention.

Evidence-Based Workgroup

North Dakota will continue the Evidence-Based Program Workgroup (named the Prevention Expert Partners Workgroup, PEP-W, in North Dakota) advisory committee membership that was established through the efforts of the SPF SIG grant. The PEP-W includes representation from the following agencies: ND Department of Human Services, ND Department of Transportation, ND Department of Health, ND Center for Tobacco Prevention and Control, ND Indian Affairs Commission, ND University System, ND Department of Public Instruction, and the ND Highway Patrol. The PEP-W acts as a subcommittee to the Governor’s Prevention Advisory Council (GPAC). The PEP-W advises the GPAC and the Division on enhancing and expanding the State’s prevention infrastructure and implementing evidence-based prevention efforts.

Specific activities of the PEP-W have included: (1) receiving and reviewing regular briefings on the progress of state and community prevention efforts (specifically SPF SIG community grantee progress); and (2) reviewing and approving community grantee plans, based on the assessment of needs, gaps and services. Through the PEP-W’s involvement with SPF SIG, a menu of pre-approved evidence-based prevention strategies was developed to guide community selection of strategies. This resource is also used to guide SAPT BG funded prevention activities. The activities of the PEP-W will continue to expand in order to guide and support the SAPT BG, along with the SPF SIG and the SPF-PFS.

Because the Division is the SSA for the state, the majority of funding targeting substance abuse prevention is allocated to the Division. The Division has only recently begun receiving a small amount of state funding that supports substance abuse prevention. Historically, all funding was federal. This allows the Division’s Substance Abuse Prevention System to leverage and align various funding sources to create a single, statewide coordinated substance abuse prevention effort. Also, the involvement and leadership in the various partner groups (GPAC, PEP-W and SEOW) encourages the single, statewide effort by ensuring efforts aren’t duplicated and that funding sources from other agencies are aligned with the state’s substance abuse prevention goals.

Primary Prevention Programs, Practices and Strategies

The North Dakota Substance Abuse Prevention System is data-driven, science-based, and follows a public health approach. Prevention services in North Dakota are delivered both directly by the SSA and through community organizations/groups/coalitions supported by the SAPT BG and other funding sources. Examples of services delivered directly by the SSA include the Prevention Resource and Media Center (PRMC), local training and technical assistance. In recent years, both of these services have

expanded and been increasingly formalized. Training and technical assistance is developed and provided on the SPF and evidence-based strategies (including information dissemination, education, alternatives, problem identification and referral, community-based processes and environmental efforts). Training and technical assistance provision has become a key function of the substance abuse prevention system and the Prevention Resource and Media Center (PRMC) is often the vehicle the assistance is delivered.

The Prevention Resource and Media Center (PRMC) supports community prevention infrastructures and implementation of evidence-based prevention by providing technical assistance resources, marketing, health communication, and as a user-friendly media resource center/clearinghouse for the citizens of North Dakota. The PRMC develops materials and tools to assist local communities in implementing effective prevention. This includes resources to support both state and community-level implementation of information dissemination, education, alternatives, problem identification and referral, community-based processes and environmental strategies. All Prevention Resource and Media Center materials are accessible online, in person, by e-mail or by phone, and select material is available through the State Library electronic system. The Prevention Resource and Media Center e-newsletter communicates recent data, news releases, research, new resources, and upcoming events to a statewide listserv.

The Division's Substance Abuse Prevention System plans to continue partnerships with the ND Attorney General's office to promote the local prescription drug Take Back Programs and with the ND Realtor Association to support safeguarding medications during open houses and showings (based on an identified need). Partnerships with the Non-Medical use of Pharmaceuticals will also enhance the statewide prescription drug abuse prevention efforts. Also, the Division plans to continue the partnership with the ND Safety Council on the development and implementation of statewide Responsible Beverage Service Training program.

Examples of services delivered at the community-level, supported by the SAPT BG and SSA, include funding to tribal prevention programs and other forms of community-level support. The Division's Substance Abuse Prevention System plans to enhance the level to which SAPT BG funds can be invested to support implementation of community prevention efforts that can achieve population-level changes. Both state and community-based processes are guided by the Strategic Prevention Framework. Through the state's SEOW, ND reviews available data to ensure services address the needs of diverse racial, ethnic and sexual gender minorities.

The Behavioral Health Division allocates approximately 25% of the SAPT BG primary prevention funding to support community-level prevention efforts on the four federally-recognized American Indian reservations in the state. These Tribal Prevention Programs are required to follow the Strategic Prevention Framework as they provide culturally-appropriate substance abuse prevention coordination and implementation of evidence based programs, practices and strategies. These community programs implement the following strategies: information dissemination, education, alternatives, community-based processes and environmental efforts. This work is one of the strengths of the ND Substance Abuse Prevention System – longstanding collaboration with the tribes in the state.

Through the leveraging, redirecting and aligning of statewide funding streams and resources for prevention, primary prevention activities to be supported by the SAPT BG can be narrowed. For example, the state's SPF SIG supports 25 communities (including the four federally-recognized tribes) to build local prevention infrastructure and implement evidence-based prevention programs, practices and strategies targeting underage drinking and adult binge drinking. The state was recently notified of being awarded the SPF PFS, which the identified priority area is underage drinking. Therefore, a large amount

of the SAPT BG primary prevention funds will likely not be allocated towards underage drinking activities since there are other funding streams supporting those efforts. However the SAPT BG primary prevention funds will need to support state and community-level prescription drug abuse prevention activities as there is no other funding source to support this. Because the SPF SIG is currently the only funding source supporting adult binge drinking prevention, SAPT BG primary prevention funds will also need to support this, especially when SPF SIG expires in September 30, 2016.

The Division's Substance Abuse Prevention system plans to investigate ways in which the state can implement a Strategic Prevention Framework, data-driven process to allocate funds for community-level prevention efforts, focusing especially on prescription drug abuse, adult binge drinking, and communities not already funded for underage drinking prevention activities. The division would require community-level prevention efforts to follow the SPF, be comprehensive, and target populations at various levels of risk.

The State partners with multiple agencies (both government and private) in an effort to build a seamless prevention system and avoid duplication of services. This occurs through the following partnership groups, Governor's Prevention Advisory Council (GPAC), Prevention Expert Partners Workgroup (PEP W; acting as the state's Evidence-Based Program Workgroup), and the State Epidemiological Outcomes Workgroup (SEOW). As the SSA, the Division reviews all funding sources that are required to be allocated to primary substance abuse prevention services and ensures that funds are aligned to not duplicate services. For example, since the North Dakota priorities for the SPF SIG and the upcoming SPF-PFS are specific to alcohol (SPF-PFS is specific to underage drinking only), the SAPT BG funds will be planned to support activities that these sources are not already supporting

Also, all contracts with other organizations include the requirement of partnership and collaboration in order to ensure SAPT BG dollars are used to fund primary substance abuse prevention services not funded through other means.

Process Data/Evaluation

The Division has developed a reporting database, titled the Daily Reporting System (DRS) for internal use in order to record state-level prevention activities and the provision of training and technical assistance to communities across the state. It is designed to capture the process data (numbers served, resources created, technical assistance activities, etc.) needed for SAPT BG reporting and the evaluation of prevention programs and efforts. Also, the Division is planning on leveraging some of the SPF-PFS funds to adopt and enhance the computer system, data infrastructure/management information systems (MIS) in order to improve community-level and statewide reporting of process and outcome measures. This will be aligned with SAPT BG reporting requirements.

All community grantees through the SAPT BG are required to submit reports on process data related to their work. These process measures include the following: number of materials disseminated, number of people served, number of media efforts (including reach), number of contacts with policy-makers, etc. The most recent contracts for the Tribal Community Prevention Programs include more well-defined reporting requirements than past contracts. For example, the Tribal Community Prevention programs funded through the SAPT BG are required to submit a data-driven strategic plan within 60 days of the start of their contract. Each month throughout their contract, they are required to submit a monthly report which summarizes process data on implemented strategies. Every six months, the grantees are required to submit an evaluation report including a summary of implementation progress, list of identified action steps for the next six months, summary of any barriers impacting implementation and a list of identified action steps to address barriers. Community grantees are encouraged to review

their monthly and bi-annual reports to monitor implementation. A final report is also required which includes a summary of outcome measures, list of notable achievements and list of any barriers that impacted implementation effectiveness.

This process data (both state and community-level) is reviewed at regular time periods (monthly, quarterly and annually) in order to ensure the implementation of prevention efforts is going as planned and to allow for adjustments in implementation to ensure success.

Outcome Data/Evaluation

The outcome data the Division intends to collect is included in the data that is continually identified, collected, and organized by the state’s SEOW. Generally, ND’s outcome measures utilized to evaluate the state’s three key priorities, as identified by data through the State Epidemiological Outcomes Workgroup (SEOW) efforts are listed below.

UNDERAGE DRINKING	ADULT BINGE DRINKING	PRESCRIPTION DRUG ABUSE
Main Data Sources: YRBS CORE DOT Crash Summary	Main Data Sources: NSDUH CORE UCR DOT Crash Summary NIAAA	Main Data Sources: NSDUH YRBS
Measures: Lifetime Use Binge Use Age of Initiation Perceived Risk of Harm Community Acceptability Alcohol-Related Crashes	Measures: Binge Use Perceived Risk of Binge Use Alcohol-Related Crashes Alcohol-Related Arrests DUI Arrests Alcohol Consumption	Measures: Past Year Rx Pain Med Use Source of Rx Pain Meds Lifetime Rx Drug Use

The following table outlines the key long-term outcome measures that are considered in the Division’s substance abuse prevention priorities and the two-year goal for each.

UNDERAGE DRINKING		ADULT BINGE DRINKING		PRESCRIPTION DRUG ABUSE	
Baseline	2 Year Goal	Baseline	2 Year Goal	Baseline	2 Year Goal
High School student lifetime: 65.8% (YRBS, 2013)	63%	18-25 past month binge use: 53.75% (NSDUH 2012-2013)	51%	High School student lifetime prescription drug abuse: 17.6% (YRBS, 2013)	15.5%
High School student past 30-day use: 35.3% (YRBS, 2013)	33%	26+ past month binge use: 27.94% (NSDUH 2012-2013)	26%	College student past 30 day prescription drug abuse: 2.5% (CORE, 2012)	2%
High School student first used before age 13: 15.2% (YRBS, 2013)	14%	College student past 2 weeks binge drinking: 51.4% (CORE, 2012)	49%	18-25 past year Non-Medical Use of Pain Relievers: 8.22% (NSDUH,	7.5%

				2012-2013)	
High School student past 30-day binge use: 21.9% (YRBS, 2013)	20%	35.5% of total arrests are for DUI and liquor law violations (<i>Crime in ND, 2013</i>)	33%	26+ past year Non-Medical Use of Pain Relievers: 3.1% (NSDUH, 2012-2013)	2.5%
		48.1% of fatal crashes are alcohol-related (<i>DOT, 2013</i>)	46%		

As the SEOW continues to develop the identification and organization of intervening variable (including risk and protective factors) data, short-term outcome data will be identified and monitored. This process has started through the development of the Context Maps within the SEOW.

Through the SEOW and the Division prevention staff, outcome data is continuously evaluated to monitor implementation of services improve our processes and make future decisions to determine which efforts should be sustained.

The Division would like to request technical assistance in reporting NOMS for the characteristics of persons (including unduplicated counts) served by population-based strategies.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

FIELD SERVICES

QUALITY MANAGEMENT PLAN

Approvals:

Alex Schweitzer
Field Services Director

Date

Andy McLean
Field Services Medical Director

Date

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PURPOSE

DHS Field Services provides the public behavioral health services for North Dakota. Care is given across a continuum of outpatient, residential, and inpatient treatment. Field Services is committed to continuous quality improvement in the overall performance of the organization through an ongoing, comprehensive performance measurement program.

The quality management function falls under the direction of the DHS Field Services Director. The purpose of the Quality Management Process is to ensure Field Services provides quality care through continuous performance improvement that informs care and meets regulations.

MISSION

Support people to live healthy lives in their home community

GOALS

- Collect, aggregate and analyze performance data
- Review the findings from all quality management activities and determine appropriateness and effectiveness of action plans.

PRINCIPLES

- Data-informed
- Committed leadership
- Provide integrated care that is
 - Evidenced based, recovery oriented, person centered, and trauma informed
 - Safe and effective
 - Accessible
 - Timely
 - Cost-efficient

PRIORITIES

- High volume, high risk, problem prone area
- Relevant to identified mission

ORGANIZATION, AUTHORITY AND RESPONSIBILITY

Quality Management Council: The Council has the oversight responsibility for the quality, effectiveness, availability and accessibility of services provided. The committee authorizes and requires the Committee Chair and the HSC Directors to establish and maintain an effective Quality Management System through the work of quality management committees at each service site.

Executive Management: The leadership of the Department of Human Services includes the Director of DHS, Director of Field Services, Director of Mental Health and Substance Abuse Division. The role of Executive Management in the QM process is to define a strategic plan consistent with the Mission and clearly communicate the mission and plan throughout the organization.

Quality Management Committees: The Quality Management Committees at each agency consists of members of Leadership Teams. These members represent the different departments and disciplines within Field Services to allow for the coordination between authority functions and other systems including local planning, policy development, network development and network management functions. The committee reviews outcome data, monitors performance improvement efforts, and approves and ensures implementation of plans for improvement. Quality management activities occur at discipline and service levels throughout the organization, reporting their efforts to the Quality Management Committees who then report to the Quality Management Council.

Medical Staff: The medical Staff members are active participants and leaders in the QM activities. All organized committees of the medical staff participate in quality management activities. These committees include the Tele-pharmacy and Tele-health committees and the Critical Incident Review committee.

Service Directors: Each Director, working with the program providers, develops and implements quality improvement. Service outcomes results (Core Measures, etc.....) are analyzed and presented to the Quality Management Committee with plans of action, if necessary.

STANDARDIZED PERFORMANCE IMPROVEMENT MODEL

1. **Define Problem and Scope** (Figure 1.1 for common brainstorming tools)
 - Include process to be improved that is meaningful – valid, scientific.
 - Define desired and measurable goals
 - Define timeline for improvement
2. **Measure baseline performance** (Figure 1.1 for common measurement tools)
 - Aggregate data
3. **Analyze the current performance to isolate the problem** (see DMAIC guide)
 - Form and test hypotheses through statistical and qualitative analysis
4. **Improve the problem by selecting a solution**
 - Design and implement interventions (who, what, when, how)
 - Monitor the progress of improvement through measurement
 - Modify/refine interventions, as necessary, to meet identified goal
5. **Sustain the improved process to ensure continued target performance**
 - Standardized procedures
 - Transfer ownership
 - Follow up to validate benefits

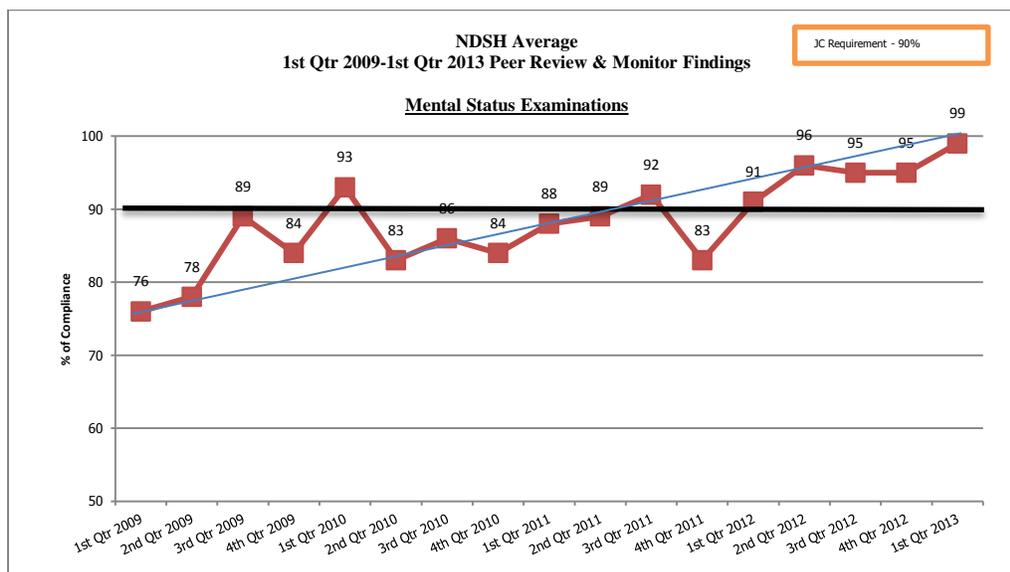
STANDARDIZED PERFORMANCE IMPROVEMENT REPORTING FORMAT

1. Defined Problem (Figure 1.1)
2. Graphical representation of performance from baseline through improvement
3. Clearly defined goal with a measurable target
4. Interventions identified with implementation dates, analysis of effectiveness and what, if any, modifications were necessary to meet goal.
5. Plan and Procedure to sustain improvement.

PI REPORT EXAMPLE

Problem Defined: MSE incomplete, not meeting TJC and/or CMS standardized requirements

Baseline Performance: (graphical representation of at least 1 year of baseline data)



Performance Goal: (clearly defined with measurable target)

MSE element requirements present 90% of the time

Analysis of process and/or root cause clearly identifying problems to solve:

Interventions with implementation dates and analysis of effectiveness:

1. Medical staff MSE and TJC/CMS education August 2008
2. Medical Staff given MSE outlines within diagnostic outline and peer review guide January 2009
3. Poor performers assigned to monthly peer review critiquing October 2011
4. Parallel Peer Review implemented January 2012

Improved Performance: (graphical representation with intervention dates)

Sustainability: Sustainability monitored quarterly with standardized peer review at medical staff meeting

STANDARDIZED ONE CENTER QUALITY MANAGEMENT COMMITTEE AGENDA

Call to Order

Minutes of the last meeting

Announcements

Performance Initiative Reports

- Priority Improvement Initiatives (current PI, FMEA, Root Cause, and/or regulatory Initiatives)
- Quarterly/Yearly Sustained Performance Reports

Survey Readiness (rotating education and review)

Tools**Figure 1.1 Common Tools to find/define the problem**

Common Tools	Plan	Design	Measure	Analyze	Improve
Focus group/interview/survey of opinion/perception	x		x		
Reviews complaints, incident reports, litigation, etc.	x		x		
Chart reviews and checklists to evaluate whether past performance has incorporated all desired elements		x	x		
Literature reviews and benchmark research	x	x			
Analysis of historical performance and trends on quality measures (often using run charts and/or control charts, if appropriate to the type of data)	x	x	x	x	
Brainstorming potential performance problems		x			x
Scatter diagrams to see relationships		x		x	x
Flow-charting process and its problems, delays, etc.		x	x	x	
Affinity diagrams to bring brainstormed ideas into thematic units	x			x	
Cause and effect (“fishbone” or Ishikawa) diagram to sort out potential process problems into categories and groups		x			x
Histogram and Pareto charts to focus on the “vital few” factors that affect performance and to set aside the “trivial many” factors that obscure issues	x		x	x	
Design of experiments methods of testing interventions and process changes systematically			x	x	x
Run charts	x	x	x	x	
Failure mode and effects analysis (FMEA)		x	x	x	x
Process mapping using SIPOC	x				

See appendix for a quick reference on statistical process control and correlation.

Figure 2.1 Performance Improvement Priorities

Initiative	Applicable Standard	Responsibility
Reduce service wait time NIATX		
Reduce assessment time NIATX		
Meet meaningful use standards	MU	
Demonstrate motivational interviewing proficiency	EBP	
Increase supported employment for individuals with SMI	NOMS-EBP	
Increase use of peer support services	NOMS	
Trauma-informed care initiatives	SAMHSA	
Increase # of eligible clients in IDDT	NOMS-EBP	
Increase antipsychotic medication adherence SMI	MU Core	
Demonstrate DSM 5 proficiency		
Medical necessity documented prior to billing		

Figure 3.1. Performance Initiative Worksheet

Performance Initiative Worksheet		
	Initiative Begins:	
	Initiative Complete:	
1. Define Problem:		
2. Measure Performance: (baseline and ongoing)		
3. Analyse Problem:		
4. Interventions: (specific dates with what specifically was done)		
5. Control the progress: (what is now in place to standardize the process to prevent future error)		
Completed by:	Team/Committee:	
Signature:		
A copy of this report should be forwarded to:	Date:	
Quality Management Council		

10. Quality Improvement Plan

The Behavioral Health Division is in a period of transition with a change in Division administration, name, and structure. During this time, the Division is actively engaged in strategic planning. This will lead to more structured/formal business practices that enhance quality and drive continued improvement.

The North Dakota Department of Human Services is in the process of replacing its electronic health record for Field Services. This will allow for the collection of more reliable performance data. Along with this, the Department of Human Services is implementing a new quality management process within Field Services to improve the overall performance of the community-based public behavioral health system. Please refer to the attached document. These endeavors will allow the Department of Human Services to better manage the quality and outcomes of the community-based public mental health system across North Dakota.

North Dakota would welcome any technical assistance that would allow us to strengthen our quality improvement processes.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

The Department does not currently have an overarching policy that directs providers to screen clients for a personal history of trauma but plans to update all administrative rules to include trauma-informed care. The update will occur within the next year. The Department did implement trauma screenings as a requirement for licensing and renewal licensing for the psychiatric residential treatment facilities. In addition, contracts are being written to include language stating the service must be a trauma informed service. At the present time the Department does have a policy issuance that directs clinicians that have been trauma trained to implement trauma treatment to the fidelity of the models.

In 2008 the Department of Human Services enhanced the system of care with the expansion of evidenced-based services for traumatized youth by collaborating with the Neuropsychiatric Research Institute (NRI) to form the Treatment Collaborative for Traumatized Youth (TCTY). Since that time, the Behavioral Health Division has partnered with the Neuropsychiatric Research Institute (NRI) to develop a statewide multidisciplinary collaborative network: the "Treatment Collaborative for Traumatized Youth" (TCTY). The mission of TCTY is "To enhance evidence-based, trauma specific, mental health treatments available to traumatized children and their families." The TCTY provides the following ongoing evidence-based trauma learning collaborative's to advanced mental health clinicians at all eight human service centers and private providers: Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Trauma Focused – Cognitive Behavior Therapy (TF-CBT) and Alternatives for Families – Cognitive Behavior Therapy (AF-CBT). These include two to three days of class training and either six or twelve months of clinical consultation calls to staff cases. Due to this comprehensive approach, 89 clinicians are now certified. Sixty-two of those trained are clinicians employed by the eight regional human service centers. North Dakota's creation of the Treatment collaborative for Traumatized Youth (TCTY), a statewide partnership designed to disseminate evidence based trauma treatment for traumatized children and monitor outcomes across a broad, rural, geographic area, was published in the Behavior Research and Therapy Journal in July 2011.

The North Dakota Department of Human Services (Department), Behavioral Health Division (BHD) applied for a SAMHSA Planning grant for the Expansion of the Comprehensive Community Mental Health Services for Children and their Families (System of Care Expansion Planning Grant). The grant was awarded in 2013 and ended in June, 2015. The grant assisted North Dakota in developing a state wide Trauma-Informed System of Care within the existing system of care for children and youth with serious emotional disturbances and their families. The goal was to improve outcomes for children and adolescents with serious emotional disturbance and their families. The objectives were as follows: Develop a trauma informed training curriculum with trauma specific mental health screening; administer statewide trauma training; develop a seamless trauma referral process; increased access to evidenced based trauma treatments; increase awareness of trauma related and co-occurring disorders along with decreasing stigma towards trauma and other related mental health treatment.

The development of a statewide trauma-informed system of care included targeted trauma training to child welfare, juvenile services, residential treatment providers, employees of the eight regional human service centers, and other providers. These results complemented the Department's additional efforts to reduce the use of psychotropic medication to treat trauma related symptoms. Medication is just one of the many tools available to help treat the social, emotional, behavioral, and mental health difficulties that are common among children with serious emotional disorders, youth, and their caregivers who have experienced maltreatment.

Over the past four years the Behavioral Health Division has used blended funding through state funds and mental health block grant funds to sustain the TCTY and develop an infrastructure of certified clinicians. The HSC clinicians complete pre and posttest assessments on each case to measure the effectiveness of the treatment. The top traumatic events include: being hit, beaten, physically assaulted by a non-family member or family member, neglect, witnessed domestic violence, and parents or siblings undergoing treatment for serious or life threatening problems. The areas known to show improvement with trauma focused services are anxiety, anger, dissociation and dissociation fantasy. These outcomes give a clear indication that the early identification and treatment of trauma decreases symptomology.

Partnerships provide wraparound case management services for children with serious emotional disorders up to 21 years of age. The Partnership staff was provided six hours of trauma specific training, that included how to implement the National Child Traumatic Stress Network Trauma Referral Tool, six months of weekly consultations calls to review cases, provide consultative services on real trauma screenings, and how to refer youth for appropriate treatment. The trauma referral tool is a measure designed to help workers make more trauma-informed decisions about the need for a referral to a trauma specific and general mental health service provider. The goal is to screen all youth with SED enrolled in Partnerships for trauma and provide appropriate treatment for those who have a positive screen. Since 2013, a total of 468 children were screened for traumatic stress symptoms. Seventy-five percent of these children had experienced at least one traumatic event and the average number of traumatic events per child was three. Of the 351 children who had experienced a traumatic event, sixty percent were positive on the screening tool for post-traumatic stress symptoms. This implies that approximately sixty percent of all the children screened met criteria for a referral for further assessment of trauma-specific mental health concerns and possible trauma-focused treatment.

Studies of complex trauma indicate that individuals who experience multiple types of trauma are at greater risk for psychosocial maladjustment and mental health and behavioral problems. According to the Winter 2013 Edition of "CW 360" A Comprehensive Look at A Prevalent Child Welfare Issue, over the last six years, it has become clear to many working in the National Child Traumatic Stress Network (NCTSN) that meaningful treatment of children' in the child welfare system must be matched with system supports. Essentially, the entire child welfare system needs to be transformed into a "Trauma-Informed system" and the system should offer universal screening for traumatic history and traumatic stress responses, which will assist the workers in understanding the history of a child or family." (CW 360: A Comprehensive Look at A Prevalent Child Welfare Issue, Trauma-Informed Child Welfare Practice, Winter 2013)

Since 2008 the department has worked to build capacity by providing annual training on two - three evidence-based trauma treatments to qualified clinicians employed by the human service centers. These trainings are held in conjunction with private providers to increase the workforce of trauma trained clinicians in North Dakota. This level of capacity building has prepared the department and the system of care for taking the next steps in providing trauma specific screenings and appropriate referrals to all children that enter North Dakota's system of care. In addition, trauma training is being incorporated into the Spring and Fall Behavioral Health Conference. The schedule for the Fall 2015 Behavioral Health Conference includes Stephen Wiland who will present on trauma-informed healthcare for older adults.

Over the last two years, the TCTY has gradually increased its presence in other child-serving systems. As a result of the additional financial funding provided by the SAMHSA SOC Expansion Grant, TCTY staff

were invited to serve as lead faculty for the ND Juvenile Court Conference in 2015. Additionally, TCTY staff led a day-long conference for ND Head Start professionals on the topic of child traumatic stress. Finally, the TCTY formed a relationship with the ND Department of Public Instruction that led to collaboration on two federal grants and a contract to develop a professional development curriculum for K-6 educators on the topic of traumatic stress and mental health. The goal is to disseminate the newly developed curriculum to all K-6 educators in the state.

In 2014 the eight regional human service centers identified clinical trauma champions to increase awareness of trauma and lead the change process at their respective centers. The trauma champions attended a two day training session and afterwards participated in an eleven month learning collaborative through TCTY that included telephone consultation and sharing of progress at each center. Each human service center developed a plan to be trauma-informed. Examples of efforts include: presentations to various units within the HSC's, presentations at "all staff" meetings, lunch and learn presentations, newsletter articles, support meetings for HSC staff impacted by secondary traumatic stress, meetings with HSC leadership to encourage center buy-in, trauma-sensitive waiting rooms for clients, and new strategies for effective screenings of traumatic stress symptoms at intake.

One of the most impressive efforts to implement trauma-informed care was the development of Trauma-Informed Care teams (TIC) within several of the HSC's. These TIC Teams were comprised of representatives from all units and administrators with the goal of implementing and sustaining the trauma-informed care efforts. Overall, the "Champions" was an effective effort to increase regional human service center awareness regarding traumatic stress and the principles of trauma-informed care. In addition, the Department of Human Services developed a trauma training through the e-learning system for staff to view during orientation and yearly thereafter.

In the fall of 2014, three training sessions focusing on trauma were provided to staff from thirteen residential child care facilities and six psychiatric residential treatment centers. Beth Caldwell and Associates provided the training on the six core principles of the Building Bridges Initiative (BBI). Each facility developed an improvement plan utilizing the BBI principles as well as the Community Based Standards (CBS). Beth Caldwell and Associates returned in the spring of 2015 and provided four training sessions on evidence-based and trauma-informed practices. The topics for the sessions included: family engagement, reducing restraints and seclusion, sensory modulation techniques, and youth training on sensory modulation. In addition to the trainings, Beth Caldwell and Associates toured the residential child care facilities and psychiatric residential treatment centers. Technical assistance and feedback was provided to reduce trauma in the facilities and to improve work with children who have experienced trauma.

A marketing plan to increase awareness of trauma was executed through a contract with KAT Communications. The audience of the campaign was the general public, social and human service professionals, clergy, and all of these populations on the four Native American Reservations. Materials were developed for a gorilla marketing campaign along with two 3 minutes videos that are culturally sensitive. One video will play on Good Health TV at the eight regional human service centers and the other one will play on Good Health TV at Indian Health Services on the reservations. The trauma awareness campaign information including the video can be viewed on the Behavioral Health Division's website at <https://www.nd.gov/dhs/services/mentalhealth/index.html>.

In addition to the training, education, and awareness funds were used for enhancements for the Voluntary Treatment Program (VTP) for SED youth. The program is utilized for SED youth providing

parents with access to out-of-home treatment for their children without relinquishing legal custody. The program has continued to help many families keep custody and assist in the treatment of youth so that they can return home and avoid contact with social services or the legal system.

A sustainability plan was started in May 2014 in preparation for the legislative session for the 2015-2017 biennium. A budget was prepared and presented to Executive Management of the Department to continue all the training efforts started with SOC Expansion Grant funds. During the 2015 legislative session funds were appropriated for the continuation of the TCTY clinician training and the Voluntary Treatment Program (VTP). In addition, an e-learning Trauma Training was developed and is assigned to new staff and accessible through our human resources online PeopleSoft system. The Department is still working on making the training accessible to all system of care partners. Trauma booster trainings will be held at the TCTY Annual Meetings and trauma will continue to be a focal point at the Departments two Behavioral Health Conferences held each year.

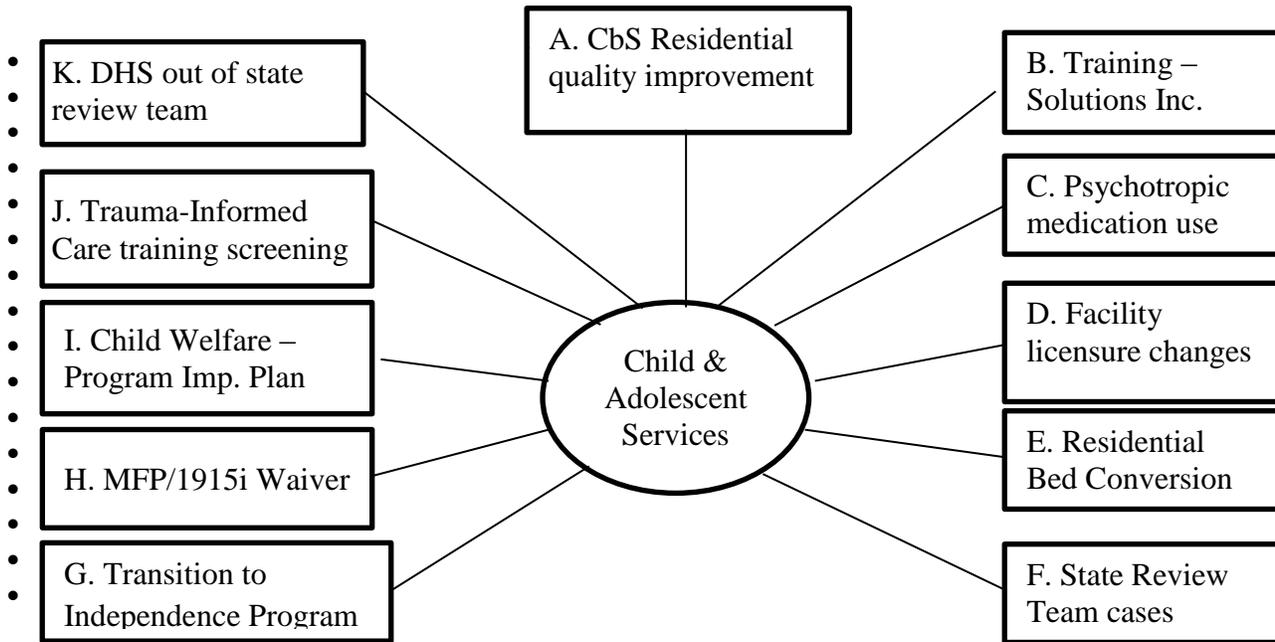
The sustainability plan has continued to evolve as the Department identifies needs. A goal that has been added since 2014 is the continued development of a 1915(i) Medicaid State Plan Amendment designed to meet the needs of children/youth with serious emotional disorders and their families. Services under consideration include but are not limited to customized goods and services, family training and supports, respite, professional resource family care (crisis stabilization), transitional case management, consultative clinical and therapeutic services, peer support services, supported employment, enhanced personal care services, non-medical transportation, and treatment for mental health and co-occurring disorders. Once the 1915(i) is in place, work will be completed to expand the current Money Follows the Person (MFP) Demonstration Grant in North Dakota to assist in the transition of children and youth from psychiatric residential treatment facilities or inpatient psychiatric settings. We know that in order to impact utilization of the highest levels of care, a strong community-based system needs to be in place. MFP will be used to assist in the infrastructure that is necessary to support a strong, flexible array of community-based services that will complement the current public and private mental health system.

A second goal added is to continue the work with the psychiatric residential treatment facilities and residential child care facilities to reduce the trauma of multiple placements, identify the barriers to keeping kids versus sending them out of state, and work with the facilities to meet their needs for the rehabilitation of youth so they can return to their communities sooner and with their treatment needs met.

The Department will continue to blend funding resources to sustain the Trauma Informed System of Care by utilizing Behavioral Health Block Grant Funds, State General Funds, and Medicaid. The Department is committed to continuing the efforts that were started through the grant and improving services state-wide.

North Dakota has strategically developed a Systems Approach to Continuous Quality Improvement plan to enhance services across the state for children and youth with serious emotional disturbances and their families. This is illustrated in the graph below:

Strategies-System Approach to Continuous Quality Improvement



In an ongoing effort to develop a stronger infrastructure and address the high and complex needs of youth in our state, North Dakota developed the State Review Team. The team is a consumer specific review process incorporating the involved systems and agencies to address challenges, barriers, and gaps preventing appropriate care, services and/or education to children, youth and caregivers.

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 system of care partners that serve on this team are: Division of Juvenile Services; Adult Corrections; Department of Public Instruction-Special Education; Children and Family Services Division-DHS; Medical Services-DHS; Behavioral Health -DHS; Developmental Disabilities-DHS; Vocational Rehabilitation-DHS; Aging Services Division – DHS; Institutions – State Hospital and Developmental Center; and a Regional Human Service Center Director.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

North Dakota has a biennial legislative calendar, and the North Dakota Legislative Assembly gathered for its 64th session in the Winter/Spring of 2015. Legislation was introduced in the 2015 Session which would have expanded and increased the use of “specialty courts,” including the type of court some refer to as “mental health court.” North Dakota has utilized “drug courts” in its more-populous judicial districts for several years, and drug courts have been successful in issuing orders to drug and alcohol treatment and diverting people with addiction issues away from incarceration. Unfortunately, the bill that could have resulted in the development of diverse specialty courts did not emerge with a “do pass” from committee. Instead, the committee directed that Legislative Management refer the matter to an existing “Alternatives to Incarceration Committee” that includes members of the legislature.

During the 2015 Legislative Assembly, the North Dakota Department of Corrections and Rehabilitation (DOCR) pressed for legislative authorization to enable delivery of substance abuse treatment to inmates by professional staff who are not licensed addiction counselors (LACs). North Dakota, like many states, is experiencing a behavioral health workforce shortage, including in the area of drug and alcohol abuse, which makes access to treatment challenging for many citizens. The drug and alcohol treatment being used, Cognitive-Behavioral Interventions for Substance Abuse (C-BISA), is an evidence-based treatment protocol that can be delivered by suitably-trained and licensed professionals without the requirement of holding a LAC credential. Additionally, C-BISA does not incorporate the “twelve-step model” associated with Alcoholics Anonymous. This DOCR-supported endeavor also failed to emerge successfully from legislative process.

The North Dakota Youth Correctional Center (NDYCC) in Mandan North Dakota, which operates under the Division of Juvenile Services within the DOCR, has utilized C-BISA for two years. The C-BISA “workbook format” imparts a structure to the process of recovery, and its linear but flexible progression through various “tasks” important to recovery seem to help the youth at NDYCC more easily understand and use concepts and strategies critical to achieving and maintaining sobriety/recovery.

The Division of Juvenile Services, at NDYCC and through its community-based case management workforce, recently began the roll-out of the “Phoenix / New Freedom 100” (PNF-100) curriculum in its residential correctional facility and at its community-based DJS offices. The PNF-100 curriculum is an evidence-based series of “lessons” that begin with discerning the youth’s level of motivation to change and then seeks to explore and increase motivation or personal attributes necessary thereto. Once motivation appears sufficient, lessons follow which involve diverse topics such as self-regulation and anger control, assertiveness, general mental health, peer relationships, family relationships, roles and responsibilities, etc. The PNF-100 “program” includes multiple process and outcome measures, and DJS staff are presently training and preparing to begin using this curriculum on a “small scale” in August of 2015.

The North Dakota Youth Correctional Center also had several key personnel trained earlier this summer in the theory and delivery of relationship-mediated and strengths-based models of therapeutic intervention known as “Girls Circle” and “Boys Council.” These parallel and gender-sensitive methods of promoting engagement with rehabilitative services among youth in the juvenile justice system are currently beginning implementation at the NDYCC. These programs, developed and authorized for use by the One Circle Foundation, have the common goal of delivering strengths-based information and experiences to youth which seeks to increase protective factors and reduce risk factors. Research on these models has identified positive outcomes such as improved body image and self-efficacy in girls and increased school engagement in boys. These strengths-based approaches are founded on evidence-based principles and integrate principles of Motivational Interviewing.

The Council of Juvenile Correctional Administrators (CJCA) developed, piloted, and launched PbS in 1995. The NDYCC committed to use of and adherence to Performance-based Standards (PbS) in 1997. The goal of PbS is to “measure what’s happening” in correctional facilities for youth, with the overarching goals of improving public safety and preventing future crime by offering effective rehabilitative experiences in facilities which are, under PbS, undergoing constant evaluation and related continuous quality improvement.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

Currently the Department of Human Service does not engage in educational efforts across public and private sectors to increase awareness and understanding among health plans and health insurance issues of the requirement of MHPAEA. The Behavioral Health Division would welcome any technical assistance that would allow us to develop such efforts.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

14. Medication Assisted Treatment

The Behavioral Health Division is currently developing a strategic plan for ensuring access to a full continuum of care including quality medication assisted treatment. Continued efforts to partner with community stakeholders will be a key step in planning and the implementation of strategies. Considerations will include creating and updating informational briefs and handouts to be disseminated to specified audiences. Training needs will be addressed through the Behavioral Health Conference, agency presentations, webinars, and other training and technical assistance opportunities.

Considerations will include updating the North Dakota Administrative Rules for Substance Abuse Treatment Programs. Efforts to advocate for access to Opioid Treatment Programs (OTPs) will remain an important consideration in planning as North Dakota does not have an operating OTP at this time. When OTPs are operating, the Behavioral Health Division is authorized to conduct licensing reviews for compliance with rules and regulations. The State Opioid Treatment Authority will remain current on guidelines for operation of OTPs and will incorporate guidelines into Administrative Rules as necessary.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

The behavioral health system in North Dakota has implemented a number of programs designed to assist individuals through a period of crisis. Southeast Human Service Center partnered with SOLUTIONS Behavioral Healthcare Professionals to implement a mobile crisis program. The target populations for this program are adults and children with a mental health diagnosis and/or a development disability. When someone is in a crisis, the mobile crisis response team will deploy to the person to offer them mental health support. Rather than using a more costly, higher level of care, individuals are able to deescalate and formulate a safety plan while remaining in their home. People are then linked to other available community resources so they can avoid future crises. This program is being rolled out at West Central Human Service Center during the 2015-2017 biennium and will be considered for other regions in the future.

Each regional human service center has a crisis assistance team referred to as Regional Intervention Service (RIS). 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, RIS 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 RIS 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 RIS 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.

The regional human service centers have crisis residential services, as well. Crisis residential provides temporary housing to for crisis intervention, treatment, and other supportive services necessary for a person to remain in the community. These services are often provided through a contract with a private provider and overseen by RIS. In addition, the human service centers contract with private entities for youth crisis "safe beds." Youth up to age 18 can go to a home or facility for a maximum of 72 hours for stabilization during a crisis situation.

The Department of Human Services, along with other agencies, financially supports services of 2-1-1. Operated by FirstLink, 2-1-1 connects callers to information about health and human services. It also provides confidential listening and support, in addition to information and referral on abuse/assault, addiction, disabilities, education, financial assistance, food, medical, mental health, military, parenting, recreation, suicide, transportation, volunteer opportunities, etc. Call specialists are trained in crisis intervention, including suicide intervention.

North Dakota Century Code (NDCC) Chapter 23-06.5 allows for the implementation of a psychiatric advanced directive. This legal document allows an individual to appoint an agent to make decisions about their psychiatric treatment if they become incompetent to make those decisions; or to write instructions about how they would like their psychiatric treatment to proceed; or both. Standard forms can be used and are accessible at: <http://ndpanda.org/docs/mhad-form0514.pdf>.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

The concept of recovery is the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-run services that comprise the behavioral health system of care. Services within this system identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment encourages hope and emphasizes individual dignity and respect. As one of its foremost priorities, the Division promotes a recovery-oriented service system for persons at risk of, or who have psychiatric or substance use disorders.

The Behavioral Health Division continually strives to address the needs of people over time and across different levels of disability, and to apply recovery principles to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles are applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders.

In partnership with the recovery communities, the Division is making revisions to existing policies, procedures, programs, and services, and ensuring that all new initiatives are consistent with a recovery-oriented service system. Future strategic planning and resource development efforts will build upon existing strengths and continue to move the Division in the direction of promoting recovery as a core concept. By doing so, the language, spirit, and culture of recovery will be embedded throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.

The Division strives to ensure the service system is notable for its quality, marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects are sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, attention is focused on ensuring the recovery-oriented service system is age and gender appropriate, culturally competent, and attends to trauma and other factors known to impact on one's recovery. Whenever possible, services are provided within the person's own community setting, using the person's natural supports. The goal is to help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

The Behavioral Health Division is involved with a number of initiatives to strengthen the recovery-oriented system including:

- Recovery Month Events: The Behavioral Health Division developed a Recovery Month Event Toolkit. The purpose of the Toolkit is to assist communities with planning and funding Recovery Events held throughout the state. Recovery Month events provide a platform to celebrate people in recovery and those who serve them and serves to educate the public on behavioral health as a national health crisis, that behavioral health is a treatable disease, and that recovery is possible. Educating the public reduces the stigma associated with behavioral health. Involving community in advocacy and recovery celebrations helps change public perceptions of recovery, promote effective public policy and demonstrate that recovery is a reality for millions of Americans. The Division offers stipends to eligible applicants to assist with funding these events and each year rallies, runs, walks, sober social events and other activities are held to educate people in our state about long-term recovery, engage children and families in community-wide events, and demonstrate the joy and new life that goes along with recovery.

- Telephone Recovery Support: The “Recoveree Connection”, North Dakota’s Telephone Recovery Support Program, was implemented statewide in June, 2008. The Department of Human Services contracts with Rehab Services, a private agency located in Minot, North Dakota to administer the program. The Recoveree Connection is a non-clinical, volunteer based, support service whereby individuals in recovery from substance use disorders receive telephone calls from trained telephone recovery support specialists, most of whom are peers in the process of recovering themselves. Volunteers provide a “check-in” with the person in the early stages of recovery and help the individual to access community supports that further support the person’s recovery in the community. For the year ending June 30th, 2015 there were 9,860 calls made to 1,133 individuals in recovery.
- Consumer Family Network: The Division of Mental Health and Substance Abuse Services provides funding to Mental Health America of North Dakota to administer the North Dakota Consumer Family Network (CFN). The CFN is a collaboration consisting of individuals, family members, and advocacy organizations dedicated to education, support, advocacy, and empowerment in the interest of promoting mental health. Goals of the CFN include consumers being well-informed of their choices and possibilities beyond those presently available and for mental health care to be consumer and family driven. Mental Health America of North Dakota and the Consumer and Family Network are members of the North Dakota Mental Health and Substance Abuse Planning Council and provide input into the planning of the behavioral health system of care.
- Supported Employment and Extended Service: Case management staff work closely with Vocational Rehabilitation to offer employment support services to consumers who desire to work. Those who go through the traditional VR Supported Employment Program transition into Extended Services. 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. In addition, the Department has implemented the evidence-based practice of Supported Employment in conjunction with the IDDT program at three of the eight regional human service centers. This model emphasizes rapid job search, zero exclusion and time-unlimited supports and has been met with very positive results. Individuals involved in the EBP model of Supported Employment can transition to extended services
- Person-Centered Treatment Planning: The Department has trained all clinicians on Person-Centered Treatment Planning. This model 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. Consumers are active participant in their treatment planning and treatment goals are documented in the consumer’s own words.

Training on stages of change and stages of treatment serves to compliment the work occurring on person-centered treatment planning. Recognizing the importance of meeting the consumer where they are at, developing an open trusting relationship, and engaging consumers in their own care is critical to successful outcomes for consumers. This has been implemented statewide. Clinicians providing services at the regional human service centers are beginning to complete a more formal “staging” of consumers as they work closely with them to develop treatment plans.

North Dakota Administrative Code (NDAC) 75-09.1 requires substance abuse treatment programs to include in client records evidence of the direct involvement of the client in the decision-making

process related to the client's program. Similarly, NDAC 75-05-04 requires regional human service center clinicians to provide documentation in the client record of the consumer's involvement in treatment planning.

- Behavioral Health Conferences: The Division funds and assists in the planning for the semi-annual Behavioral Health Conferences, each of which are attended by over 300 behavioral health stakeholders. Recovery is a key component in the presentations offered. For example, the Fall 2015 Behavioral Health Conference will include presentations on peer directed services, reframing recovery and understanding true peer support, and psychiatric advanced directives.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

17. Community Living and the Implementation of Olmstead

The current North Dakota *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 Indian Country, to allow residents with disabilities to live successfully in the community of their choice with appropriate and desired supports. Guiding principles used in the development of the plan goals included a desire to ensure that individuals will have the fullest range of choice of providers feasible and to encourage the use of evidence-based practices.

The current plan is categorized into three major goal statements. Each goal is intended to be achieved through action steps that follow the goal statement. The goals describe the reasonable modifications that the state hopes to achieve to its current system of care. The goals take into account the resources available to the state and the needs of all North Dakotans with disabilities in order to try to maintain a balanced range of care and treatment of individuals with diverse disabilities and the state's obligation to administer services with an even hand.

The first goal is for North Dakota to have the infrastructure necessary to provide to individuals with disabilities community services and supports that are accessible, effective, responsive, and safe. In order to provide a range of services to accommodate individuals with varying needs and preferences, ongoing efforts will be made to continuously improve services with available resources. The second goal is to establish a system to provide comprehensive information and education so individuals with disabilities can make informed choices about services and living options. All efforts are aimed at the prevention and diversion from institutionalization or segregation. The third goal is to administer a system of coordinated services to individuals with disabilities in the most integrated setting appropriate to the needs of the individuals.

In 2013, the state participated in the Olmstead Academy to develop a strategic framework for North Dakota. The plan established three priorities which include access to access to housing options, competitive employment, and access to peer supports. The Olmstead Commission is currently in the process of blending the Olmstead Plan with the Policy Academy Strategic Framework and identifying five to six priorities to focus on for the year. Information regarding the three priorities can be found in the following paragraphs.

In order to more effectively meet the need for affordable housing, The North Dakota Department of Human Services has partnered with the North Dakota Housing Finance Agency for the purpose of creating a statewide Supported Housing Collaborative. This collaborative includes administrators from each of the ND Department of Human Services divisions, staff from the USDA Rural Development, staff from the ND Department of Commerce - Community Services Division, representatives of the ND Homeless Coalition, ND Housing Finance Agency staff, state Housing and Urban Development office staff, eight of the state's Public Housing Authorities, non-profit affordable housing developers, and the Money Follows the Person Grant Housing Initiative staff.

The collaborative was started in October of 2013 with discussion focusing on the need for improved communication between the agencies that provide services and the housing agencies, the need to improve awareness about the services available, improve services agency understanding of how the housing programs work or develop new projects, and how federal and state funding can be developed or accessed to increase the availability of affordable, accessible housing for individuals with disabilities.

The work of this supportive housing collaborative has resulted in the development of Housing 101 Training program for human services agencies and developers, the expansion of the ND affordable housing data base, coordination of communication about housing needs to the state legislature, the preparation of service information for landlords and property owners to prevent evictions, and the development of a housing collaborative in each of the eight human service regions.

The housing collaborative, located in each of the eight regions, is addressing the specific supportive housing need that has been identified through a strategic planning process sponsored by the ND DHS Money Follows the Person Housing Initiative. Each group meets monthly and includes the local DHS regional human service behavior health personnel in the identification and planning process for creating of supportive housing.

North Dakota continues work to address a housing shortage exacerbated by the loss of housing following the spring 2012 flood disaster in Minot, N.D., and the rapid unplanned population growth due to unprecedented oil-development. The lack of available, affordable, and accessible housing for individuals with disabilities who are on fixed incomes, including those with serious mental illness, is a particular concern. To help address this need, lawmakers reauthorized the Housing Incentive Fund for a third time, which was created in 2011 to address affordable rental housing issues. The ND Housing Finance Agency has allocated over \$84 million to projects, leveraging more than \$424.5 million in construction financing to support the development of 2,500 new units. This has included 75 projects in 27 communities. In addition, the 2015 legislature approved an additional \$30 million in tax credits and an additional \$10 million in funds from the earnings of the Bank of North Dakota. The new award will create an additional 985 units in 24 projects and leverage \$181.5 million in housing development funding.

Capitalized by contributions from state taxpayers, the North Dakota Housing Incentive Fund (HIF) is a means for developing affordable multi-family housing for essential service workers, main street employees and fixed-income households. As part of tax reforms, the legislature also passed a measure that demonstrates that affordable housing is a public purpose by allowing a property tax break for housing projects owned by nonprofit entities, which will help keep rents lower.

North Dakota has achieved some other successes in meeting the housing needs of individuals with serious mental illness. In 2012, the National Association of Housing and Redevelopment Officials presented an Award of Merit for Cooper House - a community "housing first" effort in Fargo, N.D., where chronically homeless people or those at risk of homelessness can reside and receive mental health and substance abuse recovery support and services from the Department's Southeast Human Service Center and other local partners. This unique collaborative housing initiative also received grant support from a charitable foundation to fund nursing services.

In 2012, Minot, N.D., agency partners that include the Department's North Central Human Service Center, Minot Housing Authority, and a private investor opened Grayce Manor to serve transition age youth between ages 18-24 who are at risk of homelessness. North Dakota used its Olmstead stipend (and funds from a TTI grant) to provide rental assistance and basic furnishings for the home. Department staff provide outreach, case management services, information and referral services, and work with other service providers such as behavioral and physical health providers and employment support providers to meet the needs of youth.

North Dakota's Money Follows the Person (MFP) project continues to successfully transition individuals from nursing facilities and institutional settings and serves people with developmental disabilities and co-occurring mental health issues. MFP is providing financial assistance to people with serious mental illness transitioning from the State Hospital back into the community. The grant also has contracted with the N.D. Center for Persons with Disabilities to employ five housing specialists who work to connect people with disabilities to accessible affordable housing and to support the development of an online housing database.

The Department's leadership team has approved a proposal to write a 1915i State Medicaid Plan Amendment to develop an array of coordinated community-based services to assist North Dakota children, youth, and their families with transitions from psychiatric residential treatment facilities (PRTF) and to divert children from these institutional placements. In addition to the state plan amendment, the department will be requesting approval to expand its MFP grant to provide services to these children and youth as they transition from PRTFs. The 1915i has been started but with staff turnover has been put on hold at this time.

The department assisted in the development of the Housing Alliance of N.D (HAND). HAND works to ensure that every North Dakotan has access to a decent, safe, affordable, accessible place to live. HAND activities include the development of a housing policy platform, supporting legislation, ongoing work to solicit support for housing options across the state, and efforts to continue to rebalance long-term care and community-based services.

Behavioral health services that were increased during the session to address temporary or transitional housing and emergency services to provide prevent institutionalization. These include a 10 bed facility in Minot (5 bed in crisis residential and 5 in transitional living with some flexibility on the numbers, depending on how they are licensed), a 4 bed alternative care unit facility in Bismarck, the expansion of a mobile crisis unit in Bismarck, funds for the Department of Corrections to expand the number of beds at the State Hospital for the Thompkins Rehabilitation, and the ability for Fargo to have psychiatric residents from UND to focus on telemedicine for the western part of the state.

Mental Health Recovery Centers are located in all eight service regions. The Centers are member operated and promote recovery through peer support, socialization, education, and training. The centers offer a learning environment that promotes wellness and personal growth to empower individuals in recovery to live more meaningful lives in the community. The Recovery Centers offer groups, activities, and resources that empower members to work, volunteer, attend school or further enrich their lives.

The North Dakota Consumer Family Network (CFN) exists and includes individuals, family members, and advocacy organizations dedicated to education, support, advocacy, and empowerment in the interest of promoting mental health. Goals include consumers being well-informed of choices and possibilities beyond those presently available and for mental health care to be consumer and family driven.

The strategies identified in the Olmstead Plan to create the sustainability of peer supports are to review Medicaid reimbursement and other funding sources, explore ways to repurpose existing resources to add peer-to-peer support resulting in bridging and bonding, leverage technology to enhance peer support to reach consumers in their chosen communication channels, and conduct education and awareness to inform people about the value of peer support in recovery. The state currently has

recovery centers in seven regions and a warm line in the eighth region. The recovery center contracts will now include language supporting peer supports and certification through SAMHSA. Supported employment has continued to grow in the state.

North Dakota uses an evidence-based model of supported employment in its behavioral health system. The model provides employment services to individuals with severe mental illness to find and maintain competitive employment in their community. The model is assertive about helping individuals find work, as soon as they say they want to work. No one is excluded from receiving the services regardless of symptoms, past work history, or other issues such as co-occurring substance abuse. The model also focuses on the likes and preferences of each individual. Employment is integrated with mental health services. The state implemented the supported employment model in March 2009 in one major community as a pilot project. It has since been embedded into the Integrated Dual Disorder Treatment program throughout the state. A contract with a private provider for employment services is in place.

North Dakota implemented an Employment Development Initiative for individuals with serious mental illness with funding from a SAMHSA grant to the Department's Mental Health and Substance Abuse Services Division. An interagency group was formed and made recommendations to enhance competitive employment opportunities. One-on-one and group pre-employment coaching sessions were purchased and provided across the state. Benefit counselors conducted presentations to educate individuals on the impact work activities could have on benefits and to provide options and strategies for successful employment. An e-learning training module was also created on this topic and distributed statewide.

Work has been done and has continued across agencies to develop a clear definition of supported employment. The Division of Vocational Rehabilitation solicited proposals to procure supported employment services for individuals with Intellectual Disabilities and Development Disabilities that lead to integrated and competitive employment opportunities for individuals currently receiving day support service or individuals employed in segregated employment settings, or both. There are four grants that are each for three years. A separate technical assistance grant is being administered by Minot State University with staff from the State of Washington Supported Employment Program providing training and ongoing technical assistance for the delivery of evidence-based supported employment services.

The Workforce Innovation and Opportunity Act (WIOA), Section 511 of the Rehabilitation Act has limitations imposed on employers holding special age certificates and a series of steps that youth under age 24 must follow before accepting employment for less than the federal or state minimum wage. There are new restrictions against "a local educational agency" or "state educational agency" from entering into a contract with an entity for the purpose of operating a program for an individual who is age 24 or younger under which work is compensated at a subminimum wage. In North Dakota schools may not contract with sheltered work providers for transition services.

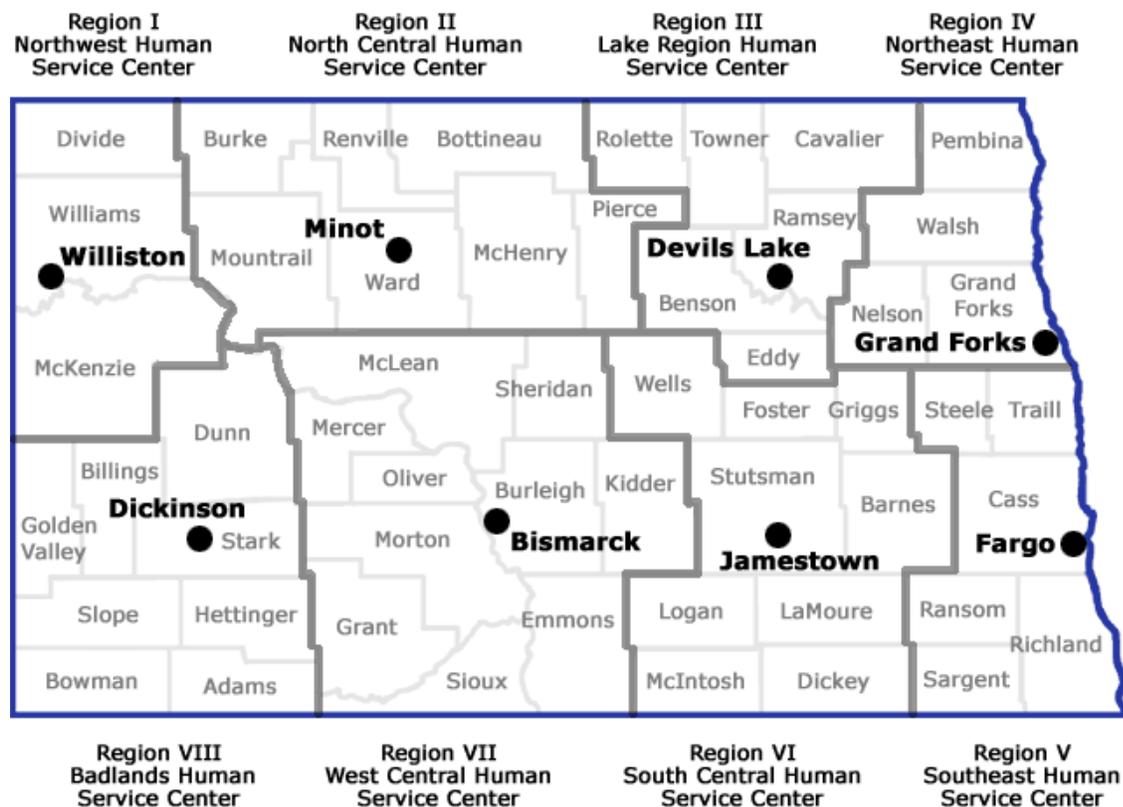
The Governor's Committee on Employment of Persons with Disabilities is conducting a research study through Minot State University to establish the current level and types of pre-employment and employment services provided and available to individuals with disabilities in ND. The research project will document the employment status of people receiving services from Community Rehabilitation Providers (CRPs) in North Dakota three years following the baseline study in 2012. The results of the survey will provide data that the Governor's Committee on Employment for People with Disabilities and other decision makers can use to identify targeted strategies to positively impact competitive integrated employment outcomes for people with disabilities. Information from the survey will tell the committee

whether or not there have been changes since the baseline study (2012). The completion date for the research study is June 30, 2016.

The Olmstead Plan is being reviewed and updated at this time and will include data driven goals and strategies. The state plans to use the Community Integration Self-Assessment Tool to gather data. HCBS data will be gathered to include the number of people served and services provided. Other data will include the number of people in institutional settings, standardized assessments statewide to see if people meet criteria for institutionalization, number of individuals needing fast track status to be discharged, barriers to discharge, and additional resources needed for transition services.

How are individuals transitioned from hospital to community settings?

The North Dakota Department of Human Services operates eight regional human service centers. Each serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services, and other human services. These services provide the primary support for individuals returning to the community. The centers are located in the eight regions of the state and their location is noted below:



The following is a summary of the core services provided by each of the regional human service center:
Children’s Mental Health

- Level I Criteria

- Care Coordination
- Level II Criteria
- Care Coordination
- Case Aide Services
- Crisis Residential/Safe beds
- Flexible funding
- Transition to Independence Program (TIP)

Serious Mental Illness (Extended Care Coordination)

- Care Coordination
- Case Aide Services
- Needs-based array of residential services
- Community Support Services
- Medical Management
- Acute/Clinical Services as deemed clinically appropriate
- Integrated Dual Disorder Treatment (IDDT)

Acute Clinical Services

Core Populations:

- Self Harm/Suicide
- Child Abuse and Neglect
- Foster Care/ Subsidized Adoption
- Acute Psychiatric
- Domestic Violence

Services

- Psychological evaluation and testing
- Psychiatric evaluation
- Clinical evaluation
- Individual Therapy
- Group Therapy
- Family Therapy
- Clinical Case Management
- Medication Management
- Crisis Residential
- Short Term Hospital
- Lab and Clinical Screening
- Battered Treatment (North Central Human Service Center)
- Survivors Treatment (West Central Human Service Center)
- Parental Capacity Evaluations
- Sex Offender Treatment

Substance Abuse Services

- Adults and Adolescents
- Care Coordination/Case Aide

- Evaluation
- Social and Medical Detoxification Services
- Needs based array of primary treatment services
- Low intensity outpatient
- Intensive outpatient
- Day treatment
- Residential Treatment
- Residential services
- Drug Courts

Crisis/Emergency Response Services

- 24-hour a day/7-days a week crisis call response from a designated, trained Center employee
- Regional Intervention Services
- Screening to the N.D. State Hospital
- Gatekeeping/referral to N.D. State Hospital and private hospitals

Aging Services:

- Aging Services Administration
- Vulnerable Adult Protective Services
- Long-Term Care Ombudsman Program
- Adult Family Foster Care Licensure
- Family Caregiver Support Program

Developmental Disabilities

- Case Management
- Day Supports
- Extended Services

Vocational Rehabilitation

- Assessment for eligibility and rehabilitation needs
- Counseling and Guidance
- Information and Referral
- Job related services
- Vision Services
- Supported Employment Services
- Rehabilitation Technology Services
- Business Services including ADA Consultation and Assessment

Child Welfare Services

- Program Supervision – Regional Reps and Child Care and Foster Care Licensing Specialists
- Foster Parent Support Services

The North Dakota State Hospital (NDSH), located in Jamestown, provides short-term acute inpatient psychiatric and substance abuse treatment, intermediate psycho-social rehabilitation services, forensic services, and safety net services for adults. The hospital also provides residential addiction treatment services for adult male and female patients referred to the Tompkins Rehabilitation and Corrections Center (TRCC) by the Department of Corrections and Rehabilitation (DOCR). The inpatient psychiatric service and TRCC are considered the traditional patient population.

North Dakota law requires that individuals voluntarily and involuntarily seeking treatment at the State Hospital receive screening by a mental health professional in one of the eight regional human service center prior to admission to the hospital. This "gatekeeper" function of the human service centers insures that, where possible, services are provided in the least restrictive, community-based environment. Other patients may be committed involuntarily to the hospital through the court system. Individuals or their family members who believe hospitalization may be needed are required to contact the regional Human Service Center in their area for assistance.

The human service centers act as the coordinating agency for discharge back to the community after treatment at the NDHS has been completed. The eight regional human service centers in North Dakota provide community-based treatment for individuals with a mental illness or chemical dependency. Individuals discharging from the NDSH work closely with a case manager at the regional center to coordinate return to community services and supports.

One of the programs in place to support the transitions from the NDSH is the Transition Assistance Program. The ND Department of Human Services has utilized the Money Follows the Person Grant Rebalancing Funds to develop the North Dakota Hospital Transition Assistance Program to provide financial assistance to support successful community integration. The North Dakota State Hospital Transition Assistance Program has assisted 130 individuals return to the community over the last three years. The Transition Assistance Program provides one-time payment of community set-up expenses for individuals who make the transition from the ND State Hospital to their own home, apartment or other similar environment in the community. Each approved participant receives up to \$2,500 to assist with transition costs.

The Transition Assistance Program includes payments for the following:

- Security and utility deposits
- Health and safety technology
- Home modifications
- Adaptive equipment
- Home/Apartment furnishings-linens, dishes, small appliances, furniture
- Assistive technology devices
- One time modifications for a vehicle owned by the individual
- Moving expenses (costs related to moving personal belongs and transport of the consumer),
- Payment of past due utility bills, etc.
- Other needs for successful return to the community

The NDSH case managers work with the SMI case managers, addiction counselors, or other case managers from the regional human service centers to assist the consumer in making a request for

payment of these items. The regional center or NDSH will make the purchases with the consumer and the items purchased for a consumer becomes the property of the consumer upon their successful transition to the community. The consumer is free to manage this property any way they see fit once the transition occurs.

What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The North Dakota Department of Human Services has continued to participate in the Money Follows the Person Rebalancing Grant (MFP) since 2007. MFP is a federal grant-funded effort that focuses on 1) transitioning qualifying Medicaid-eligible individuals from nursing homes and Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID is a federal term) to community settings, and 2) to strengthen access to and usage of home and community-based long-term care services. The MFP Grant has assisted 266 individuals transition from institutional settings back to the community. This has included assisting about 100 individuals with a co-occurring behavior health needs. The MFP Grant has been instrumental in assisting the Department in identifying gaps in services, provision of technical assistance, the development of a Housing Initiative, and in piloting the NDSH transition Assistance Program.

In 2014 the Department was awarded the MFP Tribal Initiative and has been working to engage all of the state's tribal nations in the exploration of culturally responsive services that could be developed to transition tribal members back home and to develop the infrastructure needed to maintain members in their own home. This includes the assessment of tribal current services and population needs, identification gaps in services, development of a transition program, and the possible development of one or more Medicaid authorities that would meet the needs of the state's tribal nations. The Department continued its Transition to Community Task Force to assist the North Dakota Life Skills and Transition Center work in cooperation with community agencies and advocacy organizations to transition adults and children with intellectual disabilities and co-occurring behavior health needs back to the community. The task force has facilitated the development of new community support options, policy, and programs to support community providers meet the support challenges of persons with more complex needs.

Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

North Dakota has no pending litigation or settlement agreements with the Department of Justice regarding community integration for children with SED or adults with SMI.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

There is currently one initiative or project directed from within the Behavioral Health Division that targets the behavioral health needs of *all* children and adolescents in North Dakota; the reader is reminded of the efforts to enhance public awareness of trauma and trauma-related health problems and to improve access to evidence-based treatments through the various activities described in section 11 (Trauma). Though much of the trauma-related work has been directed toward addressing the needs of youth with Serious Emotional Disturbance (SED) and their families, it is reasoned that increased public awareness and a behavioral health workforce that is better-prepared to detect and treat trauma-related conditions will benefit *all* North Dakotans.

The Council of Juvenile Correctional Administrators (CJCA) launched Performance-based Standards (PBS) in 1995 (see the reference to PbS in section 12 – Criminal and Juvenile Justice). The PbS program has been in constant use at the North Dakota Youth Correctional Center since 1997. In 2008, the CJCA began development of Community-based Standards, a project that applies the PbS model of performance evaluation in secure facilities to community residential programs for youth involved in the juvenile justice system. The goal of CbS is to establish and sustain systems for continuous improvement and accountability in community-based residential programs across the country. The Prairie Learning Center (PLC) in Raleigh North Dakota piloted CbS in 2010. Three additional residential facilities implemented CbS in 2011 (Home on the Range; Ruth Meier’s Adolescent Center; Luther Hall). The remaining youth-serving residential facilities in North Dakota joined CbS in 2012. There are 6 Psychiatric Residential Treatment Facilities (PRTFs) and 11 Residential Child Care Facilities (RCCFs) in North Dakota, and all of them presently engage in ongoing performance monitoring and evaluation and facility improvement activities. The CbS data for RCCFs is reported to the Division of Child and Family Services, which licenses RCCFs, and the CbS data for PRTFs is reported to its licensing entity, the Behavioral Health Division. The CbS data will be available for public inspection through its posting on the Department of Human Services webpage sometime in 2016.

North Dakota’s 11 RCCFs serve youth ranging in age from 10 to 21. There are 212 RCCF beds. There are 82 PRTF beds; most facilities serve youth ages 10 to 18. Only one PRTF serves younger children, ranging in age from 5 to 14, and this facility has 8 beds. There is an inquiry pending with CFS from a vendor that is considering opening a 16-bed RCCF. North Dakota has set the maximum number of RCCF beds allowed at 288, and allows for a maximum of 84 PRTF beds.

Concurrent with CbS participation, all of North Dakota’s residential facilities for youth were provided training experiences and educational materials by the Building Bridges Initiative (BBI) as delivered under a contract between the Behavioral Health Division and Beth Caldwell and Associates. Three BBI training events were held in the late Fall / early Winter of 2014, and four more training events occurred in the late Spring of 2015. The BBI material is organized around a set of guiding principles: Core Values; Family Driven and Youth Guided; Cultural and Linguistic Competence; Clinical Excellence and Quality Standards; Accessibility and Community Involvement; Transition Planning and Services (Between Settings and from Youth to Adulthood); Effective Workforce Development, and Assessment, Evaluation, and Continuous Quality Improvement. Particular areas of emphasis during training included engaging families in treatment, moving from control to collaboration, and helping youth in facilities develop effective sensory modulation (self-regulation) skills.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

19. Pregnant Women and Women with Dependent Children

The regional human service centers screen all admissions for preference as required in 45 C.F.R. 96.131 at initial contact. All regional human service centers and the Behavioral Health Division (BHD) have toll-free phone numbers. If the client identified as being a pregnant woman they were scheduled or offered appointments within 48 hours. Walk in clinics are now available at all regional human service centers.

An Assurance of Compliance with Rules and Regulations was signed by all regional human service center directors and included with substance abuse contracts in 2015 and 2017. The assurances stipulate the priority population requirements and the communication requirement with the BHD regarding their ability to admit pregnant woman. All regional human service centers are to provide preference for admission to treatment to pregnant women (who seek and are referred for and would benefit from Block Grant-funded treatment services). In the event a program would not be able to admit a client, the client is placed on a priority waiting list and interim services would be provided. Interim services may include pre-treatment groups, education, and case management.

As identified in the assurance, North Dakota has a capacity management plan for pregnant women. Human Service Centers, upon reaching 90% of its capacity to admit pregnant women, shall provide written notification of that fact to Division within 7 days. If Human Service Center does not have the capacity to admit or refer a pregnant woman to the clinically appropriate modality of care within 48 hours of requesting treatment, Human Service Center shall:

- a. Place the client's name and case number on an active waiting list,
- b. Recommend and provide interim services for the individual as required within 48 hours of the request for treatment,
- c. Provide Division with written notification immediately of the client's case number, the date treatment was requested and the status of offered interim services, and
- d. Provide written notification to Division regarding the outcome of the individual's admission status.

If a client refuses treatment, the client's name need not be placed on the waiting list. Pursuant to 45 CFR 96.126, a client who is initially receptive to treatment, but who later cannot be located for admission into treatment or refuses treatment when notified of an available treatment slot, may have that client's name removed from the waiting list.

Regional human service centers publicize priority status is provided to pregnant woman. This is found within their brochure and on the department's web page at the following link:

<http://www.nd.gov/dhs/services/mentalhealth/index.html>

To ensure that pregnant women are admitted to treatment within 48 hours, the division can communicate and maintains contact with each regional human service centers. Case files of those clients who are identified in our management information system can be pulled and reviewed electronically as to whether the appropriate services were provided in the time frames specified within the block grant.

To ensure that interim services are provided to pregnant women in the event a human service center is has insufficient capacity to provide treatment services, a plan is in place. The eight regional human service centers are required and responsible to comply with all requirements of the SAPT Block Grant including capacity management and waiting list systems. The BHD worked with regional human service

centers to create a signed Assurance of Compliance with Rules and Regulations outlining all activities required for receipt of SAPT Block Grant funds. Items included in this assurance include:

- Capacity management—Intravenous Drug Users (IVDU's);
- Capacity management—Pregnant women; and
- Interim services requirements for pregnant women and IVDU's

A Substance Abuse Prevention and Treatment Block Grant Monitoring Checklist has been distributed.

The Division maintains a toll-free number ((800) 755-2719). Providers are also instructed to call 1-800-755-2719 or e-mail immediately if they are unable to admit and/or provide interim services for intravenous drug users and pregnant women.

Interim services are intended to reduce the adverse health effects of alcohol and other drug abuse, promote the health of the individual, and reduce the risk of transmission of disease. For pregnant women, interim services shall include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care. At a minimum, interim services for other populations shall include education on HIV and TB and risks of transmission, case management, referrals for testing to public health or primary physician, and alcohol/drug screening.

When interim services are provided, the client will be seen at least weekly by a case management staff member who will provide education on a 1:1 basis. During this time, referrals to public health for testing and/or prenatal care and alcohol/drug screening can be managed.

In the event interim services cannot be provided, BHD will be notified of the client's name and case number and arrangements will be made for provision of services by another agency but to date, this has not been used.

The BHD is responsible for monitoring compliance and a plan has been developed to conduct block grant compliance reviews biennially with each of the regional human service centers and compliance with these issues assessed. The plan also includes reports to be submitted to the BHD either immediately, within 7 days, monthly or quarterly. An independent peer review team reviews 12-25 percent of the human service centers annually and assesses compliance with requirements as part of the reviews.

North Dakota has two women specific substance abuse treatment programs. These programs are North Central Human Service Center (NCHSC) and Northeast Human Service Center (NEHSC) and are providing services to pregnant women, woman and their infants, and women with dependent children from all regions of the state.

The NCHSC women's program provides high-intensity residential care (ASAM Level 3.5) with clinical services including day treatment group, case management services and mixed gender aftercare addiction groups. Treatment services also included continuing care services, referrals for the children (Children of Alcoholics) and other counseling issues as needed. Residential services provided were onsite day care, job search assistance, parenting classes, nutrition, social skills, healthy relationships, transportation, coordination of health services, and long-term transitional living services. Women who are pregnant are referred and scheduled for services as soon as possible with Trinity for Obstetrics and other medical services with UND family practice if they have Medicaid and First District Health Unit if they do not have insurance or financial means. Some services were provided through a contract with private treatment providers.

NEHSC offers women specific treatment by providing low intensity residential programming (ASAM Levels of Care 3.1) with clinical services including intensive outpatient programming and aftercare programming in a women's only group. In the residential program clients are provided assistance in arranging prenatal care at a medical provider in the community. Staff facilitates access to services and if women do not have insurance or financial means, assistance with finding funding sources is provided. Residential services provided included assistance with daycare, additional parenting support, daily living skills as well as education, support in developing sober support, working everyday living issues, job search and employment programs, nutrition, child safety issues including education, and long-term transitional living services. Some services were provided through contract with private treatment providers. NEHSC also offers an abuse/trauma group for women in addition to individual therapy for these issues. Parenting Classes are offered onsite at the residential facility while the women are in primary treatment. NEHSC also provides ASAM Levels of Care 3.1, 2.5, 2.1, and 1.0 in a mixed group facility as an alternative to the women's specific programming if capacity requires or the client requests a mixed group. NEHSC also works closely with the county social service agencies for ongoing treatment planning as well as discharge planning and arranging visits with children.

Referrals to these programs are enhanced through the use of the electronic record as all human service center programs can access client history (including treatment history), and improve the continuity of care (transitioning from admission, through continued care and discharge from a residential facility).

Women receive treatment at all regional human service centers, although some treatment services may not be women specific.

Currently, there are no publically funded medication-assisted treatment (MAT) services for the pregnant women in their care in North Dakota. Regional human service centers do coordinate care with a primary physician if needed. Programming is delivered for those who are currently being provided with medication to assist them in their recovery. The division continues to work with County Social Services regarding MAT.

The oil impact with the influx of residents coming to the western area of the state and competitive wages has resulted in underserved areas of the state. The department has undertaken several efforts in an attempt to increase substance abuse services in these regions of the state. This includes additional funding for staff, the use of tele health, a voucher program and contracting for addiction services.

Another barrier to treatment is the geographical location of these two programs. The women referred to these programs are required to make a geographical transfer to one of two regions. This is a barrier due for some women not wanting to relocate to attend a residential treatment for several months.

The division requested authority and developed administrative rules for the licensing and treatment standards for Opioid Treatment Programs (OTP). Three communities where programs have applied for OTP licenses have been resistant to programs opening in their communities. Consequently, two of these three communities have moratoriums in place creating a barrier to services being provided in ND.

The 2015 North Dakota legislative session enacted a bill (SB 2367) related to the establishment of a substance exposed newborn task force for the purpose of researching the impact of substance abuse and neonatal withdrawal syndrome, evaluating effective strategies for treatment and prevention, and providing policy recommendations. This task force will have representation from the ND Department of Human Services.

Additional resources from the ND Department of Health include the Optimal Pregnancy Outcome Program (OPOP) which is a primary prevention program designed to empower pregnant women to make informed, healthy lifestyle choices to ensure that they give birth to healthy babies. Future collaboration efforts may include exploring future partnerships with state OPOP program, sending out emails to programs with information and/or providing presentations at their statewide meeting to increase awareness of services.

To improve knowledge of SAPT Block Grant requirements, technical assistance is needed to provide Substance Abuse Prevention and Treatment Block Grant Overview as this training was last completed in 2008.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

20. Suicide Prevention

The Behavioral Health Division works closely with the ND Suicide Prevention Program which is located in the ND Department of Health – Division of Injury Prevention. This program was funded by the SAMHSA Garrett Lee Smith Grant; this program is currently funded by the State of North Dakota. The Suicide Prevention Program promotes and leads the activities of North Dakota’s Suicide Prevention Coalition. In addition, Behavioral Health Division staff have attended these coalition meetings. The Suicide Prevention Director has been actively involved with the State Epidemiological Outcomes Workgroup (SEOW). Staffing changes have occurred in both divisions, hence collaboration will continue as new staff are trained.

In 2014, the coalition used the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action to develop the North Dakota’s Suicide Prevention Plan 2014 -2016. The ND Department of Health is meeting with the Governor’s Office to discuss the strategic plan and will examine ways to increase coordination in communities.

The ND Suicide Prevention Plan (2014-2016) can be accessed at:

http://www.ndhealth.gov/suicideprevention/image/cache/Suicide_Report_2014_Final_web_2.pdf

The State Suicide Prevention Plan includes data and risk factors related to the following: survivors, adolescents/young adults, middle adulthood, older adults, LGBT, American Indians, military, substance use & mental health. In addition, the plan addresses specific action steps targeting special populations such as youth, young adults, American Indians, military, and adults.

With guidance from this state plan, recent activities were completed by the Suicide Prevention Program and partners. In addition, future plans are also highlighted below.

Strategy 1. Develop and implement effective programs and promote wellness to prevent suicide related behavior.

Goal 1: Promote best practice programs:

The North Dakota Department of Health has invested in best practice program trainings across the state including ASIST, SafeTALK, QPR, SOS , Kognito and CALM. QPR, ASIST, SafeTALK and CALM train-the-trainer events have been held throughout the state with educators, law enforcement agencies, addiction, medical and behavioral health agencies as well as for first responders. Citizens have been incorporated into evidenced based chaplaincy trainings. Veterans, military and all four Tribal populations have been target audiences. Kognito has been implemented in elementary and high schools. In addition, Kognito is now being implemented in college and university systems.

Goal 2: Promote Firstlink’s call back program for suicide prevention lifeline callers, as well as for people referred from community agencies.

Suicide Prevention has continued its partnership with the suicide prevention lifeline and Firstlink. A promotional plan has been developed. Resources and promotional materials have been developed and disseminated. A contract was awarded to further the development of advertising through the use of multimedia and social media. The Suicide Prevention Program has also partnered with the Family Planning Program to ensure all clinics routinely screen for depression and suicidal ideation and make appropriate referrals.

Goal 3. Promote and develop wellness activities:

The Suicide Prevention program and partner participate in meetings with the Indian Affairs Commission and tribal coordinators. A literature review is in process and talking points are in development regarding the relationship between bullying and suicide. Topics of resiliency, communication skills, mental wellness, connectedness and positive self-esteem are being promoted to youth in schools. Through collaboration with other partners, Sources of Strength, Project Launch, American Indian Life Skills Curriculum, Parents LEAD website and other educational materials are being utilized by community partners across the state. In an effort to reduce barriers across all ages and populations, a comparison sheet is in development and will be shared for dissemination by local leaders in wellness programs.

Strategy 2: Integrate and coordinate activities across multiple sectors and settings, including training for community and clinical service providers on suicide prevention and suicide-related behaviors.

Goal 1: Offer suicide prevention sessions at conferences across the state:

Plans are underway to provide suicide prevention sessions at the Injury Prevention, Behavioral Health and other school conferences.

Goal 2: Implement effective training and program activities for high risk populations:

Community needs assessments and projects are identifying and reporting on the needs of high risk groups and socially isolated groups across ND, including oil impact areas and Tribal lands.

The Suicide Prevention Program and contracted advertising partners are focusing on sharing the knowledge that “*suicide is preventable*” through best practice training programs, along with teaching parents and educators how to identify warning signs and how to make referrals. Suicide prevention materials have been developed and are being distributed. New materials with targeted messaging will continue to be developed and distributed in a wide variety of settings and points of access. In addition, the program is reaching out to educational institutions in order to train North Dakota’s nurses, social workers and other helping professionals to integrate suicide prevention into their training curriculum and competencies. In addition, the program will continue to work with partners to ensure suicide prevention messaging is culturally competent.

The Suicide Prevention Program will continue to build partnerships with various organizations. The program is partnering with worksite wellness programs to offer depression and suicidal ideation screenings. In addition, the program has provided a train-the-trainer workshop for first responders and tribal members of each Tribal Nation in ND. The program will continue to partner with ND military and disseminate the ND Cares (SWOT) strengths, weaknesses, opportunities and threats analysis. They will continue to engage clergy members in depression and suicidal ideation training. In addition, they will continue to engage gynecologists, obstetricians and other medical professionals regarding suicidal ideation screenings.

Goal 3: Support the integration of mental health and suicide prevention with helping professionals:

The Suicide Prevention Program continues to grant opportunities for medical facilities (primary care, emergency departments, public health and federally qualified health centers) to focus on ongoing screening and referral to mental health services. They will continue to reach out to improve the availability of suicide prevention materials and content across a wide variety of settings and share information through participation at the Behavioral Health Conference.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

The North Dakota Mental Health and Substance Abuse Planning Council's membership includes representatives from Medicaid, the North Dakota Housing Finance Agency, social services, behavioral health, the North Dakota Department of Correction and Rehabilitation, Vocational Rehabilitation, the North Dakota Indian Affairs Commission, Aging Services, and the North Dakota Department of Public Instruction. They are highly involved with the planning for the community-based public behavioral health system and actively participate in the quarterly meetings of the Council. Because of this, the Council's letter – which will become a part of this application – serves as notice of their support.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

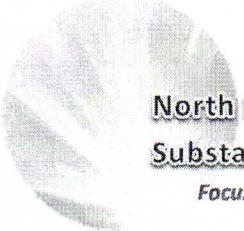
Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Under the mandate outlined in Public Law 102-321 (42 U.S.C 300X-4), thirty member board -- the North Dakota Mental Health and Substance Abuse Planning Council -- was created with members appointed by the Governor of North Dakota. The Council's objective is 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 not less than 50% of the board is composed of individuals other than state employees and providers of mental health services.

In 2013, the Council voted to change its structure to integrate mental health and substance abuse planning populations. The North Dakota Mental Health and Substance Abuse Planning Council's composition was modified and new member positions were added to bring a voice to substance use disorder issues. The structure of the North Dakota Mental Health and Substance Abuse Planning Council includes representatives of the service area population including the Indian Affairs Commission, the Aging Services Division, families of children with SED, families of adults with SMI, families of adults/children with substance use disorder, consumers, military veterans, and families of military veterans. Membership includes both rural and urban representation. There is a variety of ages represented and the membership includes two youth representatives. As ethnic and culture changes in North Dakota, the Council will remain cognizant of such changes and will make adjustments as needed.

The Council meets quarterly to discuss community-based public behavioral health services and works closely to plan for the system of care and monitor its implementation. The agenda of each meeting involves review and discussion of the priority areas found in the block grant and discussion of the system of care. The Council's input is woven into the block grant plan. A subcommittee of the Council reviewed the needs and gaps identified through various sources – including a legislative study, the Behavioral Health Barometer, and stakeholder feedback – and identified priorities for the upcoming block grant planning period. The Council priorities will be woven into the application and plan.



**North Dakota Mental Health and
Substance Abuse Planning Council**

*Focused on Wellness and Recovery
Consumer and Family Driven*

1237 West. Divide Avenue, Suite 1C
Bismarck, ND 58501
Phone: 701-328-8920
Fax: 701-328-8969

Carl Young, Chair

August 26, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

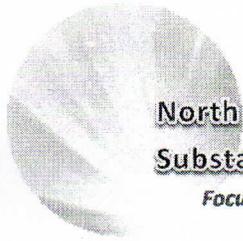
Dear Ms. Simmons

I am pleased to submit this letter on behalf of the North Dakota Mental Health and Substance Abuse Planning Council for North Dakota's Fiscal Year 2016-2017 Combined Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant Application.

North Dakota continues to make great strides in community-based mental health services though many challenges remain. In an effort to address the needs, our Council worked with the North Dakota Department of Human Services to identify priority areas and goals for the next two years.

- Integration between substance abuse and mental health services.
- Increased access to mental health services.
- Increased access to appropriate mental health services for the prison populations.
- Increased access to substance use treatment for youth and young adults.
- Expanded access to telehealth services in our rural communities
- Increase in peer to peer, parent to parent, and youth to youth support.
- Discharge planning all cases of discharge from facilities to ensure that no person falls through gaps in service.
- Establish specialized treatment for families of those individuals receiving therapy.
- Increase service and support for veteran specific care and services.
- Look at an evidence-based case management system such as Assertive Community Treatment for the SMI population

The Behavioral Health Division and the North Dakota Mental Health and Substance Abuse Planning Council use a variety of data sources to identify needs within the behavioral health system and to develop plans to address those need areas. For instance, North Dakota substance use-related data is summarized in the Epidemiological Profile (compiled/created by the state's State Epidemiological Outcomes Workgroup [SEOW]). The Department of Human Services holds stakeholder meeting each biennium to gather input on needs and gaps. The North Dakota

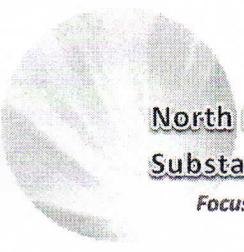


Legislature commissioned a study of the needs and gaps of the behavioral health system throughout the state. Below are needs and gaps of the behavioral health system that were identified by various groups.

North Dakota has an active State Epidemiological Outcomes Workgroup (SEOW), which was established in 2006. The ND SEOW's mission is to identify, analyze, and communicate key substance abuse and related behavioral health data to guide programs, policies, and practices. Administered by the Behavioral Health Division, the SEOW has built a broad representation of diverse partners and continues to provide leadership in identifying community data needs along with readiness to act for high need communities that will implement the evidence based prevention programming. The SEOW continues to collect, organize, analyze and develop data-sharing products (Epidemiological Profile, Data Book, Data Briefs, SUND website) with a continued look at expanding how alcohol and other drug abuse impacts other behavioral health issues.

North Dakota's SEOW identifies, collects and organizes a variety of data types, including consumption rates, consequence indicators, data describing community readiness and perceptions, and is starting to identify and collect more data describing intervening variables, including risk and protective factors. This data covers a variety of populations including, middle school, high school, youth ages 12 and over, college students, adults (ages 18-25 and 26 and over). Also, all data is available at the statewide level. Some data is available at the regional levels and very limited data is available at the county or city level (because of the rural nature of the state). The data sources utilized by the ND SEOW include the following (both national and state sources): National Survey on Drug Use and Health (NSDUH); Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Surveillance System (YRBS); Youth Tobacco Survey (YTS); Adult Tobacco Survey (ATS); Crime in ND reports; ND Department of Transportation Crash Report; ND Community Readiness Survey; ND CORE survey; and Treatment Episode Data Set (TEDS).

A comprehensive Epidemiological Profile is developed every other year. The data used in the Epidemiological Profile are at the aggregate state level, with limited sub-state analyses. A major challenge for the North Dakota SEOW is the limited availability of reliable and valid data at the local level. Limitation in the utility, reliability, and validity of data exist because of the state's small population. The challenge is even greater when considering epidemiological data from sub-state entities, such as counties and school districts. However the SEOW is continuously working to identify available sub-state data in order to enhance local needs assessment processes. The SEOW is currently developing a data sharing website, Substance Use North Dakota (SUND), modeled after Minnesota's SUMN.org in order to increase sharing of available data and support communities in applications for funding and data-driven planning.



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Carl Young, Chair

The SEOW's deliberation and review of the data on substance use consumption patterns, consequences of use, perceptions, and intervening variables resulted in the identification of priority areas in which the SAPT BG primary prevention funds should be allocated: (1) Underage Drinking; (2) Adult Binge Drinking; and (3) Prescription Drug Abuse.

Also produced by the ND SEOW is the Substance Use in North Dakota data booklet, which overlays some of the key data indicators from the Epidemiological Profile in a story-telling manner. This booklet, along with the Data Briefs produced by the SEOW, is targeted to the general population with the goal of raising the awareness of substance use issues and guiding programming and policy decisions.

Within the past year, through the SEOW effort, Context Maps were developed. These Context Maps contain models visually depicting the root causes (intervening variables) and consequences of excessive alcohol use, tobacco consumption and illicit drug abuse in N.D. These models were developed with a small group of subject matter experts (SMEs), and subsequently validated by the SMEs and a targeted literature search. Each context map also features prioritized conditions, which are underlying conditions the SMEs believe should be targeted, given resource and time constraints. For example, the intervening variables that were prioritized for alcohol include, lack of alcohol law; limited enforcement of alcohol laws/policies; community norms supportive of alcohol use; social availability of alcohol; young age of initiation.

Also through this process, unmet service needs (i.e. all prioritized underlying conditions for which there are no activities) are being identified, which will lay the foundation for improving the effectiveness of the current primary prevention system.

Although the North Dakota substance abuse prevention system has many strengths, there are also identified gaps. A continuing need of the state's substance prevention system is the development and maintenance of the community-level substance abuse prevention infrastructure, even with the enhancements in recent years. Local substance abuse prevention in the state is relatively new to the use of evidence-based strategies. The rural and frontier culture also presents barriers due to limited access to trained workforce and long distances to resources. There are limited prevention training opportunities in ND, professional prevention workforce shortages, and no statewide prevention specialist certification process. One gain, within the past two-three years, was the first two Master's in Public Health programs became available in the state.

Another identified gap is that the Division's substance abuse prevention system has developed many pieces of a strategic plan to guide substance abuse prevention; however, it has not all been put together into one comprehensive "strategic plan" document. For example, priority areas have been identified through the review of data

through the SEOW and logic models for priority areas/efforts identify activities and process and outcome measures. The Division plans on pulling all of this information together in order to develop a comprehensive strategic plan to guide decisions about the use of the primary prevention set-aside of the SABG. This plan will also include information as to how the Division will leverage, redirect and align statewide funding streams and resources for prevention.

The North Dakota Legislature contracted with Shulte Consulting, LLC to study the behavioral health system in North Dakota and to create a plan to improve those services. Schulte Consulting, LLC, conducted over 35 face-to-face meetings with various groups and individuals. Five public hearings were conducted statewide. Bi-weekly public conference calls occurred. Over 414 separate people participated for a total of over 19,738 minutes logged by North Dakotans. Over 230 documents, not including email, were reviewed and considered for the report. Gaps identified included:

- Service Shortages:
 - Access to services.
 - Lack of case management.
 - Lack of crisis assessment options.

- Expand Workforce:
 - Professional licensing issues.
 - Lack of use of peers, family support peers, recovery coaches and other alternatively trained persons.

- Insurance Coverage Changes Needed:
 - Lack of funding options for services
 - Lack of coverage for providers

- Changes in DHS Structure and Responsibility
 - Lack of transparency and choice in services
 - Need for proposed structural changes

- Improve Communications
 - Lack of integrated physical and behavioral health treatment
 - Lack of record sharing and real time information
 - Lack of communication between HSCs and everyone else

- Data Collection and Research
 - Lack of data for providers outside the HSC system
 - Lack of data for services provided outside the HSC system
 - Lack of data driven services utilized for treatment

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Carl Young, Chair

Overall, the NDMHSAPC appreciates the work of the Division. We endorse the application and will continue to collaborate with the Division in the accomplishment of the solutions needed to best meet the needs of the people of the State of North Dakota, regardless of age or need.

If you have any questions, please feel free to contact me.

Sincerely



Carl Young
Chair

North Dakota Mental Health and Substance Abuse Planning Council
carl@clientfactor.com

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Pamela Sagness	State Employees	North Dakota Department of Human Services	1237 W. Divide Avenue, Suite 1C Bismarck, ND 58501 PH: 701-328-8824 FAX: 701-328-8969	psagness@nd.gov
Gail Schauer	State Employees	North Dakota Department of Public Instruction	600 E. Boulevard Avenue, Dept. 201 Bismarck, ND 58505 PH: 701-328-2265 FAX: 701-328-2461	gschauer@nd.gov
Robyn Throlson	State Employees	North Dakota Department of Human Services	1237 W. Divide Avenue, Suite 1B Bismarck, ND 58501 PH: 701-328-8955 FAX: 701-328-8969	rthrolson@nd.gov
Lisa Peterson	State Employees	North Dakota Department of Corrections and Rehabilitation	PO Box 1898 Bismarck, ND 58502 PH: 701-328-6790 FAX: 701-328-6651	lapeterson@nd.gov
Jennifer Henderson	State Employees	North Dakota Housing Finance Agency	PO Box 1535 Bismarck, ND 58502 PH: 701-328-8055 FAX: 701-328-8090	jhenaderson@nd.gov
Debbie Baier	State Employees	North Dakota Department of Human Services	600 E. Boulevard Avenue, Dept. 325 Bismarck, ND 58505 PH: 701-328-4864 FAX: 701-328-1544	dabaier@nd.gov
Michelle Gayette	State Employees	North Dakota Department of Human Services	1237 W. Divide Avenue, Suite 6 Bismarck, ND 58501 PH: 701-328-4613 FAX: 701-328-8744	mgayette@nd.gov
Brad Hawk	State Employees	North Dakota Indian Affairs Commission	600 E. Boulevard Avenue, Judicial Wing Room 117 Bismarck, ND 58505 PH: 701-328-2428 FAX: 701-328-1537	bhawk@nd.gov
Lynden Ring	State Employees	West Central Human Service Center	1237 W. Divide Avenue, Suite 5 Bismarck, ND 58501 PH: 701-328-8758 FAX: 701-328-8900	lring@nd.gov
Rosalie Etherington	State Employees	North Dakota State Hospital	2605 Circle Drive Jamestown, ND 58401 PH: 701-253-3694 FAX: 701-253-3999	retherinton@nd.gov
Troy Ertelt	Providers	Assessment and Therapy Associates of Grand Forks, PLLC	725 Hamline Street Grand Forks, ND 58203 PH: 701-780-6881	tertelt@atagf.com
Carlotta McCleary	Others (Not State employees or providers)	Mental Health America of North Dakota	PO Box 4106 Bismarck, ND 58502-4106 PH: 701-255-3692	cmcclary@mhand.org

Shiobahn Deppa	Others (Not State employees or providers)	Consumer Family Network ND	2130 s. 12th Street, #310 Bismarck, ND 58504 PH: 701-223-8535	siobhandeppa@gmail.com
Deb Jendro	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2709 Elm Street Fargo, ND 58102 PH: 701-235-9923 FAX: 701-235-9923	debjefederation@yahoo.com
Debra Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		930 N. 3rd Street Grand Forks, ND 58203 PH: 701-795-9143 FAX: 701-772-5560	djohnsonphf@yahoo.com
Teresa Larsen	Others (Not State employees or providers)	Protection and Advocacy Project of North Dakota	400 East Broadway, Suite 409 Bismarck, ND 58501 PH: 701-328-2950 FAX: 701-328-3934	tlarsen@nd.gov
Timothy Wicks	Others (Not State employees or providers)		Bismarck Military Service Center, 1850 E. Bismarck Expressway Bismarck, ND 58506 PH: 701-333-4828	timothy.j.wicks.nfg@mail.mil
Jodi Stittsworth	Parents of children with SED		739 Great Plains Ct Grand Forks, ND 58201 PH: 701-610-1724	jodi1510@hotmail.com
Darrin Albert	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5619 20th Street Circle South Fargo, ND 58104 PH: 701-235-8315	darrin.albert@yahoo.com
Jeffrey Olson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 473 Wilton, ND 58579 PH: 701-426-6308	jro.ptf@hotmail.com
Derek Solberg	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1006 N. 29th Street Bismarck, ND 58501 PH: 701-530-2420	dacksolberg@hotmail.com
Jane Johnson	Providers	North Dakota National Guard	3920 31st St. North Fargo, ND 58102 PH: 701-451-6078 FAX: 701-451-6064	jane.m.johnson.nfg@mail.mil
Kim Osadchuk	State Employees	Burleigh County Social Services	415 E. Rosser Avenue, Suite 113 Bismarck, ND 58501 PH: 701-222-6670	kosadchuk@nd.gov
Carl Young	Parents of children with SED		206 2nd Street SE Garrison, ND 58540 PH: 701-463-7804	carl@clientfactor.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	30	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	<input type="text" value="6"/>	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	17	56.67%
State Employees	11	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	13	43.33%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="1"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="2"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes: