

North Dakota

UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/16/2019 2:47:12 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 2020

End Year 2021

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 Behavioral Health Division

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 Laura

Last Name Anderson

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 7013288918

Fax 701-328-8969

Email Address lauranderson@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 Laura

Last Name Anderson

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

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 58503

Telephone 7013288918

Fax 701-328-8969

Email Address lauranderson@nd.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name NA

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Laura

Last Name Anderson

Telephone 4067941368

Fax

Email Address lauranderson@nd.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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.
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 Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Pamela Sagness

Signature of CEO or Designee¹: _____

Title: Director, Behavioral Health Division

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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- to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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.
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 17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
 18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
 19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR 575.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: North Dakota

Name of Chief Executive Officer (CEO) or Designee: Pamela Sagness

Signature of CEO or Designee: 

Title: Director, Behavioral Health Division

Date Signed: 8-9-19

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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

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- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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 1. Abide by the terms of the statement; and
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- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
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2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Pamela Sagness

Signature of CEO or Designee¹: _____

Title: Director, Behavioral Health Division

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: ~~_____~~

Signature of CEO or Designee¹: *Pamela Sagness* ↙ ↘

Title: *Director, Behavioral Health Division* Date Signed: *8-9-19*
mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

Title

Organization

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

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

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GENERAL STATE DEMOGRAPHICS

North Dakota is a vastly rural and frontier state with a relatively small population. North Dakota covers 69,000.80 square miles and has a 2018-estimated population of 760,077 people. As of 2010, North Dakota had 9.7 people per square mile compared to the United States at 87.4 people per square mile. According to the 2010 Census, North Dakota has 357 incorporated communities. Fifty-five percent of these communities have 200 people or less. The state’s largest cities are Fargo (122,359), Bismarck (72,865), Grand Forks (57,056), and Minot (47,822) (2017 Estimate).

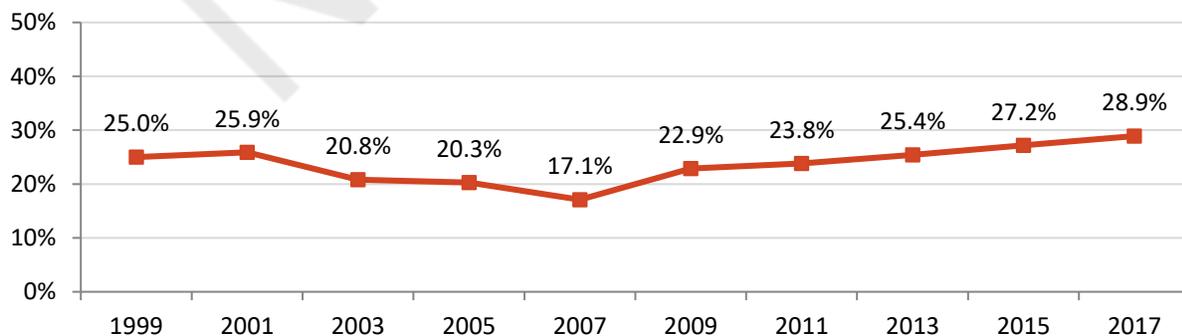
Just over fifteen percent of the state’s population is over age 65 and 23.5 percent is under age 18 (2018 estimate). Ten percent of persons live below the poverty level, compared to 12.3% nationally. According to the U.S. Census Bureau, 88.7% of the state’s population is white, 5.5% is American Indian/Alaska Native, 3.1% is Black or African American and 3.7% is of Hispanic/Latino origin (2017 Estimate). There are five federally recognized American Indian Tribes located at least partially within the State of North Dakota: Mandan, Hidatsa, & Arikara Nation (Three Affiliated Tribes); Spirit Lake Sioux Tribe; Standing Rock Sioux Tribe (bestrides North Dakota and South Dakota); Turtle Mountain Band of Chippewa Indians (including Trenton Indian Service Area); and Sisseton-Wahpeton Oyate Nation (majority located in South Dakota). There are 47,228 civilian veterans in North Dakota, comprising approximately 8% of the adult population.

The western half of North Dakota consists of many small communities spread across thousands of acres of farmland, with farming as one of the primary 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. This led to dramatically increased population, which taxed the surrounding infrastructure and community-based systems. In 2015, expansion of oil production began to slow steadily, leading to economic shifts that have equally impacted these same communities.

Mental Health System Data Epidemiology (MHBG Criterion 2)

YOUTH: Over one in four (28.9%) ND high school students report feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past year. [i]

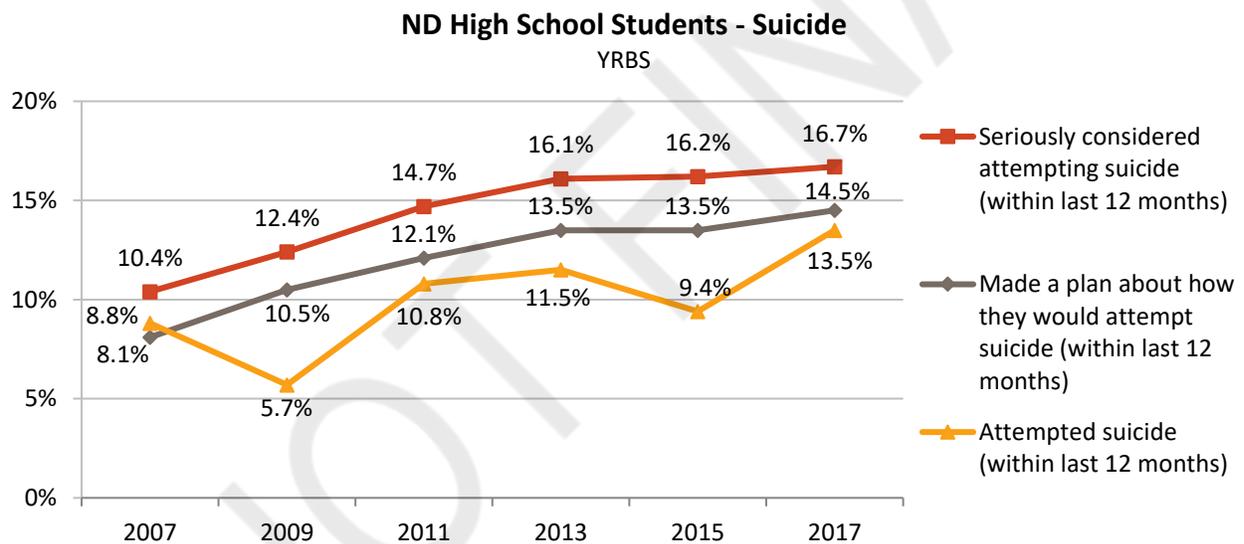
ND High School Students reported feeling sad or hopeless
(almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the last 12 months)
YRBS



Among children and youth, prevalence of mental health conditions is similar to national estimates. An estimated 12% to 25% of North Dakotan students have an emotional or behavioral disorder [ii].¹ In 2016, the annual average proportion of North Dakotan adolescents aged 12 to 17 with a major depressive episode² in the past year was 11%, slightly lower than the corresponding national annual average percentage of 12.8% (2016 NSDUH).

ADULTS: In 2016, an estimated 17% of adults aged 18 and older (about 99,199 people) in North Dakota met the criteria for any mental illness in the past year. This is less than the national annual average (18.3%) [iii]. A total of 4.0% of North Dakota adults aged 18 or over (about 23,454 people) in 2016 had a serious mental illness (SMI) in the past year; this figure is similar to the corresponding national annual average percentage (4.1%).

SUICIDE: Suicide, a significant health issue nationwide, is a serious concern in North Dakota. In 2016, 134 North Dakotans died by suicide, which was the ninth leading cause of death in the state that year [iv]. Suicide is the second leading cause of death in the state for those between the ages of 15 and 24 [v]. Just over sixteen percent of ND high school students seriously considered attempting suicide at some point during the past year and 14.5% of made a plan about how they would attempt suicide. [vi]



The annual average percentage of North Dakotan adults aged 18 or older with serious thoughts of suicide in the past year was 4%, similar to national annual average, and 16% of North Dakota's high school youth considered attempting suicide in the past year, which is slightly lower than the national average of 18%. Rates of suicide among veterans and military service have risen higher than the rates of suicide among the general population in recent years. Since 2001, more North Dakota National Guard members have died by suicide than in combat [vii].

¹ Definition of emotional disorder (ED) (34 CFR 300.8(4)(i)): A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: A) An inability to learn that cannot be explained by intellectual, sensory, or health factors; B) An inability to build or maintain satisfactory interpersonal relationships with peers and teacher; C) Inappropriate types of behavior or feelings under normal circumstances; D) A general, pervasive mood of unhappiness or depression; E) A tendency to develop physical symptoms or fears associated with personal or school problems.

² Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, which specifies a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

STRUCTURE OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

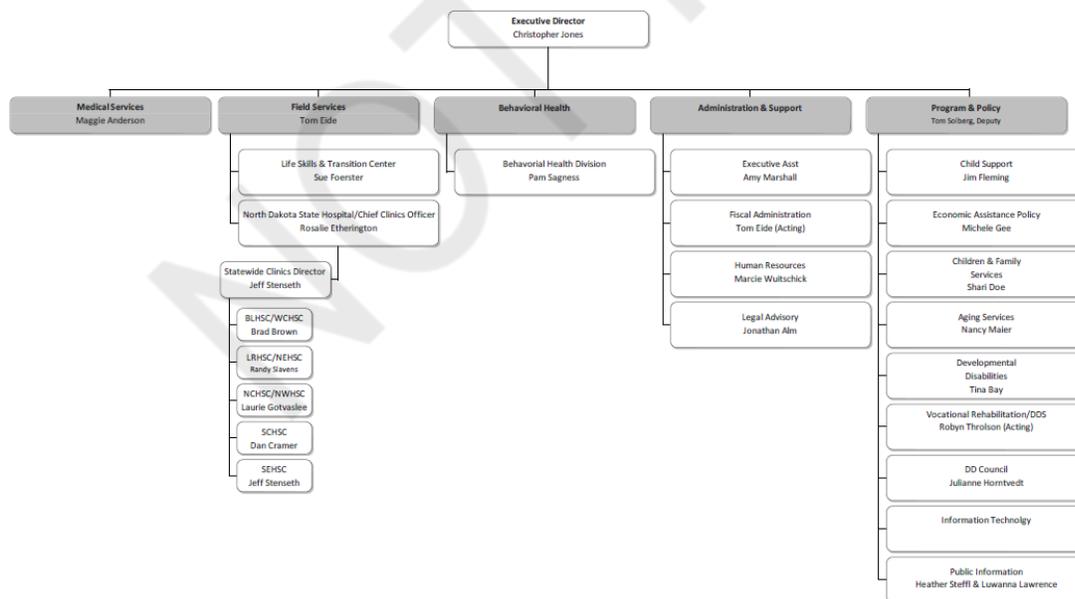
North Dakota Department of Human Services

The mission of the North Dakota Department of Human Services is to provide quality, efficient and effective human services, which improve the lives of people. This mission is driven by several principles:

- Services and care should be provided as close to home as possible
- Services should be provided consistently across service areas to promote equity of access and citizen focus of delivery
- Services should be administered to optimize for a given cost the number served at a service level aligned to need
- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
 - Supporting access to the social determinants of health
 - Mitigating threats to quality of life such as lack of financial resources, emotional crisis, disabling conditions, or inability to protect oneself.

The Department is an umbrella agency headed by Executive Director Christopher Jones who was appointed by Governor Doug Burgum on Feb. 3, 2017. 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. The Department, through the ND State Hospital, Life Skills and Transition Center and Statewide Community Clinics (Human Service Centers), is a direct provider of human services and the state institution for individuals needing inpatient psychiatric services.

North Dakota Department of Human Services

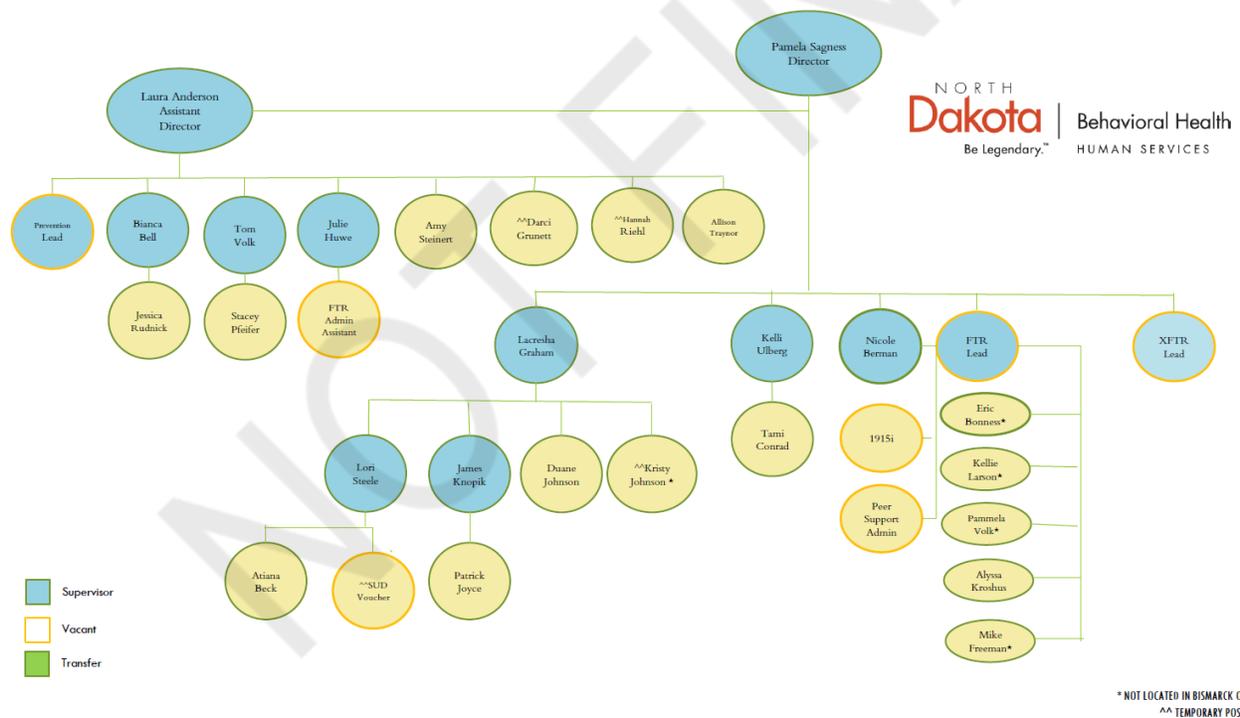


BEHAVIORAL HEALTH DIVISION

The Behavioral Health Division within the Department of Human Services serves as the State Mental Health Authority (SMHA), State Substance Abuse Authority (SSA), and the State Opioid Treatment Authority (SOTA). The Behavioral Health Division (NDCC 50-06-01.4) is a policy division responsible for reviewing and identifying

service needs and activities in the state's behavioral health system to ensure health and safety, access to services, and quality of services. The Division is also responsible for establishing quality assurance standards for the licensure of substance use disorder program services and facilities and providing policy leadership in partnership with public and private entities. The Behavioral Health Division does not provide direct services, rather the role of the Division is to ensure health and safety and access to a wide range of quality behavioral health services across the state.

The Behavioral Health Division commissioned a study of the state's behavioral health system in 2017-2018. The Human Services Research Institute (HSRI) assessed data, held focus groups, community listening sessions, and conducted interviews around the state. In April 2018, HSRI issued its final report, detailing findings and providing 13 major recommendations for improvement. These recommendations were based on the quantitative and qualitative analysis, principles for a 'good and modern' behavioral health system, and North Dakotans' vision for system change. Led by the Behavioral Health Planning Council and endorsed by the Department of Human Services and the Governor's office, the state is creating a strategic plan for systems change grounded in the findings and recommendations of the 2018 study and ongoing stakeholder conversations. This process resulted in a targeted set of 2019 Strategic Goals that will support focused systems change efforts in the coming year. The HSRI will continue to support the state in the implementation of the strategic goals through June 2021.



PUBLIC BEHAVIORAL HEALTH SYSTEM

The Field Services Division within the Department of Human Services operates eight regional human service centers, the State Hospital and the Life Skills and Transition Center. During the 2017 Legislative Session, Senate Bill 2039 (NDCC 50-06-01.4) further defined the purpose of the service delivery division within the Department of Human Services. This service delivery division is responsible for providing chronic disease management, regional intervention services, and twenty-four-hour crisis services for individuals with behavioral health disorders.

Each human service center serves a designated multi-county area, providing 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. Open access walk-in behavioral health assessments has been implemented throughout many of the human service centers on certain days and times of the week. During these times, individuals can walk in and meet with a triage specialist and the business office and are then connected to services. Those with acute, severe symptoms are served right away. Others may be served within one to several days or may be referred to other community behavioral health service providers. Crisis lines are answered 24 hours a day, seven days a week. During the 2019 Legislative Session, the Field Services Division was funded to fully implement a crisis service system statewide. 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.

North Dakota Human Service Centers

<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: dhsnwhsc@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: dhsnchsc@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: dhslrhsc@nd.gov</p>
<p>Outreach Office - Rolla 113 Main Ave. East, Rolla, ND 58367-0088</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>701-477-8272 Fax: 477-8281</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>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>701-352-4334 Toll Free: 888-845-2215</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>701-253-6300 Fax: 701-253-6400</p>

Counties served for human service programs: Barnes, Dickey, Foster, Griggs, LaMoure, Logan, McIntosh, Stutsman, and Wells.

TTY: 701-253-6414
Crisis Line: 701-253-6304
 Toll Free: 1-800-260-1310
 E-mail: dhsschsc@nd.gov

Region VII: West Central Human Service Center - Bismarck

1237 W Divide Ave Suite 5
 Bismarck, ND 58501-1208

Counties served for human service programs: Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux.

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: dhswhsc@nd.gov

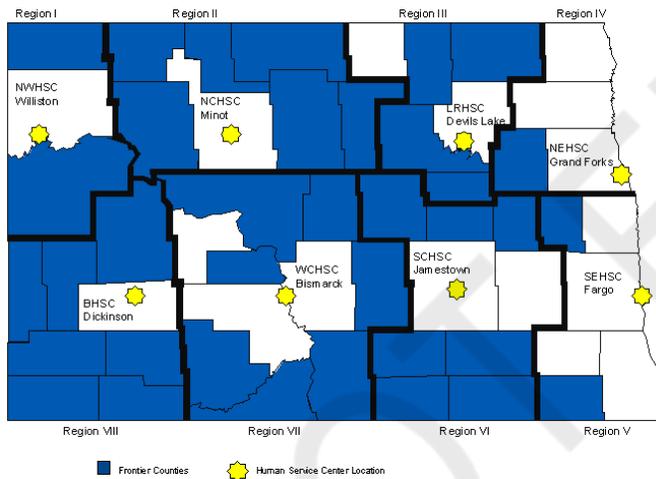
Region VIII: Badlands Human Service Center - Dickinson

300 13th Ave W, Suite 1, Dickinson, ND 58601

Counties served for human service programs: Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark.

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

Regional human service center locations and frontier counties in North Dakota



The North Dakota State Hospital, located in Jamestown, is 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 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.

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.

MANAGEMENT SYSTEMS (MHBG CRITERION 5)

In planning for allocation of the Mental Health Block Grant funding in North Dakota, the Behavioral Health Division took many considerations into account, including needs and gaps identified in the 2018 North Dakota Behavioral Health Systems Study and corresponding strategic plan. The North Dakota Behavioral Health Planning Council, working with stakeholders - including service users and families, advocates, providers, administrators, and other North Dakotans, in collaboration with the Human Services Research Institute, engaged in coordinated, data-driven system transformation activities based on the recommendations from the 2018 Behavioral Health System Study.

Following these recommendations and other needs and gaps in the system, the North Dakota Behavioral Health Division plans to allocate the Mental Health Block Grant funds in the following way:

- Partnerships Program (through the regional Human Service Centers): Mental Health Block Grant funding will support five Partnerships Programs located at the human service centers serving children with serious emotional disturbances.
- Peer Support: North Dakota is continuing to develop mental health peer support services throughout the state. Peer support specialists will have the opportunity to become certified by July 1, 2020. In addition, peer support services will become reimbursable in the state Medicaid plan for individuals with a qualifying behavioral health condition July 1, 2020.
- First Episode Psychosis Treatment Program: The Division will continue work with the existing state vendor to expand the Coordinated Specialty Care program to provide evidence based First Episode Psychosis (FEP) treatment services to individuals between 15 and 25 years of age.
- Advocacy: The Division provides support for a consumer-run advocacy program to increase quality and access to mental health services, assist consumers to ensure that they are the catalyst for transforming the mental health system, and increase positive messaging while reducing the stigma associated with mental health diagnosis. The Division also plans on assisting advocates in receiving training at the national level.
- Aging and Mental Health: The Division plans to assist with training for long term care staff regarding mental illness and best practices in working with older adults experiencing mental illness.
- Workforce Training: To increase the utilization of best practices, the Division plans to support the training of clinicians and other mental health stakeholders, including continuing education for peer support specialists. One way of doing this is through the annual Behavioral Health Conference hosted by the Behavioral Health Division. Additionally, funds may be expended to train emergency health service providers in conjunction with crisis services.
- Planning Council: The Division supports the functioning of the State's Behavioral Health Planning Council, including administrative support services and travel reimbursement for the federally required North Dakota Behavioral Health Planning Council.

Additional Resources in the State's Behavioral Health System of Care

Private Behavioral Health Providers

North Dakota Century Code requires the Behavioral Health Division to license substance use disorder treatment programs in operation in the state. Almost 100 programs are licensed throughout the state (programs may be licensed for treatment and/or early education [ASAM 0.5]). Because all substance use disorder programs are required to be licensed, there is the ability to identify the levels of services available in various areas of the state to identify gaps. This same information regarding mental health providers is not available because there is no centralized registry.

Local Public Health

North Dakota's public health system is decentralized with 28 independent local public health units working in partnership with the North Dakota Department of Health. The 28 local public health units are organized into single or multi-county health districts, city/county health departments or city/county health districts. Seventy-five percent of the local health units serve single county, city or combined city/county jurisdictions, while the other twenty-five percent serve multi-county jurisdictions. The majority of the multi-county jurisdictions reside in the western part of the state. In this decentralized approach, the units are required to meet state standards and follow state laws and regulations, but they can exercise their own powers and have administrative authority to make decisions to meet their local needs.

North Dakota local public health units have a long history of providing personal and population-based health services to residents in their city and/or county jurisdictions. The local public health infrastructure represents the capacity and expertise necessary to carry out services and programs. Therefore, the health units function differently and offer an array of services. The most common activities and services provided by local public health are child immunizations, adult immunizations, tobacco use preventions, high blood pressure screening, injury prevention screening, blood lead screening and Early and Periodic Screening Diagnosis and Treatment.

Through North Dakota's Strategic Prevention Framework State Incentive Grant (SPF SIG) and Partnership for Success grant (PFS), up to twenty-five community grantees (twenty-one Local Public Health Units [LPHUs] and four Tribes) were funded to build local infrastructure and implement evidence-based prevention strategies targeting underage drinking and/or adult binge drinking, following the SPF model. The Behavioral Health Division also supports local implementation of substance abuse prevention efforts implemented by Local Public Health through the SAPT BG prevention set-aside. By partnering with Local Public Health Units and Tribes the state continues to align and leverage prevention funds and resources to the state's data-driven substance abuse prevention priorities of underage drinking, adult binge drinking and opioid misuse and overdose.

Social Services

North Dakota currently does not have comparable scale to states that have state-supervised, county-administered programs. The North Dakota Department of Human Services, the North Dakota Association of Counties and county social services leaders are working together with the support of Governor Doug Burgum and state lawmakers to redesign social services to better serve North Dakotans and deliver effective services in a more efficient way. The goal is to offer quality human services statewide to North Dakotans that improve lives. This collaborative work began with the passage of Senate Bill 2206 study process approved by lawmakers in 2017. The following are guiding principles for this redesign process:

- No reduction in access points
- Redistribution of dollars from administration to direct client service delivery
- No reductions in force or reductions in pay
- Promote equity in access and meet clients where they are
- Promote specialization of efforts where possible to improve consistency of service
- Promote decision making as close to the client as possible

The plan is to direct delivery of human services in up to 19 multi-county "zones" that preserve all current service access locations. These zones are to be fully implemented by January 1, 2021.

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. Most 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:

- Developmental Disabilities Advocacy Program
- Mental Health Advocacy Program
- Protection & Advocacy Project for Individual Rights
- Protection & Advocacy for Beneficiaries of Social Security
- Assistive Technology Advocacy Program
- Help America to Vote Program (HAVA)
- Protection and Advocacy for Individuals with Traumatic Brain Injury
- 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.

INITIATIVES OF THE BEHAVIORAL HEALTH SYSTEM OF CARE

Prevention and Promotion (SABG Priority Population)

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, SPF-PFS, Opioid STR, State Opioid Response (SOR) grant and other funding sources. Examples of services delivered directly by the SSA include funding community prevention efforts, provision of training and technical assistance to communities across the state, and statewide communication/media. 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.

Through the SPF SIG, SPF-PFS and SAPT BG, 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 through continued support by the SAPT BG. Examples of services delivered at the community-level, supported by the SAPT BG, include funding to tribal prevention programs and local public health units. The Division's Substance Abuse Prevention System continues to enhance the level to which SAPT BG funds are invested to support implementation of community and tribal prevention efforts that can achieve population-level changes. The 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 state suicide prevention program had historically lived within the ND Department of Health. During the 2019 state legislative session, the suicide prevention program was moved into the Behavioral Health Division within the ND Department of Human Services. This transition will allow for further integration of suicide prevention in behavioral health services, policies and systems across the continuum of care.

The ND Substance Abuse Prevention System leads and is a participant in many state-level partnerships 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, Indian Affairs Commission, Injury Prevention coalition, and the State Suicide Coalition.

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. 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. State community prevention specialists completed the train-the-trainer program with CAPT for the SAPST and have held annual SAPST to continue building the community-level workforce. Also, a formal community coalition network, registration, training or certification process does not exist in the state. The Division did work with CAPT to receive support regarding the development of a statewide coalition network system. However, with the change from CAPT to the PTTC, this effort has halted.

Early Identification/Intervention

Early identification/intervention is a gap in the North Dakota behavioral health system. The Behavioral Health Division certifies and licenses Driving Under the Influence education providers and programs. There are approximately 41 licensed providers of the DUI education course in the state.

In the 2017 ND Legislative Session, House Bill 1040 passed which gave the Behavioral Health Division authority to write administrative rules setting a minimum standard for Minor in Possession education classes. Administrative Rules were written and passed the summer of 2018. Following some clean-up language being passed in the 2019 ND Legislative Session, courts are required to sentence individuals charged with a Minor in Possession to an evidence-based early intervention class provided by an individual certified by the Behavioral Health Division. The Behavioral Health Division has offered several free trainings in order to increase workforce and the availability of this evidence-based early intervention service.

Treatment and Recovery Support Services

An overarching theme that emerged from the 2018 Behavioral Health System Study is that North Dakota's behavioral health system—like many others throughout the country—pours a majority of its resources into residential, inpatient, and other institution-based services with relatively fewer dollars invested in prevention and community-based services.

Based on the 2018 Behavioral Health System Study, the state identified the following three overarching goals: (1) support the full continuum of care; (2) increase community-based services; and (3) prevent criminal justice involvement. During the 2019 ND legislative session, the state was authorized to submit a state plan amendment to establish a 1915i home and community-based services benefit for both youth and adults.

Also authorized during the 2019 ND legislative session, the Behavioral Health Division will be developing a community-based behavioral health program supporting parents and families with a substance use disorder and/or mental illness. The program will be modeled after the “Free Through Recovery” program but will not require participants to be involved in the criminal justice system.

Telebehavioral health approaches have steadily increased in North Dakota, both in services delivered through HSCs and in other settings that receive Medicaid reimbursement. In SFY 2013, fewer than one person per 1,000 population received at least one telebehavioral health service; in SFY 2017, the penetration rate was four times higher: 4.1 individuals per 1,000 population.

Pregnant Women and Women with Dependent Children in Need of Treatment

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 was comprised of representatives from state agencies, the legislature, medical providers, nonprofit entities focused on children’s health and wellbeing, Indian tribes, law enforcement, and the foster care community. This task force developed a report with the following four goals:

- Collect and organize data concerning the nature and extent of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS) from substance use/abuse in the state.
- Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from substance use/abuse.
- Identify available federal, state and local programs that provide services to mothers who use/abuse drugs or alcohol and to newborns who have NAS* and evaluate those programs and services to determine if gaps in programs or ineffective policies exist.
- Evaluate methods to increase public awareness of the dangers associated with substance use/abuse, particularly to women, expectant mothers and newborns.

The Division is working in collaboration with the Field Services Division to post a Request for Proposal for specific programs focused on best practice to treat pregnant women and women with dependent children in need of treatment.

Also, the Division is piloting a new program in one county in collaboration with the local social services agency and healthcare system where a trained peer support specialist will be available via phone twenty-four hours a day. Pregnant women and new moms can call to talk with a mom who has been there to engage in non-judgmental conversation and receive information and referral to local resources.

Medication Assisted Treatment

North Dakota has only recently had methadone as an option for opioid use disorder as the first opioid treatment program (OTP) opened in 2016. Currently there are three OTPs in North Dakota and in 2018 there were 559 admissions for medication assisted treatment. The state’s three OTPs are easily accessible to approximately 17.6 percent of the state’s population, with the other 82.4 percent of the population needing to travel, some around 300 miles, in order to receive this service.

During the 2019 Legislative Session, the Department of Human Services were given authority to develop administrative rules allowing Medication Units to open in North Dakota. This will allow for OTPs to expand their dosing locations across the state and increasing access to medication assisted treatment.

The Division continues efforts to partner with community stakeholders with the goal of increasing access to medication assisted treatment. The Behavioral Health Division was awarded the State Targeted Response to

the Opioid Crisis Grant Opioid STR) in May 2017 and the State Opioid Response (SOR) grant in October 2019. The Substance Abuse Prevention and Treatment Block Grant will continue to support efforts implemented through the state's Opioid STR.

Recovery Support Services

As one of its foremost priorities, the Division promotes a recovery-oriented service system. 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 an individual may need. Recovery principles are also applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders.

North Dakota's First Lady Kathryn Helgaas Burgum's platform is to erase the social stigma around addiction and spread the word that it's a chronic disease, not a character flaw – "Recovery Reinvented". The Behavioral Health Division is working with the First Lady to disseminate messages surrounding the Recovery Reinvented platform. The Division is also working closely with the First Lady's office to host the third annual Recovery Reinvented event scheduled for November 2019.

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 Behavioral Health Planning Council and provide input into the planning of the behavioral health system of care.

Eight Recovery Centers (one in each region throughout the state) employ peer staff and are contracted through the HSCs or, in the case of Williston, run by the local HSC. These voluntary community-based centers are typically open Monday through Friday, with some operating during the weekends as well. The Recovery Centers offer structured and unstructured activities including job coaching, wellness groups, educational programs, and skills training as well as volunteering opportunities.

Peer Support: The Behavioral Health Division contracted with the University of North Dakota Center for Rural Health (the Center) to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. Currently, peer support services and peer support training opportunities in North Dakota are limited, though there has been considerable progress toward increasing peer support trainings.

Several initiatives in the state have supported continued development of peer support in the state. The state's Free Through Recovery program, initiated through the \$7 million alternatives to incarceration initiative initiated in January 2018 includes funding for expanding peer support for individuals returning to the community after incarceration. Peer support expansion is also part of the federal opioid (State Targeted Response to the Opioid Crisis (STR) and State Opioid Response (SOR)) grant activities. More than 250 individuals in the state have been trained as peer support specialists since February 2018.

In the 2019 ND Legislative Session, several bills were passed to support the continued development of peer support. The Behavioral Health Division was authorized to develop administrative rules to guide the certification of peer support specialists. The North Dakota Medical Services Division will be amending the state plan to include peer support as a reimbursable service. Also, peer support will be included as a reimbursable service in the 1915i state plan amendment.

Telephone Recovery Support: The Behavioral Health Division is working with a contracted vendor to implement a twenty-four-hour, statewide telephone recovery support service utilizing peer support specialists who provide additional support to individuals working to maintain recovery from a substance use disorder. This service is planned to begin late summer of 2019.

COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICE SYSTEMS (MHBG CRITERION 1)

Through the public behavioral health service delivery system, 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. The core services offered through the Extended Care Treatment Units, either directly or through public/private provider partnership or contracting include: case management, Supported Employment and Extended Service, and other services such as group, individual, and family therapy, psychological services, and medication monitoring. This same system also provides services for children diagnosed with a serious emotional disturbance. The wraparound process includes a set of core elements: 1) person centered plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting. The array of services provided through the Partnerships Program within the children's mental health system of care include: care coordination, case aide, flexible funding, crisis residential services, substance abuse/dual diagnosis services. Going forward a variety of community-based services, including peer support, will be reimbursed in the state Medicaid plan for individuals with a qualifying behavioral health condition.

The state currently offers services for individuals involved in the criminal justice system. The model provides care coordination, recovery services, housing and employment supports, and peer support in a community-based health program. It is designed to divert individuals from returning to the criminal justice system simply due to a behavioral health issue that is able to manage with additional community supports.

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. For individuals with criminal justice system involvement case management may be available through Free Through Recovery. Services include an ongoing source of connection, assistance accessing treatment and recovery support services, and addressing barriers to individual success. Assessments, care planning, referrals, clinical and probation and parole collaboration, access to supportive housing, meaningful employment, and other resources are also available.

CHILDREN'S SERVICES (MHBG CRITERION 3)

North Dakota offers a range of services to support coordination of services for children and youth, with an emphasis on services that support children and youth in foster care or at risk of foster care placement. These include Medicaid-funded Targeted Case Management services, which involve comprehensive assessment, care planning, and ongoing connection to services and supports for children and youth with complex needs.

The Department of Human Services houses several divisions which play a key role in the children's system of care, including the Behavioral Health Division (BHD), Children and Family Services Division, Medical Services Division (the state Medicaid agency), and Field Services Division (which includes eight regional public human service centers located across the state and the state hospital). The BHD currently partners with all these sister divisions in a variety of projects with the aim to transform the behavioral health system of care in the state.

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.
- 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.
- 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.

Other supports/services available within the children's mental health system of care include:

- 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: The Voluntary Treatment Program provides out-of-home treatment services for Medicaid eligible children with a serious emotional disorder without requiring parents to relinquish custody.
- 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 childcare 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.
- 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 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.
- Other Supportive Services: Acute, Psychological Services, and psychiatric services are available through the regional human service centers.

It is also worth noting that ND Department of Human Services is in the midst of redesigning social services from a process, culture and structure perspective. The goal of the redesign is to identify efficiencies, hidden capacity and ensure the right services are accessible in the community.

Several legislative bills passed during the state's 2019 legislative session which will support the continued development of a system of care. One of these bills requires the creation of a Children's Cabinet - consisting of representation from the three branches of government, state directors from education, human services, health, Indian affairs commission, corrections and rehabilitation, and protection and advocacy. The purpose of this cabinet is to assess, guide, and coordinate the care for children across the state's branches of government and tribal nations. The establishment of the Children's Cabinet will also assist in efforts to coordinate payment structures for services designed to support children with SED and their families. This cabinet assures cross-department communication and opportunity to creatively braid funding for comprehensive supports and services.

North Dakota applied for the System of Care grant in April 2019 and is awaiting to hear if our state is chosen as an awardee.

RURAL, HOMELESS POPULATION AND OLDER ADULTS (MHBG CRITERION 4)

In accordance with the state's key priorities of person-centered planning, increased access to services, and supporting the full continuum of care, North Dakota has focused on adding qualified individuals to the behavioral health workforce through the advancement of peer support and telemedicine options. Peer support services in rural areas is in its beginning stages. Community providers will be offering services in (X communities- LSS info). County social services is going through a redesign process to align with the state priorities of person-centered planning and access to community services. This will allow for increased access to services through telemed options in rural counties with limited behavioral health providers outside of the social services offices.

Homelessness continues to be an issue in North Dakota. The state lacks enough affordable housing, especially for low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is also very limited – transitional units, low demand housing, and supported permanent housing are in very short supply. Housing subsidy funds are limited and waiting periods of 6 months to more than 1 year are common. 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 the number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process. Rental and credit history requirements create significant barriers for people to transition out of homelessness. There continues to be barriers, particularly with HUD subsidized housing, for people with criminal histories, and for individuals with a history of sexual offenses.

Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness (PATH) 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. State funded programming focuses on the criminal justice population, targets employment and housing assistance alongside behavioral health supports, to help individuals stay out of the system and off the streets.

DHS administers programs and services that help older adults with disabilities to live safely and productively in the least restrictive, appropriate setting. Services offered include counseling, support groups, and training services to meet the needs for family members acting as the primary care giver for an older adult. HBCS are offered through the SPED, Ex-SPED, Medicaid Waiver, and Older Americans Act. The state is currently working on the implementation of behavioral health screenings to be used in conjunction with these service providers.

Special Topics/Populations

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN/ INTRAVENOUS DRUG USERS / TUBERCULOSIS SERVICES (SABG PRIORITY POPULATION)

The regional human services centers have adopted open access assessment services and each individual seeking an assessment is triaged and screened for pregnancy and injection drug use. If an individual does identify as being pregnant or using drugs intravenously, they are given priority and an assessment is completed that day. If a situation were to occur and an assessment is not available that same day, it is completed no later than 48 hours and services begin directly following the assessment. Several of the human service centers offer treatment mall model of services and individuals are able to begin services directly following the assessment. If services are not available directly following the assessment, the individual is placed on a prioritized waiting list and offered interim services to include engagement group, case management or referred to education-based programming. Regional human service center directors and clinical directors sign a memorandum of understandings to stipulate priority population requirements are met.

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:

- Place the client's name and case number on an active waiting list,
- Recommend and provide interim services for the individual as required within 48 hours of the request for treatment,
- 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
- 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 services centers have adopted open access assessment services and each individual seeking an assessment is triaged and screened for pregnancy and injection drug use. If an individual does identify as being pregnant or using drugs intravenously, they are given priority and an assessment is completed that day. If a situation were to occur and an assessment is not available that same day, it is completed no later than 48 hours and services begin directly following the assessment. Several of the human service centers offer treatment mall model of services and individuals are able to begin services directly following the assessment. If services are not available directly following the assessment, the individual is placed on a prioritized waiting list and offered interim services to include engagement group, case management or referred to education-based programming. Regional human service center directors and clinical directors sign a memorandum of understandings to stipulate priority population requirements are met.

The regional human service centers have incorporated TB screening in their Electronic Health Record as a required screening. When an individual is identified as high risk for TB, the clinician provides education regarding TB and provides a referral. Some regional human service centers have nurses available with the ability to conduct a TB test and provide for the follow up appointments. Other regional human service centers have agreements with local public health units to accept the referrals for TB testing and follow up appointments. Compliance checks are completed to ensure the programs are complying with this requirement.

AMERICAN INDIAN POPULATIONS

The North Dakota Behavioral Health Division continues to partner and work with the American Indian Tribes in the state to ensure culturally relevant behavioral health services are accessible. 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.

The Division will also be taking over contracts for treatment/recovery services with the Native American reservations in the state, which were previously managed through the regional Human Service Centers. Doing so respects the government to government relationship and allows the tribe to identify through data/assessment their highest priority needs. The Division is planning on furthering the development of partnerships between prevention and treatment efforts funded through the SAPT BG in order to align and leverage resources.

In 2018, North Dakota participated in the Tribal State Policy Academy. Three of the four federally recognized tribes were present, and a plan was developed to increase communication, identify services available, and explore opportunities to provide training and resources based on tribal identified needs. These goals were consistent with the needs assessment and have been incorporated into the statewide implementation.

CRIMINAL JUSTICE POPULATIONS

In the 2017 North Dakota Legislative Session, Senate Bill 2015 established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. The goal of this effort, titled, Free Through Recovery is to improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services linked with effective community supervision.

The Departments of Correction and Rehabilitation and Human Services in partnership with local agencies and governments deliver coordinated and comprehensive services to people in the program. Using a certified paraprofessional workforce and an integrated, multidisciplinary approach, community-based agencies provide a range of services including comprehensive case planning, linking participants to services, peer recovery supports, and facilitating communication.

Since the inception on February 1, 2018, Free Through Recovery has served over 1,000 individuals. Free Through Recovery Providers are reimbursed with a pay for performance model. In addition to monthly base pay, providers can receive performance pay if participants meet at least 3 of 4 outcome metrics (Housing, Employment, Recovery, and Involvement with Law Enforcement). Overall, from March 2018 to January 2019, providers earned performance pay for the 68% of their participants.

COLLABORATION WITH MILITARY SUPPORT ORGANIZATIONS

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 45 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. 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.

In April 2017, the Behavioral Health Division and ND Cares Coalition coordinated a training to increase access to quality behavioral health treatment options, especially in rural areas, where service members may have fewer choices. The training focused on military culture and deployments, the challenges and difficulties often

associated with military service that can affect service members and their families and learn clinical skills that focus on specific evidence-based treatments to address some deployment-related behavioral health issues. These include post-traumatic stress disorder, traumatic brain injuries and suicide. Participating providers were selected based on their location, with priority given to providers serving rural areas, along with their credentials and ability to ensure access by being able to accept new clients.

Participating behavioral health professionals have committed to providing the specialized evidence-based services for three years. The Behavioral Health Division developed a registry of ND Cares Behavioral Health Providers listing those providers who complete the training:
<https://behavioralhealth.dhs.nd.gov/ndcaresprovider>.

[i] North Dakota Youth Risk Behavior Survey, 2017

[ii] Forness, S.R., Kim, J., & Walker, H.M. (2012). Prevalence of students with EBD: Impact on general education. *Beyond Behavior*, 21(2), 3-10. Retrieved from: <https://eric.ed.gov/?id=EJ975007>

[iii] Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm>

[iv] North Dakota Department of Health Division of Vital Records. *North Dakota Fast Facts 2016*. Retrieved from: <http://www.ndhealth.gov/vital/pubs/ff2016.pdf>

[v] North Dakota Suicide Prevention Program, North Dakota Department of Health. (n.d). *Facts and Statistics*. Retrieved from: <http://www.ndhealth.gov/suicideprevention/?id=57>

[vi] North Dakota Youth Risk Behavior Survey, 2017

[vii] ND Cares. (n.d.). *North Dakota Military Data Book, 2017-2018*. Retrieved from: <https://ndcares.org/uploads/5/NDCaresDataBook.pdf>

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD 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 the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. 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 sets 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](#), 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 use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

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](#)¹⁶ 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.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

STEP 2: IDENTIFY THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM. MHBG

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STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP

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. The SEOW's membership includes representation from the following agencies: ND Department of Corrections and Rehabilitation, ND Department of Health, ND Department of Human Services, ND Department of Public Instruction, ND Department of Transportation, ND Highway Patrol, ND Indian Affairs Commission, ND Office of the Attorney General, ND Office of the State Tax Commissioner, ND University System, University of North Dakota, Wyoming Survey and Analysis Center, Spirit Lake Tribe, Standing Rock Sioux Tribe, Three Affiliated Tribes, and Turtle Mountain Band of Chippewa Indians

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 Alcohol Use; (2) Adult Binge Drinking; and (3) Prescription (especially opioid) 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.

UNMET SERVICE NEEDS AND GAPS AND PLANS TO MEET THESE NEEDS AND GAPS

General

Over The past several years, North Dakota's behavioral health system has received much attention and review, with stakeholders from multiple disciplines coming together initiating dialogue that would lead to effective change. Numerous suggestions, recommendations and priorities have previously been identified. In 2017, the Behavioral Health Division commissioned a study of the behavioral health system completed by the Human Services Research Institute (HSRI).

The evaluation examined publicly available data as well as peer-reviewed research articles and national literature. HSRI also analyzed service utilization and expenditure patterns using North Dakota Medicaid claims and other public behavioral health service utilization data. HSRI also reviewed other available data including the National Survey on Drug Use and Health and the Youth Risk Behavior Survey. To fully assess the system and identify gaps, they interviewed 120 stakeholders around the state, including service users and their family members, providers, and representatives from state and local agencies. They also convened a talking circle with representatives from four tribal nations. In April 2018, HSRI issued its final report, detailing findings and providing 13 major recommendations for improvement. The HSRI recommendations were based on our quantitative and qualitative analysis, principles for a 'good and modern' behavioral health system, and North Dakotans' vision for system change. The thirteen recommendations are listed below.

1. Develop a comprehensive implementation plan
2. Invest in prevention and early intervention
3. Ensure all North Dakotans have timely access to behavioral health services
4. Expand outpatient and community-based service array
5. Enhance and streamline system of care for children and youth
6. Continue to implement/refine criminal justice strategy
7. Engage in targeted efforts to recruit/retain competent behavioral health workforce
8. Expand the use of tele-behavioral health
9. Ensure the system reflects its values of person-centeredness, cultural competence, trauma-informed approaches
10. Encourage and support the efforts of communities to promote high-quality services
11. Partner with tribal nations to increase health equity
12. Diversify and enhance funding for behavioral health
13. Conduct ongoing, system-side data-driven monitoring of needs and access

Led by the Behavioral Health Planning Council and endorsed by the Department of Human Services and the Governor's office, North Dakota is creating a strategic plan for systems change grounded in the findings and recommendations of the 2018 study and ongoing stakeholder conversations. This process resulted in a targeted set of 2019 Strategic Goals that will support focused systems change efforts in the coming year. Working with stakeholders – including service users and families, advocates, providers, administrators, and other North Dakotans – HSRI is helping the state set its course for ongoing system monitoring, planning, and improvements in the long term.

SABG and MHBG Required Populations

The North Dakota Department of Human Services' Behavioral Health Division continues to assess and address needs and gaps within the MHBG required populations: children with SED and their families, adults with SMI, older adults with SMI, Individuals with SMI or SED in the rural and homeless populations and individuals who

have an early serious mental illness. The North Dakota Department of Human Services' Behavioral Health Division also continues to assess and address needs and gaps within the SABG priority populations: pregnant women and women with dependent children, injecting drug users, persons at risk for tuberculosis and individuals in need of primary substance abuse prevention.

The gaps listed below impact all of the SABG and MHBG required populations in some way and were identified by a comprehensive qualitative and quantitative data review published in the 2018 ND Behavioral Health System Study. The aims for each gap describe the plan to address the unmet need/gap and are based on the strategic plan developed by HSRI which comes from the 2018 Behavioral Health System Study.

1. GAP 1: Inadequacy of crisis response services, particularly for children and youth, and for adults outside the Fargo area where mobile crisis response services are unavailable. The rates of behavioral health-related emergency department and ambulance use observed in Medicaid data indicate an unmet need for more proactive community crisis response services. *[Priority Populations: children with SED and their families, adults with SMI, older adults with SMI, individuals with SMI or SED in the rural and homeless populations, individuals who have an early serious mental illness, injecting drug users, pregnant women and women with dependent children.]*
 - a. Aim: Establish statewide mobile crisis teams for children and youth in urban areas. In order to achieve this aim, the following objectives have been identified: expand funding for mobile crisis teams for children and youth in urban areas, review existing mobile crisis programs to understand implementation challenges and opportunities, explore relevance to the child/youth population, and inform efforts to scale the service out to other areas of the state, and lastly to create contract language for mobile crisis teams for children and youth in urban areas.
2. GAP 2: A decrease in case management utilization rates for adults and youth was identified in the 2018 Behavioral Health System Study. Also, the study documented a need for increased targeted supports for children and youth as well as for parents whose children are at risk of out-of-home placement and justice involvement. *[Priority Populations: children with SED and their families, adults with SMI, older adults with SMI, individuals with SMI or SED in the rural and homeless populations, individuals who have an early serious mental illness, injecting drug users, pregnant women and women with dependent children.]*
 - a. Aim: Provide targeted case management services on a continuum of duration and intensity based on assessed need, with a focus on enhancing self-sufficiency and connecting to natural supports and appropriate services. In order to achieve this aim, the following objectives have been identified: revise the Medicaid state plan to include private providers of targeted case management services for adults with serious mental illness and children with serious emotional disturbance, use the DLA to inform transitions to and from targeted case management consistently across the human service center regions, and expand capacity within the human service centers to support transitions from human service center services to primary care for those with lower assessed need.
3. GAP 3: Past behavioral health assessments, in addition to the 2018 system study, have been clear in identifying a need for improved coordination for child and youth-serving systems in the state. *[Priority Populations: children with SED and their families]*
 - a. Aim: Expand school-based mental health and substance use disorder treatment services for children and youth. In order to achieve this aim, the following objectives have been identified: maximize opportunities for Medicaid reimbursement of school-based mental health and SUD treatment services, continue to engage with the Department of Public Instruction and regional educational authorities through the children's behavioral health school pilot to ensure a shared vision and continue to

identify opportunities for collaboration, and finally to adopt and scale up successful (evidence-based, culturally-responsive, trauma-informed, youth-centered) school-based service models.

- b. Aim: Establish and ratify a shared vision of a community system of care for children and youth. The following objectives have been identified to achieve this aim: establish a vision of a state system of care for children and youth, convene all relevant stakeholders to ratify the shared vision of a community system of care for children and youth, and submit a response to the SAMHSA System of Care Expansion and Sustainability Grant Funding Opportunity announcement to support System of Care planning and expansion in the state. North Dakota submitted an application spring 2019 and is awaiting to hear if the state is awarded.
4. GAP 4: Nationwide, stakeholders have described the criminal justice system as the “de facto behavioral health system” for those with serious behavioral health conditions, referring to the overrepresentation of people with behavioral health issues in jails and prisons. This dynamic was observed in North Dakota as well, though we were impressed by the breadth and depth of current state and local initiatives to address issues at the intersection of behavioral health and criminal justice. *[Priority Populations: adults with SMI, older adults with SMI, individuals with SMI or SED in the rural and homeless populations, individuals who have an early serious mental illness, injecting drug users, pregnant women and women with dependent children.]*
 - a. Aim: Implement a statewide crisis intervention team training initiative for law enforcement, other first responders and prison staff. The following objectives have been identified in order to achieve the aim: identify and secure training resources, create a plan for a statewide CIT initiative based on local and national best practice, and secure buy-in and commitment from at least one agency of each type in each human service region.
5. GAP 5: North Dakota has begun efforts to increase the peer support specialist workforce, but certification is needed in order for there to be reimbursement. *[Priority Populations: children with SED and their families, adults with SMI, older adults with SMI, individuals with SMI or SED in the rural and homeless populations, individuals who have an early serious mental illness, injecting drug users, pregnant women and women with dependent children.]*
 - a. Aim: Establish a formalized training and certification process for peer support specialists. To achieve this aim, the following objectives have been identified: designate personnel to oversee formalized training and credentialing process and establish a formalized training and credentialing process based on local and national best practice that includes tracks for specific sub-groups including culturally specific peers, family peers and youth peers.
 - b. Aim: Establish peer services as a reimbursed service in Medicaid state plan. The following objectives have been identified in order to achieve this aim: secure legislative approval to add peer support as a Medicaid state plan service and amend the Medicaid state plan to include peer support as a Medicaid state plan service.
6. GAP 6: The 2018 Behavioral Health System Study found that providers lack financial and personnel resources to establish capacity to provide and receive telebehavioral health services. Also, although a range of providers offer telebehavioral health services, the majority of those services are mental health-related, not substance use-related. We also observed that children and youth and American Indian populations are less likely to receive telebehavioral health services. Therefore, efforts to expand telebehavioral health should target these three areas, and any other areas of need identified in future assessments and ongoing data tracking activities. *[Priority Populations: children with SED and their families, adults with SMI, older adults with SMI, individuals with SMI or SED in the rural and homeless*

populations, individuals who have an early serious mental illness, injecting drug users, pregnant women and women with dependent children.]

- a. Aim: Increase the types of services available through tele-behavioral health. In order to achieve this aim, the following objectives have been identified: identify and facilitate resolution of any regulatory or funding barriers to adoption of telebehavioral health services, develop clear, standardized procedural and regulatory guidelines for telebehavioral health, identify priority services for telebehavioral health expansion, and expand capacity for school-based telebehavioral health services.
7. The 1915(i) state plan amendment (SPA) has been the most common avenue for states to pursue funding for community-based services via the Centers for Medicare and Medicaid Services (CMS). Through a 1915(i), North Dakota can institute services identified as lacking in our data sources: peer-provided services, supported employment, and supported housing, among others. Adding these services could significantly reduce demand for emergency, inpatient, and long-term care services that are not reimbursed by Medicaid, which could reduce overall system costs in the long run. Ensuring Medicaid reimbursement for services that support recovery and wellness and linkages to social services will help the state to better-address the social determinants of health for North Dakotans. *[Priority Populations: children with SED and their families, adults with SMI, older adults with SMI, individuals with SMI or SED in the rural and homeless populations, individuals who have an early serious mental illness, injecting drug users, pregnant women and women with dependent children.]*
- a. Aim: Establish 1915i Medicaid state plan amendment to expand community-based services for key populations. The following objectives have been identified in order to achieve this aim: secure legislative approval for the 1915i state plan amendments, draft 1915i state plan amendments, and submit 1915i state plan amendments to CMS for approval.

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.

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Footnotes:

NOT FINAL

QUALITY AND DATA COLLECTION READINESS

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NOT FINAL

GENERAL

The Division places high priority on compiling, analyzing and utilizing a variety of data to guide programmatic decisions and evaluate the effectiveness of current efforts. 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.

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).

Data is reviewed annually to ensure programs and funding is targeting the right areas (those areas impacting the most people or having the most public health impact, etc.). The work of the SEOW has set the following priorities for the substance abuse prevention system: (1) Underage Alcohol Use; (2) Adult Binge Drinking; and (3) Prescription (especially opioid) Drug Abuse.

SUBSTANCE ABUSE PREVENTION DATA COLLECTION AND REPORTING SYSTEMS

Process Measures

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. The Division also tracks statewide communication process measures including reach, frequency, web hits, etc.

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 policymakers, etc. The most recent contracts for the Tribal Community Prevention Programs have moved to be performance-based. Each month throughout their contract, they are required to submit a monthly report which summarizes process data on implemented strategies. Community grantees are encouraged to review their monthly 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 Measures

Many of the outcome measures utilized when reviewing substance abuse prevention goals and outcomes are secondary data sources (YRBS, NSDUH, DOT Crash Data, etc.). Through the state's SPF SIG and SPF-PFS the Division, through contract, was able to conduct a statewide Community Readiness Survey and a Young Adult Survey to further enhance data collection and efforts guiding prevention efforts.

The North Dakota SEOW was established in 2006 and has the mission 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 community data needs along with readiness to act for high need communities that will implement the evidence-based prevention programming. The SEOW will continue to collect, organize, analyze and develop data-sharing products (Epidemiological Profile, Data Book, Data Briefs, SUND website) including consumption patterns and consequences of the abuse of alcohol and other drugs, with a continued look at expanding how alcohol and other drug abuse impacts other behavioral health issues.

TREATMENT AND RECOVERY DATA COLLECTION AND REPORTING SYSTEMS

Process Measures

The Division requires all vendors by contract to submit reports with relevant process data. These reports are reviewed by the Division to ensure efforts are being implemented as they were planned. The public behavioral health service delivery system has an electronic health record which is where the TEDs data is extrapolated. This data provides the state information on who is getting treatment through the public behavioral health system, what treatment they participated in – all of which are process measures. Data summarizing process measures through private behavioral health providers is nonexistent in North Dakota.

Outcome Measures

The data available through the public behavioral health system's electronic health record can provide some short-term outcomes, including the success of individuals while actively participating in treatment. However, the collection long-term outcome measures is a gap in the state public behavioral health system. This is an area the Division would like to request additional technical assistance.

The North Dakota SEOW was established in 2006 and has the mission 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 community data needs along with readiness to act for high need communities that will implement the evidence-based prevention programming. The SEOW will continue to collect, organize, analyze and develop data-sharing products (Epidemiological Profile, Data Book, Data Briefs, SUND website) including consumption patterns and consequences of the abuse of alcohol and other drugs, with a continued look at expanding how alcohol and other drug abuse impacts other behavioral health issues.

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, PWID, TB

Goal of the priority area:

Comprehensive and accessible community services available statewide to individuals with a behavioral health diagnosis.

Objective:

Support the development of new community-based services across the state.

Strategies to attain the objective:

Increasing services through reimbursement for individuals with SMI/SED/Brain Injury. Enhancing peer support workforce. Development of medication unit licensing process. Enhancing behavioral health and school collaboration.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Reimbursement for services for individuals with SMI/SED/Brain Injury
Baseline Measurement: No reimbursement for certain services for individuals with SMI/SED/Brain Injury
First-year target/outcome measurement: 1915i state plan amendment submitted to CMS
Second-year target/outcome measurement: Reimbursement is available for services for individuals with SMI/SED/Brain Injury

Data Source:

Medicaid

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Peer support specialist services are reimbursable
Baseline Measurement: No state certification; 259 individuals trained as peer support specialists as of August 1, 2019
First-year target/outcome measurement: Peer support specialist certification process is developed
Second-year target/outcome measurement: Peer support specialist services are reimbursed through Medicaid

Data Source:

ND Administrative Code, Medicaid

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Increase availability of methadone for the treatment of OUD in the state.

Baseline Measurement: North Dakota has currently has 3 OTPs in the state; however, no medication units

First-year target/outcome measurement: Administrative rules are written and approved to authorize medication units

Second-year target/outcome measurement: One medication unit opens.

Data Source:

ND Administrative Code; Behavioral Health Division tracking

Description of Data:

qualitative and quantitative

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Education and Behavioral Health Collaboration

Baseline Measurement: One ND school is funded to develop a behavioral health pilot.

First-year target/outcome measurement: Increase the number of schools funded from one to three

Second-year target/outcome measurement: Technical assistance product and process developed to support implementation in schools across the state.

Data Source:

Behavioral Health Division contract management

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Prevention and Early Intervention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Decrease the harms associated with substance use and abuse and suicide in North Dakota

Objective:

Decrease adult binge drinking, underage drinking, and suicide

Strategies to attain the objective:

- Fund North Dakota communities to follow the Strategic Prevention Framework model and implement evidence-based strategies.
- Provide support for North Dakota communities to follow 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: 48.14%. Ages 26+: 30.5% (2016-2017 NSDUH)
First-year target/outcome measurement: Increase the number of funded communities who implement evidence-based prevention efforts targeting adult binge drinking from 18 in 2018 to 22 in 2019.
Second-year target/outcome measurement: 2% decrease for ages 18-25 and 1% decrease for ages 26+

Data Source:

Behavioral Health Division contract management and technical assistance tracking. The National Survey on Drug Use and Health (NSDUH) will be utilized to monitor adult consumption rates.

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

The National Survey on Drug Use and Health (NSDUH) state-level data combines 2 years of data, so looking at the data annually is not as telling as looking at the trend over three years.

Indicator #: 2
Indicator: Decreased past month alcohol use among ND high school students
Baseline Measurement: 29.1% ND High School students reported alcohol use in the past 30 days
First-year target/outcome measurement: Increase the number of funded communities who implement evidence-based prevention efforts targeting underage drinking Increase the number of funded communities who implement evidence-based prevention efforts targeting adult binge drinking from 26 in 2018 to 30 in 2019.
Second-year target/outcome measurement: A 2% decrease in past 30 days alcohol usage among ND high school students.

Data Source:

Behavioral Health Division contract management and technical assistance tracking; North Dakota Youth Risk Behavior Survey (YRBS)

Description of Data:

Data issues/caveats that affect outcome measures::

None identified at this time.

Indicator #: 3
Indicator: Increasing availability of early intervention services for individuals with a MIP.
Baseline Measurement: 17 providers are certified in ND to provide MIP education services.
First-year target/outcome measurement: Increase the number of certified providers from 17 to 25.
Second-year target/outcome measurement: Increase the number of certified providers from 25 to 35.

Data Source:

Behavioral Health Division

Description of Data:

qualitative

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Suicide prevention

Baseline Measurement: Limited integration of suicide prevention in behavioral health systems and services.

First-year target/outcome measurement: A statewide suicide prevention strategic plan is developed, which highlights integrations with the behavioral health system across the continuum. ntinuum

Second-year target/outcome measurement: Increase the number of communities funded to implement suicide prevention efforts from 0 in 2018 to 10 in 2020.

Data Source:

Behavioral Health Division

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Person-Centered Practice

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, TB

Goal of the priority area:

Ensure behavioral health services provided across the state are person-centered and culturally appropriate.

Objective:

Increase implementation of person-centered strategies and efforts.

Strategies to attain the objective:

Implement services for specific populations and develop policies and procedures across the Department of Human Services to support person-centered practices.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased implementation of evidence-based practices among behavioral health and healthcare providers serving pregnant women and women with dependent children.

Baseline Measurement: Qualitative information from current providers illustrating limited evidence-based practice implementation. No SUD treatment program exists in the state that is specific for the PPW population.

First-year target/outcome measurement: One SUD treatment provider is available in the state that provides services specific to the PPW population.

Second-year target/outcome measurement: Training and technical assistance is implemented to providers and community stakeholders in order to increase evidence-based practice serving PPW.

Data Source:

internal tracking, contract management, qualitative feedback

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase implementation of SUD treatment services for adolescents.

Baseline Measurement: Currently no adolescent residential treatment services for youth with SUD.

First-year target/outcome measurement: Secure an adolescent residential treatment program for adolescents with a SUD with statewide access.

Second-year target/outcome measurement: Increase number of adolescents receiving evidence-based treatment for SUD.

Data Source:

internal tracking, stakeholder feedback, organizational assessments, qualitative feedback

Description of Data:

qualitative and quantitative

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Person-centered implementation in the DHS

Baseline Measurement: no current data available

First-year target/outcome measurement: Complete assessments across DHS divisions and identify existing barriers in policy and administration; begin implementation of policy and procedure change

Second-year target/outcome measurement: Create plan to align practices, structures and priorities for those who work with disability populations across the state with criteria for good PCP. /review all law/policies across internal DHS agencies

Data Source:

internal tracking, stakeholder feedback, organizational assessments, qualitative feedback

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	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	\$11,993,453		\$0	\$7,049,231	\$11,087,891	\$0	\$5,557,714
a. Pregnant Women and Women with Dependent Children**	\$0		\$0	\$0	\$0	\$0	\$0
b. All Other	\$11,993,453		\$0	\$7,049,231	\$11,087,891	\$0	\$5,557,714
2. Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$4,140,268		\$0	\$11,080,419	\$225,000	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$367,914		\$0	\$0	\$0	\$0	\$0
10. Total	\$16,501,635	\$0	\$0	\$18,129,650	\$11,312,891	\$0	\$5,557,714

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	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. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention [†]		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$0	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$0	\$0	\$0
7. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
9. Administration (Excluding Program and Provider Level)***		\$0	\$0	\$0	\$0	\$0	\$0
10. Total	\$0	\$0	\$0	\$0	\$0	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

NOT FINAL

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	127
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	0	2193
4. Persons who inject drugs	0	814
5. Persons experiencing homelessness	0	444

Please provide an explanation for any data cells for which the state does not have a data source.

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Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$4,574,186
2 . Primary Substance Abuse Prevention	\$1,633,638
3 . Early Intervention Services for HIV **	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	\$326,727
6. Total	\$6,534,551

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 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 45 CFR § 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 the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/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 a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. 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 will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

NOT FINAL

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Strategy	A	B
	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	\$311,491
	Total	\$311,491
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	\$77,873
	Total	\$77,873
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	\$77,873
	Total	\$77,873
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	\$77,873
	Total	\$77,873
	Universal	

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	\$545,109
	Total	\$545,109
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	\$467,236
	Total	\$467,236
7. Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	\$35,000
	Total	\$35,000
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	\$0
	Total	\$0
Total Prevention Expenditures		\$1,592,455
Total SABG Award*		\$6,534,551
Planned Primary Prevention Percentage		24.37 %

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

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Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	\$0
Total SABG Award*	\$6,534,551
Planned Primary Prevention Percentage	0.00 %

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

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Footnotes:

NOT FINAL

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

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

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	\$0	\$4,608	\$0
2. Infrastructure Support	\$0	\$6,912	\$0
3. Partnerships, community outreach, and needs assessment	\$0	\$17,376	\$0
4. Planning Council Activities (MHBG required, SABG optional)	\$0	\$0	\$0
5. Quality Assurance and Improvement	\$0	\$2,495	\$0
6. Research and Evaluation	\$0	\$3,072	\$0
7. Training and Education	\$0	\$6,720	\$0
8. Total	\$0	\$41,183	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019

MHBG Planning Period End Date: 03/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	\$0
2. Infrastructure Support	\$0
3. Partnerships, community outreach, and needs assessment	\$0
4. Planning Council Activities (MHBG required, SABG optional)	\$20,000
5. Quality Assurance and Improvement	\$0
6. Research and Evaluation	\$0
7. Training and Education	\$0
8. Total	\$20,000

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

NOT FINAL

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

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.²² 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.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

Currently, 50 states have organizationally consolidated their mental and substance use disorder 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.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.²⁷ Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD 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 M/SUD 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 EHRs and telehealth are examples of important strategies to promote integrated care.³⁰ 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 M/SUD prevention, treatment, 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 homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD 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. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁶ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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 work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.³⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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 M/SUD 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. The 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. The SSAs and SMHAs should collaborate with their states' 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.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, 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.⁴⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴¹ 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 and substance use disorders.

²² 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

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ 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/>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.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. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://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/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ 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 Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ 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); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ 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>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ 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

³⁸ 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

³⁹ 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-BHWORR/PEP13-RTC-BHWORR.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ 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>

⁴¹ 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 respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

North Dakota does not have adequate integration of mental health and primary health care. There is some practice of providing specialty care services in primary care settings and some primary care services in the community behavioral health clinics. There are some tele-behavioral health services for primary care. Federally qualified health clinics have specialty services on site. The community behavioral health centers partner with public health and certain primary care clinics for medical services to the vulnerable and needy.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The community behavioral health centers have applied an objective tool measuring the integration of services for co-occurring disorders with demonstrated average capacity and an identified set of goals for improvement. 75% of clients served in the community behavioral health centers have co-occurring disorders and thus treatment models and care delivery have adapted to meet this need. Current initiative, in early stages of development, is to link our specialty behavioral health specialists with primary care so that we may offer support and consultation for the purpose of retaining behavioral health clients in their primary care settings for all their healthcare.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? Yes No
- b) and Medicaid? Yes No
4. Who is responsible for monitoring access to M/SUD services by the QHP?
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes No
6. Do the M/SUD providers screen and refer for:
- a) Prevention and wellness education Yes No
- b) Health risks such as
- ii) heart disease Yes No

- iii) hypertension Yes No
- iv) high cholesterol Yes No
- v) diabetes Yes No

c) Recovery supports Yes No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation 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, etc.) 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)⁴⁵.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS 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 HHS Secretary's top priority in the Action Plan is to "assess 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."⁴⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁴⁷. 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 populations⁴⁸. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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 populations 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 and is 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.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

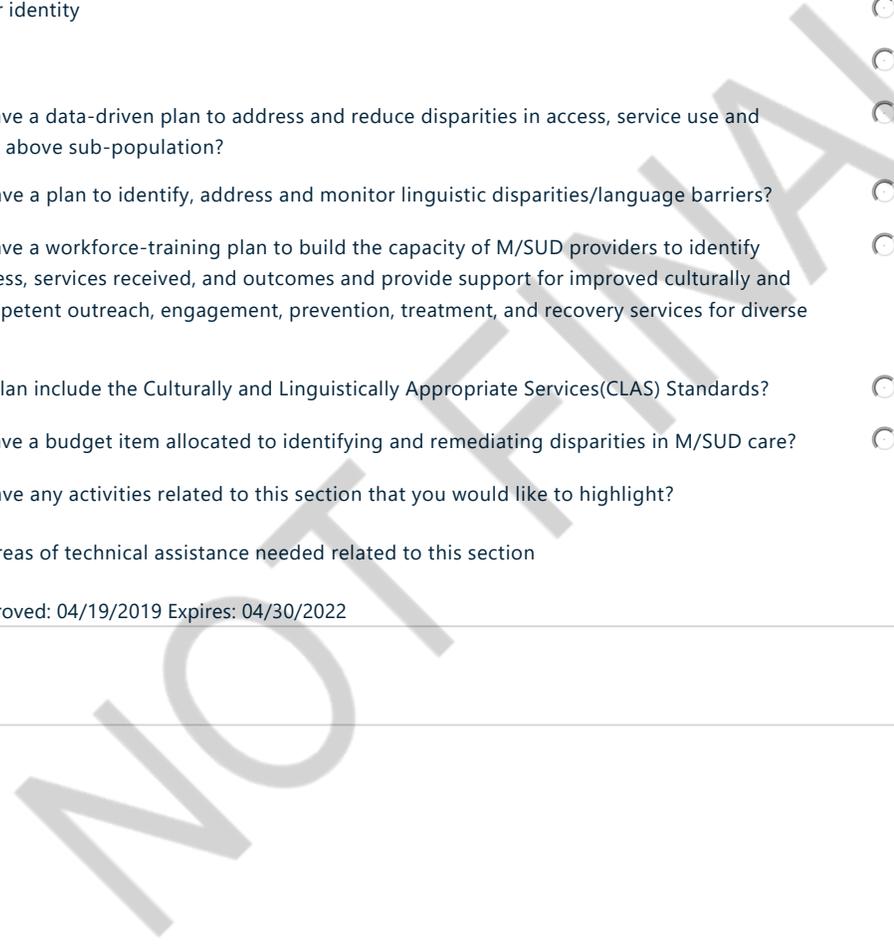
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
 - a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:



Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse 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 IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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 General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² 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."⁵³ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. 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 Protocol Series (**TIPS**)⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA 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 SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)⁵⁵ was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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 M/SUD services.

⁴⁹ 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

⁵⁰ 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.

⁵¹ 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.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? Yes No
2. Which value based purchasing strategies do you use in your state (check all that apply):
 - 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 and non-financial incentives for providers or consumers.
 - d) Provider involvement in planning value-based purchasing.
 - e) Use of accurate and reliable measures of quality in payment arrangements.
 - f) Quality measures focus on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.
3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? Yes No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

North Dakota contracts with a private behavioral health provider, Prairie St. John's (located in Fargo, ND) to provide first episode psychosis services. Prairie St. John's uses the NAVIGATE model of evidence based first episode psychosis treatment services.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The state promotes the use of evidence-based practices for individuals with an ESMI through community presentations, email, social media, and website content. Prairie St. John's provides education and information regarding First Episode Psychosis via community presentations, marketing materials and a video describing first episode psychosis, its symptoms and available services. This video is accessible on Prairie St. John's website along with the North Dakota Behavioral Health Division webpage.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Through a contract with Prairie St. John's (a private behavioral health provider located in Fargo, ND), ESMI services are being implemented through the NAVIGATE model of evidence-based first episode psychosis treatment services. Prairie St. John's provides statewide education regarding first episode psychosis throughout the state. This includes working closely with the eight regional human service centers, state hospital, community-based organizations and colleges in addition to community partners to increase knowledge of the program and services available.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Planned activities for the ESMI program for FFY 2020 and FFY 2021 include expanding services throughout the state via telemedicine, additional NAVIGATE training for clinical staff, and expanding outreach and education efforts throughout the state.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The current contractor submits monthly data reports identifying number of clients served, referral date, eligibility determination, follow through with services, discharge date and reason, Individual Resiliency Training (IRT) hours, Supported Employment and Education (SEP) hours, medication management hours, family therapy hours, team meeting hours and case coordination hours.

10. Please list the diagnostic categories identified for your state's ESMI programs.

- Schizophrenia spectrum and other psychotic disorders
- Bipolar disorder with psychotic features
- Major Depressive Disorder with psychotic features
- Rule out any substance induced psychosis

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

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Footnotes:

NOT FINAL

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? Yes No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

The North Dakota Department of Human Services (DHS) Person-Centered practices (PCP) have evolved for decades, however; person-centered practices, training and policy efforts have resulted in significant variation across the department specifically in policy, training, and practice. In response to this need, the department has developed a cross-division work group that will facilitate the development and implementation of a statewide plan with a goal to establish a system-wide culture for person-centered practices.

As an NCAPPS selected state, the current goal is to develop and execute a statewide plan to enhance overall commitment to person-centered practice for all disability populations served by the DHS and our multiple service partners to ensure the service system reflects its values of person-centeredness. The first step is, conduct a cross-system organizational assessment of person-centered practices and the system changes needed in all divisions and services provided by or funded by the DHS to assure PCP. The strategic plan will include a plan to provide guidance and information toward dignity of risk and interpretation of, identification, and mitigation strategies to employ within person centered service planning to maximize service user voice and choice and balance "important to" and "important for." The second phase will focus on training once the system changes needed to enable PCP are completed. This training effort will include the development of a train-the-trainer process for person centered approaches with development/utilization of resources and toolkits that will guide in the implementation of person-centered practices for all involved in the service system. The DHS is also seeking assistance to provide targeted training and education to executive leadership throughout DHS, and to engage with service users and families throughout the process to ensure they are informing all activities related to the initiative.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The state encourages consumers and caregivers to make health care decisions through a shared decision making model, engagement services, and specific education and encouragement for advance planning with specifically documented advance directives. Shared decision making is a method of communication within the broad context of person-centered care.

All contracts for behavioral health services through the Behavioral Health Division require vendors to be person-centered. This is consistent with the statewide effort for all state agencies to provide services with empathy, mutual respect, that are well-intentioned, and the overall state values of gratitude, humility, curiosity, courage that aspires to a culture that supports our overall purpose to work as one, be citizen focused, have a growth mindset, make a difference, with leadership everywhere. DHS strives always to provide services that reflect current knowledge and technology that are grounded in evidence-based practice with a continuous promotion of healthy behaviors and lifestyles. The state will be reviewing all internal DHS agency policy to ensure that there is a shift in the state culture that aligns to the procedural changes expected of all behavioral health providers.

4. Describe the person-centered planning process in your state.

All contracts for behavioral health services through the Behavioral Health Division require vendors to be person-centered. This is consistent with the statewide effort for all state agencies to provide services with empathy, mutual respect, that are well-intentioned, and the overall state values of gratitude, humility, curiosity, courage that aspires to a culture that supports our overall purpose to work as one, be citizen focused, have a growth mindset, make a difference, with leadership everywhere. DHS strives always to provide services that reflect current knowledge and technology that are grounded in evidence-based practice with a continuous promotion of healthy behaviors and lifestyles. The state will be reviewing all internal DHS agency policy to ensure that there is a shift in the state culture that aligns to the procedural changes expected of all behavioral health providers.

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

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Footnotes:

NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

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 M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 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 U.S.C. § 300x-55(g), 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 made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify 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 use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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 respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes No
3. Does the state have any activities related to this section that you would like to highlight?

The State of North Dakota has made it a priority that all programs will be data and best practice driven. New and existing contracts will include quality measures and compliance reviews, created with a Behavioral Health Division data analyst, to ensure the State is maximizing benefits, avoiding duplication of services, realigning resources, and collecting all required data. Additionally, the State will continue its effort to compile quality, comprehensive, state wide data on behavioral health programming, it's consumers, and outcomes.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

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](#)⁵⁶ 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 approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

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.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

There have been approximately 25 separate consultation sessions conducted with the state and federally recognized tribe regarding behavioral health including a Talking Circle that occurred as a part of the statewide needs assessment and collaborations with Medicaid.

2. What specific concerns were raised during the consultation session(s) noted above?

Eight specific areas for growth were recommended from talking circles and other consultation sessions with federally recognized tribes. 1. Form a tribal nation behavioral health collaborative to develop an inter-tribal behavioral health strategic plan; meet regularly to communicate progress toward the objectives in the strategic plan. 2. Redouble efforts to establish partnerships between tribal nations and the state. Create opportunities for state leadership to visit tribal communities and meet regularly with tribal leadership. Reestablish an office of health equity at the state level. 3. Develop services and program directories for each tribal nation so all community members know what services are available. 4. Educate tribal leaders about what services they can bill and be reimbursed for and provide training specific to each tribal nation. 5. Invest the monies recouped from the 100% FMAP back into the tribal communities. 6. Include regular and ongoing American Indian cultural competency training as part of all state, county and provider employee orientations. 7. Integrate traditional medicine as part of the behavioral health care continuum and explore options for sustainable financing of traditional approaches. 8. Explore additional sustainable options for delivering care and strengthening the workforce – telemedicine, tribal colleges for workforce development, expanded use of community health workers.

3. Does the state have any activities related to this section that you would like to highlight?

The North Dakota Behavioral Health Division continues to partner and work with the American Indian Tribes in the state to ensure culturally-relevant behavioral health services are accessible.

In 2018, North Dakota participated in the Tribal State Policy Academy. Three of the four federally recognized tribes were present and a plan was developed to increase communication, identify services available, and explore opportunities to provide training and resources based on tribal identified needs. These goals were consistent with the needs assessment and have been incorporated into the statewide implementation.

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), the Governor's Prevention Advisory Council (GPAC), Problem Gambling Advisory Council, and Behavioral Health Planning Council.

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.

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

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Footnotes:

NOT FINAL

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - a) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) Intervening variables (including risk and protective factors)
 - d) Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

The SEOW's deliberation and review of the data on substance use consumption patterns, consequences of use, perceptions, and intervening variables results in the identification or priority areas in which the SAPT BG primary prevention funds should be allocated: (1) underage alcohol use (2) adult binge drinking, and (3)opioid misuse.

If no, (please explain) how SABG funds are allocated:

NOT FINAL

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

The Division provides training and technical assistance to the prevention workforce across the state via two pathways: proactive and reactive. The proactive approach includes in-person and webinar trainings, compilation and dissemination of technical assistance resources, etc. The reactive approach includes the availability of training and technical assistance staff for community-specific needs and requests. Training and technical assistance can be requested and is free to anyone in the state through the prevention website: www.prevention.nd.gov. In 2017, three Division staff participated in a train the trainer for the Substance Abuse Skills Trainings (SAPST) curriculum and have since provided an annual training to the prevention workforce.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

Through the SPF-PFS SEOW funding, the state (through contract with the Wyoming Survey and Analysis Center) funded the implementation of a statewide community readiness survey. The survey was completed in 2015, 2017, and again in 2019. The completed community readiness reports can be found at www.prevention.nd.gov/data.

Narrative Question

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Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The state's Evidence-Based Workgroup is not necessarily active, but on reserve for when questions/needs arise. All members are involved in prevention efforts or partnerships and area called upon when needed.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
 The Behavioral Health Division operates the Prevention Resource and Media Center which actively disseminates information to communities and stakeholders.
 The Behavioral Health Division implements evidence-based mass media/communication efforts targeting priorities set by the state's SEOW:
 - Parents Lead
 - Lock. Monitor. Take Back.
 - Stop Overdose
 Information dissemination strategies are funded through community and tribal contracts.
 - b) Education:
 Education strategies are funded through community and tribal contracts.
 Training and technical assistance is provided to communities and tribes on evidence-based education efforts.
 - c) Alternatives:
 Alternative strategies are funded through community and tribal contracts.
 Training and technical assistance is provided to communities and tribes on evidence-based alternatives

d) Problem Identification and Referral:

Problem Identification and Referral strategies are funded through community and tribal contracts.

Training and technical assistance is provided to communities and tribes on evidence-based problem identification and referral.

The Behavioral Health Division certifies providers for DUI and MIP education courses.

e) Community-Based Processes:

Community-Based process strategies are funded through community and tribal contracts.

Training and technical assistance is provided to communities and tribes on evidence-based community-based processes.

f) Environmental:

Environmental strategies are funded through community and tribal contracts.

Training and technical assistance is provided to communities and tribes on evidence-based environmental strategies.

- 3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

Strong partnerships with other state agencies have assisted the Division in identifying needs/strategies to focus SABG dollars on in a way that will supplement and enhance current efforts without duplicating

NOT FINAL

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use
- Perception of harm
- c) Disapproval of use

- d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) Other (please describe):

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Through the public behavioral health service delivery system, 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. The core services offered through the Extended Care Treatment Units, either directly or through public/private provider partnership or contracting include: case management, Supported Employment and Extended Service, and other services such as group, individual, and family therapy, psychological services, and medication monitoring. This same system also provides services for children diagnosed with a serious emotional disturbance. The wraparound process includes a set of core elements: 1) person centered plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting. The array of services provided through the Partnerships Program within the children's mental health system of care include: care coordination, case aide, flexible funding, crisis residential services, substance abuse/dual diagnosis services. Going forward a variety of community-based services, including peer support, will be reimbursed in the state Medicaid plan for individuals with a qualifying behavioral health condition.

The state currently offers services for individuals involved in the criminal justice system - "Free Through Recovery". The model provides care coordination, recovery services, housing and employment supports, and peer support in a community-based health program. It is designed to divert individuals from returning to the criminal justice system simply due to a behavioral health issue that is able to manage with additional community supports.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

- | | |
|---|---|
| a) Physical Health | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| b) Mental Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Housing services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| g) Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| h) Medical and dental services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| i) Support services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| k) Services for persons with co-occurring M/SUDs | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

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.

For individuals with criminal justice system involvement case management may be available through Free Through Recovery. Services include an ongoing source of connection, assistance accessing treatment and recovery support services, and addressing barriers to individual success. Assessments, care planning, referrals, clinical and probation and parole collaboration, access to supportive housing, meaningful employment, and other resources are also available.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The State has several activities aimed at the reduction of hospitalizations and hospital stays across the continuum of care. These activities include partnering with private and public healthcare entities to include screening tools in the primary healthcare setting, increasing awareness of behavioral health and tools to help individual, family, and behavioral health advocacy network support. Support for those in treatment and recovery include increased access to services through the implementation of Medicaid expansion and the SUD Voucher, supported housing, peer support services, and programming offered at the 8 regional recovery centers.

Prioritizing person-centered practices will reduce the rate of hospitalizations of those already connected to the public behavioral health service delivery system by targeting their needs in the home and community and working to provide them with the services that best supports their current need.

New initiatives within current state legislature include; the expansion of Medicaid to cover community based services, case management, and additional supports for individuals with a qualifying behavioral health condition and the extension of Free Through Recovery focusing on supporting families and providing services to children while keeping them in the home.

NOT FINAL

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	824	1557
2.Children with SED	494	1003

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Prevalence and incidence rates for adults with SMI are calculated using information provided from 2016-2017 National Survey on Drug Use and Health: Model-Based Prevalence Estimates acquired through the SAMHSA website. Rates for children with SED are based on the 2016 National Health Interview Survey, Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis published in Psychiatric Services. 2018 Jan 1;69(1):32-40. doi: 10.1176/appi.ps.201700145. Epub 2017 Sep 1, and the North Dakota Department of Public Instruction Guidance Document, Guidelines for Serving Students with Emotional Disturbance in Educational Settings, published in 2016.

NOT FINAL

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services Yes No
- b) Educational services, including services provided under IDE Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse prevention and SUD treatment services Yes No
- e) Health and mental health services Yes No
- f) Establishes defined geographic area for the provision of services of such system Yes No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

In accordance with the state's key priorities of person-centered planning, increased access to services, and supporting the full continuum of care, North Dakota has focused on adding qualified individuals to the behavioral health workforce through the advancement of peer support and telemedicine options. Peer support services in rural areas is in it's beginning stages.

County social services is going through a redesign process to align with the state priorities of person-centered planning and access to community services. This will allow for increased access to services through telemed options in rural counties with limited behavioral health providers outside of the social services offices.

b. Describe your state's targeted services to the homeless population.

Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness (PATH) 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.

State funded programming, focusing on the criminal justice population, targets employment and housing assistance along side behavioral health supports, to help individuals stay out of the system and off the streets - "Free Through Recovery".

c. Describe your state's targeted services to the older adult population.

The public behavioral health service delivery system administers programs and services that help older adults with disabilities to live safely and productively in the least restrictive, appropriate setting. Services offered include counseling, support groups, and training services to meet the needs for family members acting as the primary care giver for an older adult. HBCS are offered through the SPED, Ex-SPED, Medicaid Waiver, and Older Americans Act. The state is currently working on the implementation of behavioral health screenings to be used in conjunction with these service providers.



Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

In planning for allocation of the Mental Health Block Grant funding in North Dakota, the Behavioral Health Division took many considerations into account, including needs and gaps identified in the North Dakota Behavioral Health Systems Study and corresponding Vision 20/20. The North Dakota Behavioral Health Planning Council, working with stakeholders - including service users and families, advocates, providers, administrators, and other North Dakotans, in collaboration with the Human Services Research Institute, engaged in coordinated, data-driven system transformation activities based on the recommendations from the 2018 Behavioral Health System Study.

Following these recommendations and other needs and gaps in the system, the North Dakota Behavioral Health Division plans to allocate the Mental Health Block Grant funds in the following way:

- Partnerships Program (through the regional Human Service Centers): Mental Health Block Grant funding will support five Partnerships Programs located at the human service centers serving children with serious emotional disturbances.
- Peer Support: North Dakota is continuing to develop mental health peer support services throughout the state. Peer support specialists will have the opportunity to become certified by July 1, 2020. In addition, peer support services will become reimbursable in the state Medicaid plan for individuals with a qualifying behavioral health condition.
- First Episode Psychosis Treatment Program: The Division will continue work Prairie St. John's in Fargo to expand the Coordinated Specialty Care program to provide evidence-based First Episode Psychosis (FEP) treatment services to individuals between 15 and 25 years of age.
- Advocacy: The Division provides support for a consumer-run advocacy program to increase quality and access to mental health services, assist consumers to ensure that they are the catalyst for transforming the mental health system, and increase positive messaging while reducing the stigma associated with mental health diagnosis. The Division also plans on assisting advocates in receiving training at the national level.
- Aging and Mental Health: The Division plans to assist with training for long term care staff regarding mental illness and best practices in working with older adults experiencing mental illness.
- Workforce Training: To increase the utilization of best practices, the Division plans to support the training of clinicians and other mental health stakeholders, including continuing education for peer support specialists. One way of doing this is through the annual Behavioral Health Conference hosted by the Behavioral Health Division. Additionally, funds may be expended to train emergency health service providers in conjunction with crisis services.
- Planning Council: The Division supports the functioning of the State's Behavioral Health Planning Council, including administrative support services and travel reimbursement for the federally required North Dakota Behavioral Health Planning Council.



Footnotes:

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening Yes No
- ii) Education Yes No
- iii) Brief Intervention Yes No
- iv) Assessment Yes No
- v) Detox (inpatient/social) Yes No
- vi) Outpatient Yes No
- vii) Intensive Outpatient Yes No
- viii) Inpatient/Residential Yes No
- ix) Aftercare; Recovery support Yes No

b) Services for special populations:

- Targeted services for veterans? Yes No
- Adolescents? Yes No
- Other Adults? Yes No
- Medication-Assisted Treatment (MAT)? Yes No

NOT FINAL

Criterion 2

NOT FINAL

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, and custody issues? Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The regional human services centers have adopted open access assessment services and each individual seeking an assessment is triaged and screened for pregnancy and injection drug use. If an individual does identify as being pregnant or using drugs intravenously, they are given priority and an assessment is completed that day. If a situation were to occur and an assessment is not available that same day, it is completed no later than 48 hours and services begin directly following the assessment. Several of the human service centers offer treatment mall model of services and individuals are able to begin services directly following the assessment. If services are not available directly following the assessment, the individual is placed on a prioritized waiting list and offered interim services to include engagement group, case management or referred to education-based programming. Regional human service center directors and clinical directors sign a memorandum of understandings to stipulate priority population requirements are met.

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.

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement Yes No
 - b) 14-120 day performance requirement with provision of interim services Yes No
 - c) Outreach activities Yes No
 - d) Syringe services programs Yes No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Has your state identified a need for any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached Yes No
 - b) Automatic reminder system associated with 14-120 day performance requirement Yes No
 - c) Use of peer recovery supports to maintain contact and support Yes No
 - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? Yes No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Regional human services centers have adopted open access assessment services and each individual seeking an assessment is triaged and screened for pregnancy and injection drug use. If an individual does identify as being pregnant or using drugs intravenously, they are given priority and an assessment is completed that day. If a situation were to occur and an assessment is not available that same day, it is completed no later than 48 hours and services begin directly following the assessment. Several of the human service centers offer treatment mall model of services and individuals are able to begin services directly following the assessment. If services are not available directly following the assessment, the individual is placed on a prioritized waiting list and offered interim services to include engagement group, case management or referred to education-based programming. Regional human service center directors and clinical directors sign a memorandum of understandings to stipulate priority population requirements are met.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The regional human service centers have incorporated TB screening in their Electronic Health Record as a required screening. When an individual is identified as high risk for TB, the clinician provides education regarding TB and provides a referral. Some regional human service centers have nurses available with the ability to conduct a TB test and provide for the follow up appointments. Other regional human service centers have agreements with local public health units to accept the referrals for TB testing and follow up appointments. Compliance checks are completed to ensure the programs are complying with this requirement.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No

2. Has your state identified a need for any of the following:
- a) Establishment of EIS-HIV service hubs in rural areas Yes No
 - b) Establishment or expansion of tele-health and social media support services Yes No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

- 1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? Yes No
 - 2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No
 - 3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No
- If yes, please provide a brief description of the elements and the arrangement

NOT FINAL

Criterion 8,9&10**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? Yes No
2. Has your state identified a need for any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of services for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? Yes No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) An organized referral system to identify alternative providers? Yes No
 - c) A system to maintain a list of referrals made by religious organizations? Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No
 - c) Identify workforce needs to expand service capabilities Yes No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? Yes No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements Yes No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
 - c) Updating written procedures which regulate and control access to records Yes No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure Yes No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

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.

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan Yes No
 - b) Establishment of policies and procedures related to independent peer review Yes No
 - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations Yes No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If Yes, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Has your state identified a need for any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? Yes No
 - b) Mental Health TTC? Yes No
 - c) Addiction TTC? Yes No
 - d) State Targeted Response TTC? Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No

c) Coordination of Various Activities and Services

Yes No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

North Dakota Century Code: <https://www.legis.nd.gov/cencode/t50c06.pdf>

North Dakota Administrative Code: <https://www.legis.nd.gov/information/acdata/html/75-09.1.html>

NOT FINAL

Footnotes:

NOT FINAL

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11. Quality Improvement Plan- Requested

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.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? Yes No

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

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12. Trauma - Requested

Narrative Question

Trauma⁵⁷ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening 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 M/SUD 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.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. 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 M/SUD 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. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁵⁸ paper.

⁵⁷ 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.*

⁵⁸ Ibid

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
5. Does the state have any activities related to this section that you would like to highlight.

The Behavioral Health Division (BHD) continues to collaborate with Trauma Focused-Cognitive Behavior Therapy (TF-CBT) experts at the Neuropsychiatric Research Institute (NRI) to expand and sustain a statewide clinical network of TF-CBT trained therapists. Also, through contract the BHD maintains the Treatment Collaborative for Traumatized Youth (TCTY) website: <https://www.tcty-nd.org/>. TCTY is a network of 350 clinicians in 40 agencies across the state of North Dakota. NRI keeps the TCTY webpage updated with current information on where to find trained clinicians.

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

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NOT FINAL

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13. Criminal and Juvenile Justice - Requested

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 mental and substance use problems. Youth 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.⁵⁹

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶⁰

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 M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.

⁵⁹ 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 Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No

5. Does the state have any activities related to this section that you would like to highlight?

In the 2017 North Dakota Legislative Session, Senate Bill 2015 established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. The goal of this effort, titled, Free Through Recovery is to improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services linked with effective community supervision.

The Departments of Correction and Rehabilitation and Human Services in partnership with local agencies and governments deliver coordinated and comprehensive services to people in the program. Using a certified paraprofessional workforce and an integrated, multidisciplinary approach, community-based agencies provide a range of services including comprehensive case planning, linking participants to services, peer recovery supports, and facilitating communication.

Since the inception on February 1, 2018, Free Through Recovery has served over 1,000 individuals. Free Through Recovery Providers are reimbursed with a pay for performance model. In addition to monthly base pay, providers can receive performance pay if participants meet at least 3 of 4 outcome metrics (Housing, Employment, Recovery, and Involvement with Law Enforcement).

Overall, from March 2018 to January 2019, providers earned performance pay for the 68% of their participants.

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

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in 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 MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

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.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No

5. Does the state have any activities related to this section that you would like to highlight?

North Dakota has only recently had methadone as an option for opioid use disorder as the first opioid treatment program (OTP) opened in 2016. Currently there are three OTPs in North Dakota and in 2018 there were 559 admissions for medication assisted treatment. During the 2019 Legislative Session, the Department of Human Services were given authority to develop administrative rules allowing Medication Units to open in North Dakota. This will allow for OTPs to expand their dosing locations across the state and increasing access to medication assisted treatment.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved 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, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD 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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ 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 M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"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 M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice 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 check those that are used in your state:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

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

3. Post Crisis Intervention/Support

- a) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

North Dakota has pockets of Crisis services across the state utilizing evidence-based strategies. The regional human service centers are in the process of developing a more robust crisis management program in each of the regions across the state to include crisis triage, residential/respite care, and mobile outreach. These efforts include working with local community resources such as law enforcement, homeless shelters, public health clinics, hospitals, and treatment providers.

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

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. 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.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
- b) Required peer accreditation or certification? Yes No
- c) Block grant funding of recovery support services. Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

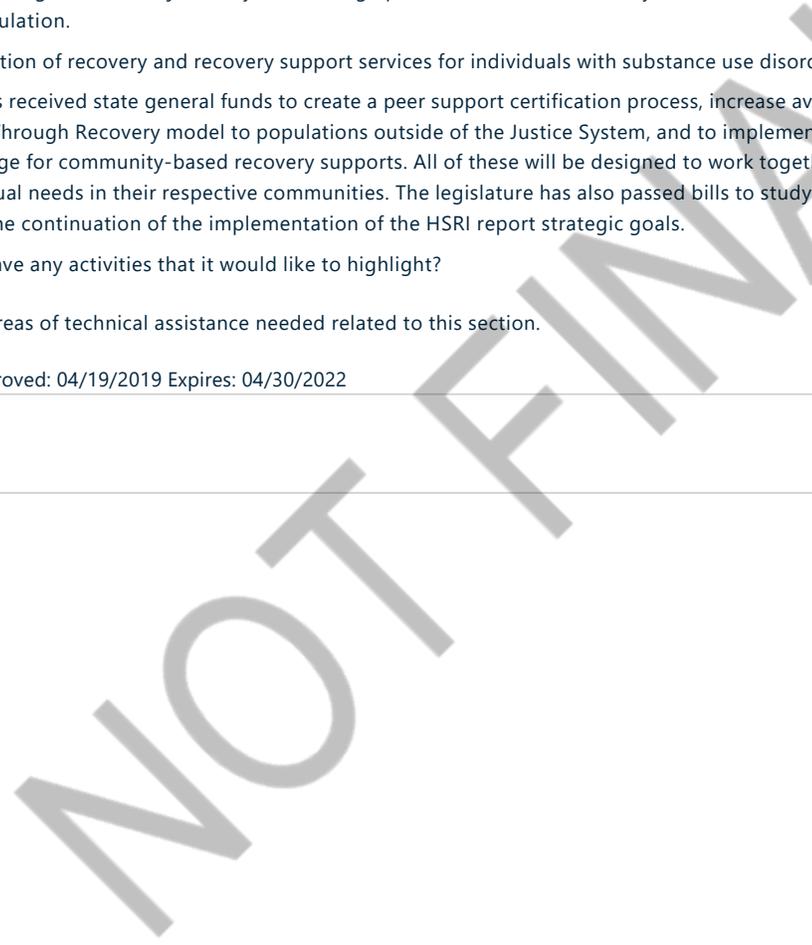
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
 Recovery and recovery support services for SMI and SED include targeted case management and care coordination, skills training and other rehabilitative services, supported employment, peer support, residential services, supported housing, medication management, and Recovery Centers for socialization activities. The state also hosts trainings for providers on a recovery focused model of care. The state has made peer support services and continuing education for peer support specialists a priority to more thoroughly integrate them into the continuum of care. The state also has focused on diverting individuals with mental health issues from reentering the criminal justice system through person centered, community-based services designed specifically to support this population.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
 North Dakota has received state general funds to create a peer support certification process, increase availability of crisis services, extend the Free Through Recovery model to populations outside of the Justice System, and to implement a Medicaid expansion providing coverage for community-based recovery supports. All of these will be designed to work together to create supports based on individual needs in their respective communities. The legislature has also passed bills to study a redesign of Olmstead and to support the continuation of the implementation of the HSRI report strategic goals.

5. Does the state have any activities that it would like to highlight?
 Please indicate areas of technical assistance needed related to this section.

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17. Community Living and the Implementation of Olmstead - Requested

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 M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual 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 M/SUD 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 for 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 settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based 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:

Please respond to the following items

- Does the state's Olmstead plan include :
 - Housing services provided. Yes No
 - Home and community based services. Yes No
 - Peer support services. Yes No
 - Employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- 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 2019 North Dakota Legislature approved a study directive into issues related to the Olmstead Commission and services for individuals with behavioral health issues. This includes a redesign of the structure and the potential of an 1115 waiver to bypass IMD. Additionally, the state is continuing the implementation of the HSRI report. This will serve to support the full continuum of care for individuals requiring behavioral health services in the least restrictive environment in their community.

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. 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 emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶³ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁶⁴ For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.⁶⁵

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 21.⁶⁶ 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 point person 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 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

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 SUD and co-occurring M/SUD 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, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. 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 M/SUD 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, 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.

⁶⁵Centers 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.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department 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 <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? Yes No
 - for youth in foster care? Yes No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

North Dakota applied for the System of Care grant in April 2019 and is awaiting to hear if our state is chosen as an awardee.

The Department of Human Services houses several divisions which play a key role in the children's system of care, including the Behavioral Health Division (BHD), Children and Family Services Division, Medical Services Division (the state Medicaid agency), and Field Services Division (which includes eight regional public human service centers located across the state and the state hospital). The BHD currently partners with all these sister divisions in a variety of projects with the aim to transform the behavioral health system of care in the state.

It is also worth noting that ND Department of Human Services is in the midst of redesigning social services from a process, culture and structure perspective. The goal of the redesign is to identify efficiencies, hidden capacity and ensure the right services are accessible in the community.

Several legislative bills passed during the state's 2019 legislative session which will support the continued development of a system of care. One of these bills requires the creation of a Children's Cabinet - consisting of representation from the three branches of government, state directors from education, human services, health, Indian affairs commission, corrections and rehabilitation, and protection and advocacy. The purpose of this cabinet is to assess, guide, and coordinate the care for children

across the state's branches of government and tribal nations. The establishment of the Children's Cabinet will also assist in efforts to coordinate payment structures for services designed to support children with SED and their families. This cabinet assures cross-department communication and opportunity to creatively braid funding for comprehensive supports and services.

7. Does the state have any activities related to this section that you would like to highlight?

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

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

The Suicide Prevention Program in North Dakota previously lived in the ND Department of Health. During the state's 2019 legislative session, the Suicide Prevention Program moved to the ND Department of Human Services, Behavioral Health Division in order to better integrate suicide prevention efforts with the behavioral health initiatives across the continuum of care.

The Suicide Prevention Program developed a strategic plan in 2017 (for 2017-2020) in partnership with the ND Suicide Prevention Coalition. Zero Suicide continues to be an effort supported by the program and the coalition. The program also continues to support the implementation of the evidence-based Sources of Strength program in schools across the state.

An updated suicide prevention plan will be created which integrates efforts across the continuum of care.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? Yes No

If so, please describe the population targeted.

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

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20. Support of State Partners - Required for MHBG

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 M/SUD 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 factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, 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 homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

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, Brain Injury Advisory Group, and the Problem Gambling Advisory Council. A Children's Cabinet was created during the 2019 legislative session.

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, 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 Task force.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The North Dakota Behavioral Health 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.

The State of North Dakota has made it a priority that, going forward, all programs will be data and best practice driven. New and existing contracts will include quality measures and compliance reviews, created with a Behavioral Health Division data analyst, to ensure the State is maximizing benefits, avoiding duplication of services, realigning resources, and collecting all required data .

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

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21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁶⁹

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. 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.

⁶⁹ <https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Under the mandate outlined in Public Law 102-321 (42 U.S.C 300X-4), thirty-member board -- the North Dakota Behavioral Health Planning Council (BHPC) -- 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. These individuals are family members of or consumers of behavioral health services.

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. The Council developed recommendations which drove the decisions regarding the Mental Health Block Grant budget allocations. The Council also has provided recommendations to both the Department of Human Services and the Governor's Office.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? Yes No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No

3. 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.

As identified in the North Dakota Behavioral Health Council By-Laws, the following duties of the council are established: Review and evaluate services and programs provided by the State of North Dakota and make periodic reports to the Department of Human Services and the Governor's office, including any recommendations for improvements in services, programs, or facilities. Review the status of combined behavioral health assessments and plan, staff resources, expenditure of funds and available case management information at least semi-annually. Review the combined behavioral health assessment and plan at least annually. Work with legislators in members' respective regions to familiarize lawmakers with the need for appropriate mental health and substance abuse issues.

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

Services.

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

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

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

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

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

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

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There 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.

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Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Nicole Amsbaugh	Others (Advocates who are not State employees or providers)			
Debbie Baier	State Employees			
Brenda Bergsrud	Others (Advocates who are not State employees or providers)			
Barbara Burghart	State Employees	North Dakota Department of Human Services		
Lorraine Davis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Shauna Eberhardt	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Rosalie Ethrington	State Employees	North Dakota Department of Human Services		
Michelle Gayette	State Employees	North Dakota Department of Human Services		
Brad Hawk	State Employees			
Jennifer Henderson	State Employees	North Dakota Housing Finance Agency		
Stacey Hunt	Providers			
Deb Jendro	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Robin Lang	State Employees	North Dakota Department of Public Instruction		
Teresa Larsen	Others (Advocates who are not State employees or providers)			
Glenn Longie	Representatives from Federally Recognized Tribes			
Carlotta McCleary	Others (Advocates who are not State employees or providers)			

Kim Osadchuk	State Employees	Burleigh County Social Services		
Lisa Peterson	State Employees	North Dakota Department of Corrections and Rehabilitation		
Emma Quinn	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Tom Regan	Others (Advocates who are not State employees or providers)			
Pamela Sagness	State Employees	North Dakota Department of Human Services - Behavioral Health Division		
Kirby Schmidtgall	Others (Advocates who are not State employees or providers)			
Kurt Snyder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Derrick Solberg	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Jodi Stittsworth	Parents of children with SED/SUD			
Paul Stroklund	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Timothy Wicks	Others (Advocates who are not State employees or providers)			
Carl Young	Parents of children with SED/SUD			

*Council members should be listed only once by type of membership and Agency/organization represented.

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State Education Agency - Robin Lang

State Vocational Rehabilitation Agency - Barbara Burghart

State Criminal Justice Agency - List Peterson

State Housing Agency - Jennifer Henderson

State Social Services Agency - Kim Osadchuk

State Health (MH) Agency - Pamela Sagness

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Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	30	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	1	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	18	60.00%
State Employees	10	
Providers	1	
Vacancies	1	
Total State Employees & Providers	12	40.00%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, 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.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
- a) Public meetings or hearings? Yes No
 - b) Posting of the plan on the web for public comment? Yes No
If yes, provide URL:
 - c) Other (e.g. public service announcements, print media) Yes No

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