North Dakota

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 09/01/2023 4.12.02 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 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID GSKXYGKGX6A4

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

Agency Name North Dakota Department of Health & Human Services

Organizational Unit Behavioral Health Division

Mailing Address 600 E Boulevard Ave

City Bismarck

Zip Code 58505

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

First Name Pamela

Last Name Sagness

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

Mailing Address 600 E Boulevard Ave

City Bismarck

Zip Code 58505

Telephone 701-328-8824

Fax 701-328-8969

Email Address psagness@nd.gov

State CMHS Unique Entity Identification

Unique Entity ID GSKXYGKGX6A4

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

Agency Name North Dakota Department of Health & Human Services

Organizational Unit Behavioral Health Division

Mailing Address 600 E Boulevard Ave

City Bismarck

Zip Code 58505

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

First Name Pamela

Last Name Sagness

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

Mailing Address 600 E Boulevard Ave

City Bismarck

Zip Code	58501
Telephone	701-328-8824
Fax	701-328-8969
Email Address	psagness@nd.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
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	Lacresha
Last Name	Graham
Telephone	701-328-8922
Fax	
Email Address	lgraham@nd.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

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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 19 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, as applicable, with 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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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.).
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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 [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

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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[1]:

Title: Executive Director

Date Signed: 8-31-23

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State of
North Dakota
Office of the Governor

Doug Burgum
Governor

April 13, 2017

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

Dear Ms. Simmons:

As Governor of North Dakota, I hereby designate Pamela Sagness to make all assurances required by the Public Health Services Act for the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance in Transition from the Homelessness Grant.

The designation shall remain in effect as long as I am the Governor of North Dakota and Ms. Sagness is the Director of the Behavioral Health Division of the North Dakota Department of Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to Ms. Sagness at the Department's Behavioral Health Division, 1237 West Divide Avenue, Suite 1C, Bismarck, ND 58501-1208.

Sincerely.

Doug Burgum
Governor

600 E Boulevard Ave · Bismarck, ND 58505-0001 · Phone: 701.328.2200 · www.governor.nd.gov

State Information

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

Fiscal Year 2024

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
Tile 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**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
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 19 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, as applicable, with 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.
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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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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.)
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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.
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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.
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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 Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Crisis 5%:

North Dakota will utilize BSCA supplemental funds to expand behavioral health crisis services through evidence-based training within the state including the school systems. The State will collaborate with agencies to provide crisis response trainings (for e.g. therapeutic crisis intervention and de-escalation) to providers identified in the statewide plan. A train-the-trainer plan will allow for sustainable practice in all areas of the state including rural and tribal regions.

Funds will also be used to enhance the critical incident response for those affected by mental health emergency/crisis-related trauma, including mass shootings/school violence. Critical Incident Stress Management (CISM) training was provided this past year to a number of private providers, law enforcement, and behavioral health providers within three of the eight regional human service centers. The state will expand this effort to additional public and private providers and utilize funds to establish a consistent protocol for CISM debrief efforts, and create a network of providers available to first responders of all types

FEP 10%:

The 10% set-aside supporting interventions for individuals with mental illness will continue to support expansion of North Dakota's First Episode Psychosis teams. Funding will be used for additional evidence-based training including attendance at a national conference and the procurement of an additional provider to serve the Western part of the state.

BUDGET

Crisis 5%	
De-escalation train-the-trainer for ND Schools	80,000
Critical Incident Debrief Enhancements	32,068
FEP10%	12,453
BSCA Award	**124,521**

State Information

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

Fiscal Year 2024

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
Tile 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
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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.

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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 Designee[1]:

Title: Executive Director

Date Signed: 8-31-23

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State of
North Dakota
Office of the Governor

Doug Burgum
Governor

April 13, 2017

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

Dear Ms. Simmons:

As Governor of North Dakota, I hereby designate Pamela Sagness to make all assurances required by the Public Health Services Act for the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance in Transition from the Homelessness Grant.

The designation shall remain in effect as long as I am the Governor of North Dakota and Ms. Sagness is the Director of the Behavioral Health Division of the North Dakota Department of Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to Ms. Sagness at the Department's Behavioral Health Division, 1237 West Divide Avenue, Suite 1C, Bismarck, ND 58501-1208.

Sincerely.

Doug Burgum
Governor

600 E Boulevard Ave · Bismarck, ND 58505-0001 · Phone: 701.328.2200 · www.governor.nd.gov

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: 04/19/2021 Expires: 04/30/2024

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 (description of the current prevention system's attention to individuals in need of substance use primary 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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 2022-estimated population of 779,261 people. ND has 11.3 people per square mile compared to the United States at 94.0 people per square mile. According to the 2010 Census, ND has 357 incorporated communities. Fifty-six percent of these communities have 200 people or less. According to the 2020 Census, North Dakota has 357 incorporated communities. 55% of these communities have 200 people or less. The state's largest cities are Fargo (125,952), Bismarck (73,625), Grand Forks (59,170), and Minot (48,384) (2020 Census).

Just over 16% of the state's population is over age 65 and 23.5% is under age 18 (2022 Population Estimates – U.S. Census). 11.1% percent of persons live below the poverty level, compared to 11.4% nationally. According to the 2020 U.S. Census, 86.6% of the state's population is white, 5.3% is American Indian/Alaska Native, 3.6% is Black or African American and 4.6% is of Hispanic/Latino origin (2022 Population Estimates – U.S. Census). 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 45,020 civilian veterans in North Dakota, comprising approximately 6% of the adult population. (2022 Population Estimates – U.S. Census)

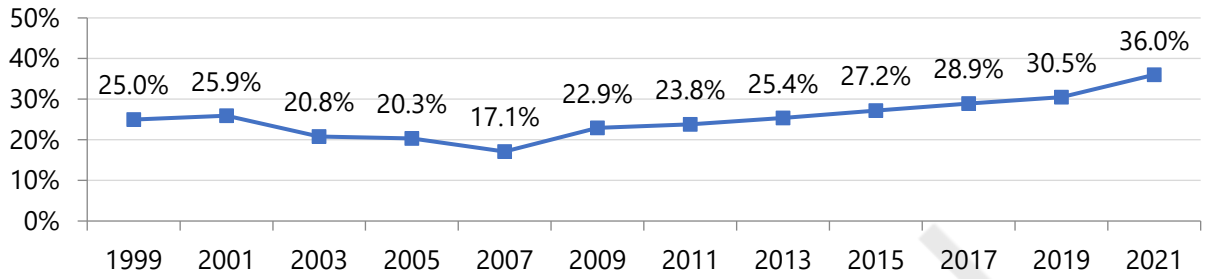
The western half of North Dakota consists of many small communities spread across thousands of acres of farmland, with farming as one of the primary sources of income. A "Virginia-sized", 24,000 square mile oil reserve of an estimated 4.3 billion barrels lies 10,000 feet below the surface of western 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: 36% of ND high school students report feeling sad or hopeless almost every day for two 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



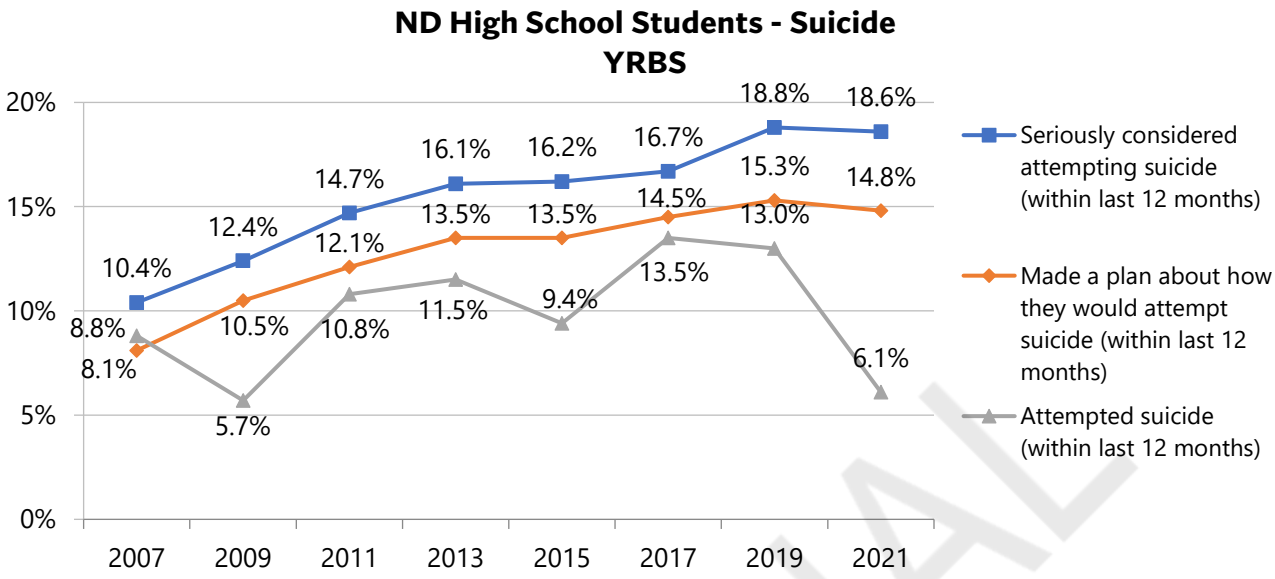
Nearly 20% of children and young people ages 3-17 in the United States have a mental, emotional, developmental, or behavioral disorder [ii]. Among ND children and youth, prevalence of mental health conditions is similar to national estimates. In 2021, the annual average proportion of North Dakotan adolescents aged 12 to 17 with a major depressive episode[1] in the past year was 21.1% percent (2021 NSDUH).

ADULTS: In 2021, an estimated 25.79% of adults aged 18 and older in North Dakota met the criteria for any mental illness in the past year (2021 NSDUH). This aligns with the national annual average of 22.8% [iii]. A total of 7.06% of North Dakota adults aged 18 or over in 2021 had a serious mental illness (SMI) in the past year; this figure is similar to the corresponding national annual average of 5.5% (2021 NSDUH).

SUICIDE: Suicide, a significant health issue nationwide, is a serious concern in North Dakota. In 2021, 153 North Dakotans died by suicide, which was the tenth leading cause of death in the state that year [iv]. Approximately 18.6 % of ND high school students seriously considered attempting suicide at some point during the past year and 14.8% of made a plan about how they would attempt suicide. [v]

The annual average percentage of North Dakotan adults aged 18 or older with serious thoughts of suicide in 2021 was 6.4%, slightly higher than the national annual average of 4.8% (2021 NSDUH). Almost one in five (18.6%) of North Dakota's high school youth considered attempting suicide in the past year. Rates of suicide among veterans and military service have risen higher than the rates of suicide among the general population in recent years. In 2019, 14.6 percent of those who died by suicide in North Dakota were veterans. [vi].

[1] 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.



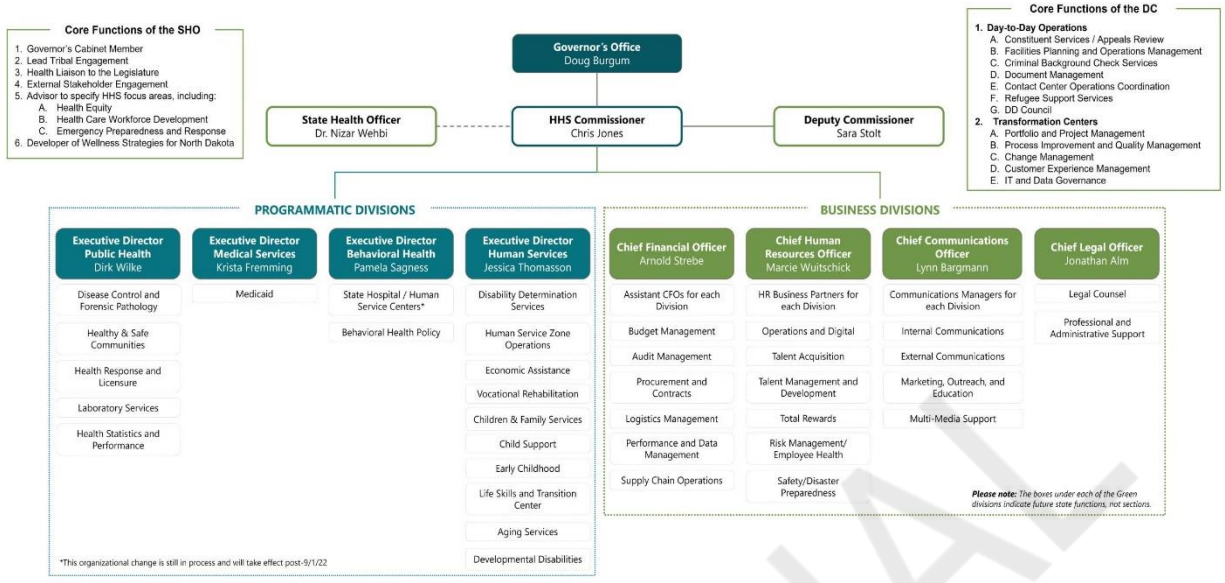
STRUCTURE OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

North Dakota Department of Health and Human Services

On September 1, 2022 the North Dakota Department of Health and North Dakota Department of Human Services merged to become the North Dakota Department of Health and Human Services (HHS). The vision of HHS is to make North Dakota the healthiest state in the nation. HHS has developed three primary goals to achieve this vision:

- Deliver one streamlined path to quality, equitable programs and services.
- Continue to improve quality, effective and efficient health and human services.
- Create career growth and development opportunities for team members and build a one-team culture.

HHS is an umbrella agency headed by Commissioner Christopher Jones who was appointed by Governor Doug Burgum on Feb. 3, 2017. HHS is organized into five major subdivisions consisting of Public Health, Medical Services, Behavioral Health, Human Services and Business Divisions (Legal, Human Resources, Finance, Communications). HHS receives and distributes funds furnished by the North Dakota Legislature and Congress. HHS, through the ND State Hospital, Life Skills and Transition Center and Statewide Community Behavioral Health Clinics (Human Service Centers), is a direct provider of human services and the state institution for individuals needing inpatient psychiatric services.



Behavioral Health Division

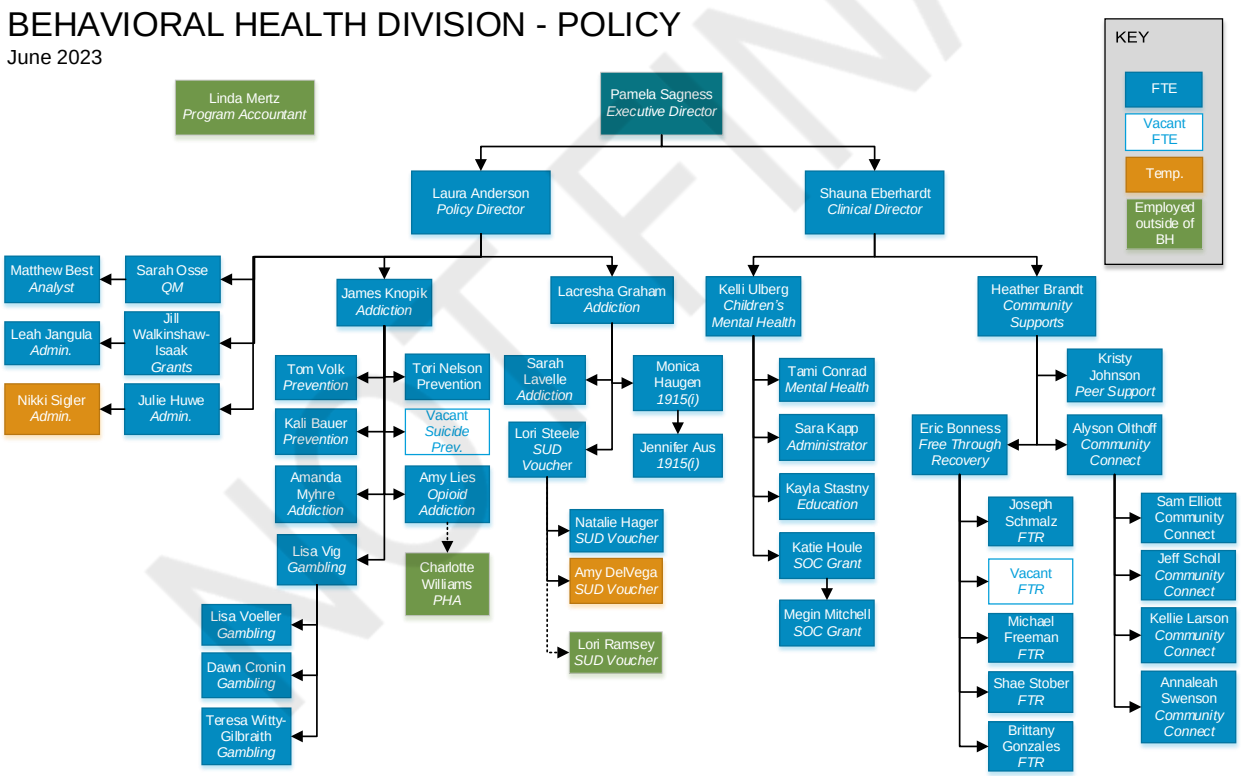
The Behavioral Health Division within the Department of Health and Human Services serves as the State Mental Health Authority (SMHA), State Substance Abuse Authority (SSA), and the State Opioid Treatment Authority (SOTA).

On September 1, 2022 when the Departments of Health and Human Services merged, the field services division within legacy Department of Human Services merged with the Behavioral Health policy division. Pamela Sagness is the Executive Director overseeing the Policy Team, Community Behavioral Health Clinics (Human Service Centers) and the State Hospital.

The Policy Team within the Behavioral Health Division (NDCC 50-06-01.4) is a team 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 Policy Team 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 Policy Team does not provide direct services, rather the role of

the Team is to ensure health and safety and access to a wide range of quality behavioral health services across the state.

The Policy Team 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 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 has created a strategic plan for systems change grounded in the findings and recommendations of the 2018 study and ongoing stakeholder conversations. The HSRI has continued to support the state in the implementation of the strategic goals. A dashboard summarizes progress on these efforts: www.hsri.org/files/uploads/publications/ND_BHStrategicPlan210416_Accessible.pdf.

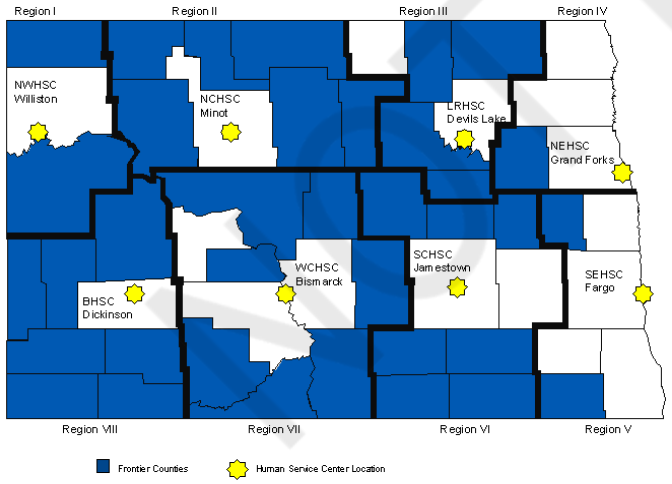


The Community Behavioral Health Clinics and State Hospital functions were defined during the 2017 Legislative Session, Senate Bill 2039 (NDCC 50-06-01.4). This service delivery team is responsible for providing twenty-four-hour crisis services for citizens of North Dakota, integrated, evidence-based service for individuals with behavioral health disorders, and rehabilitative services designed to restore functioning and quality of life. There are eight Community Behavioral Health Clinics, each serving a designated multi-county area, providing behavioral health services. The clinics serve as the access point for State Hospital admissions

through crisis service provision and screening within critical access hospitals and jails. Each clinic has expanded the open access behavioral health assessment process through the utilization of a hub and spoke model. Currently, individuals can walk in and meet with a triage specialist and either have a warm hand off to a community service that will fit their need or become registered through the clinic and seen for a full diagnostic assessment and assigned to a behavioral health services team. It is the expectation within this model that those in crisis are provided an immediate service or connection to appropriate service as well as those with the highest or most complex behavioral health needs are screened into services at the clinic and may begin treatment services the same day.

In the past several years, this service delivery team– Community Behavioral Health Clinics and State Hospital – has focused on expanding the twenty-four-hour crisis services available. Crisis stabilization facilities currently exist in all eight regions – operated through the regional clinics; however, there are plans for each of these facilities to allow for a walk-in option 24 hours/7 days a week for a brief assessment. At the facility, individuals will receive short-term, recovery-focused services with the goal to resolve the crisis. Services will also include withdrawal management, supportive therapy and referral to any additional needed services. The service delivery team is also implementing plans to expand mobile crisis response throughout the state, with several regions currently operational. These trained mobile crisis intervention teams will meet a person in crisis where they are, assess for risk of harm to self/others, and help problem-solve the crisis situation. Contact information, including the counties served, is provided below.

Regional Community Behavioral Health Clinic 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 Community Behavioral Health Clinics 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 Department of Health and Human Services also operates the Life Skills and Transition Center, which 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 Policy Team 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 Policy Team plans to allocate the Mental Health Block Grant funds in the following way:

- Peer Support: The Division is continuing to develop mental health peer support services throughout the state including peer support certification, peer support supervision training and expanding the types of peer support training available for peer support specialists.
- Care Coordination: The Division is expanding care coordination and recovery support services for pregnant women, families, caregivers, and individuals with a SMI which impacts functionality in multiple domains including housing, employment, parenting, physical health, and/or community connections.
- Crisis Services: The Division is continuing to expand behavioral health crisis service delivery throughout the state.
- First Episode Psychosis Treatment Program: The Division is providing First Episode Psychosis (FEP) services in two Human Service Centers in the state and will expand this service to the Western part of the state. The Division provides services to a core population of individuals with serious mental illness including schizophrenia, schizoaffective, schizophreniform, brief psychotic disorder, trauma-related and mood disorders. Division staff will provide evidence based FEP treatment services to individuals between 15 and 25 years of age through the Coordinated Specialty Care program.

- Advocacy: The Division provides funding to support a consumer-run advocacy program to more effectively respond to the needs of children, youth, and young adults with serious emotional disturbances (SED) and their families by providing information, referrals, and support, increase the quality and access to mental health services, assist consumers to ensure 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 provides funding to a program to support, provide resource, referral and advocacy for adults with SMI and their families. The program maintains a statewide council, coordinates a statewide conference, and staffs a call line to provide resources and referrals to assist families with accessing mental health services in the state. The agency also has a staff member trained in the SSI/SSDI Outreach, Access and Recovery (SOAR) model to assist adults with SMI to apply for social security benefits.
- Aging and Mental Health: The Division plans to assist with training for long term care and home and community-based service 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. The Division plans to provide workforce trainings to enhance services for children with SED and adults with SMI. Trainings planned include the following topics: LGBTQ+ Affirming Psychiatric Residential Treatment Facilities, LGBTQ+ Adult Behavioral Health, Motivational Interviewing, Compassion Fatigue, Developing Agri-Cultural Competence for Mental Health Professionals, and Building Successful Initiatives in Rural Communities to Build Resilience. In addition, the annual Behavioral Health Conference hosted by the Behavioral Health Division, plans to collaborate with the Child and Family Services to provide additional training and professional development.
- 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 Policy Team to license substance use disorder treatment programs in operation in the state. Currently 102 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.

During the 2021 legislative session, North Dakota lawmakers passed Senate Bill No. 2161 allowing the development and administration of mental health program directory. On October

3, 2022, the North Dakota Department of Health and Human Services launched a mental health program directory to better help North Dakotans locate and access mental health services in the state. The directory allows users to search for mental health programs by location, population served, type of mental health specialty and treatment and intervention options. People can also search for programs that offer telehealth services. There are currently 244 locations registered in the mental health program directory.

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 and Human Services. 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.

The Behavioral Health Division Policy Team supports local implementation of substance abuse prevention efforts implemented by local public health units through the SUPTRS 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

The North Dakota Department of Health and Human Services, the North Dakota Association of Counties and local social services leaders worked together with the support of Gov. 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 and continues with the passage of Senate Bill 2124 in 2019.

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 Human Service Zones' local offices in the counties (formerly known as county social service offices) have professionals on site who can help people who need these services and supports: Supplemental Nutrition Assistance Program (SNAP/Food Stamps), Temporary Assistance for Needy Families (TANF), heating assistance (LIHEAP), Medicaid, including children's health services; basic care assistance; child care assistance; in-home and community-based services and supports for elderly and disabled individuals; personal care assistance; child welfare (foster care, child protection services, child care licensing and related services); and referrals to other local resources and programs. The "Host County" in a Human Service Zone is responsible for the administrative functions (payroll, other HR functions, etc.) in the zone.

The transition to direct delivery of service through to 19 multi-county “zones”, which preserve all current service access locations became fully implemented by January 1, 2020.

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 (SUPTRS Priority Population)

The North Dakota Substance Use 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 SUPTRS, 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 previous SPF SIG and SPF-PFS awards and current SUPTRS prevention set aside, substance use 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 SUPTRS. Examples of services delivered at the community-level, supported by the SUPTRS, include funding to tribal prevention programs and local public health units. The Behavioral Health Division Policy Teams' Substance Use Prevention System continues to enhance the level to which SUPTRS 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 use prevention coordination and implementation of evidence-based programs, practices and strategies. This work is one of the strengths of the ND Substance Use Prevention System – longstanding collaboration with the tribes in the state.

A continuing need of the state's substance use prevention system is the development and maintenance of the community-level substance use prevention infrastructure, even with the enhancements in the past decade. 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 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.

Early Identification/Intervention

Early identification/intervention is a gap in the North Dakota behavioral health system. The Behavioral Health Division Policy Team certifies and licenses Driving Under the Influence education providers and programs. There are currently 50 certified providers of the DUI education course in the state and 37 licensed DUI seminar programs.

In the 2017 ND Legislative Session, House Bill 1040 passed which gave the Behavioral Health Division Policy Team 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 the 2021 ND Legislative Session, courts are required to sentence individuals charged with a second offense of a Minor in Possession to an evidence-based early intervention class provided by an individual certified by the Policy Team. The Policy Team has offered several free trainings to increase workforce and the availability of this evidence-based early intervention service. There are currently 23 certified Minor in Possession early intervention instructors in the State.

During the 2021 ND Legislative Session, resulted Senate Bill 2264 which will require individuals under the age of 21 who experience a second marijuana offense to complete an evidence based early intervention program. During the 2023 ND Legislative Session the Department received authority to develop administrative rules for the certification of marijuana education instructors.

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.

The Behavioral Health Division Policy Team continues to focus on the three overarching goals from the 2018 Behavioral Health Study: (1) support the full continuum of care; (2) increase community-based services; and (3) prevent criminal justice involvement. North Dakota was approved to implement a 1915i Medicaid State Plan amendment increasing access to home and community-based services for both youth and adults. Services are now available through Medicaid for qualifying individuals are care coordination, training & supports for unpaid caregivers, community transition services, benefits planning, non-medical transportation, respite, prevocational training, supported education, housing support services, family peer support, and peer support.

North Dakota has implemented a substance use disorder treatment voucher program since 2016. Funding for this was increased during the 2021 legislative session to continue supporting individuals ages 14 and older meeting income eligibility and needing substance use disorder treatment. Also, during the 2021 legislative session, the Behavioral Health Division Policy Team was authorized to procure grants to open residential addiction treatment programs for adults in the underserved areas of North Dakota where services are limited. As a result, a sixteen-bed adult residential treatment program will be opening in western North Dakota to serve individuals with a substance use disorder.

Pregnant Women and Women with Dependent Children in Need of Treatment

Pregnant individuals who use substances are provided priority outpatient addiction treatment across North Dakota at the eight regional human service centers. When an individual makes initial contact with one of the eight regional human service centers, they are asked if they are pregnant and if pregnancy is indicated, they are provided with priority status and treatment. North Dakota has been without a residential addiction treatment program for pregnant and parenting women in need of treatment since 2019. The Policy Team has posted three separate Request for Proposals for programs focused on best practice to treat pregnant women and women with dependent children in need of treatment. Unfortunately, these solicitations resulted in no proposals being received. During the 2023 legislative session, the Policy Team requested and was allocated one time funding to reimburse a program in the completion of construction needs to secure a location for a residential program for pregnant and parenting women. North Dakota anticipates utilizing the funding to open a residential addiction treatment program for pregnant and parenting women to have their children stay with them while they attend treatment services.

Medications for Opioid Use Disorder (MOUD)

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 four OTPs in North Dakota and today there are currently 958 individuals enrolled for services at these OTPs. On Average individual's travel 15 miles one way to an OTP for treatment services. The state's four OTPs are located in 4 cities that contain 39 percent of the state's population, with the other 61 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 MOUD.

The Policy Team continues efforts to partner with community stakeholders with the goal of increasing access to MOUD. The Behavioral Health Division Policy Team was awarded the State Opioid Response (SOR) grant in October 2020. The SUPTRS will continue to support efforts not covered by the SOR grant.

Recovery Support Services

As one of its foremost priorities, the Behavioral Health Division Policy Team promotes a recovery-oriented service system. The Policy Team 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 Policy Team is also

working closely with the First Lady's office to host the seventh annual Recovery Reinvented event scheduled for October 2023.

The Behavioral Health Division Policy Team provides funding to support a consumer-run advocacy program to more effectively respond to the needs of children, youth, and young adults with serious emotional disturbances (SED) and their families by providing information, referrals, and support, increase the quality and access to mental health services, assist consumers to ensure they are the catalyst for transforming the mental health system, and increase positive messaging while reducing the stigma associated with mental health diagnosis. The Policy Team has provided funding to Mental Health America of North Dakota to administer the North Dakota Consumer Family Network (CFN) which 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.

Eight Recovery Centers (one in each region throughout the state) employ peer staff and are contracted through the Community Behavioral Health Clinics or run by the local clinics. 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. They have connected with peer supports within each Community Behavioral Health Clinic to expand membership and offer collaborative opportunities.

Peer Support: The North Dakota Behavioral Health System study recommendation,7.6 included establishing training/credentialing program for peer services and recommendation, 7.8 included supporting a robust peer workforce through training, professional development, and competitive wages.

Since 2018 the Behavioral Health Division Policy Team in conjunction with Appalachian Consulting has facilitated 39 peer support trainings, training over 900 individuals as Peer Support Specialists. The Division offers ongoing continuing education opportunities for peers, peer supervisors and behavioral health providers that are working towards integrating peer support services.

The Division offers peer support endorsements, endorsements are a continuing education training that is available to peer support specialists to help promote the professional development of a peer support specialist, current endorsements include criminal justice setting endorsements and brain injury endorsements. The Division will be adding peer support endorsements to enhance training for peers related to New American, Foreign Born Immigrants and Refugees and American Indians.

The Division hosts ongoing peer support connection meetings for peers, these connection meetings offer an opportunity for peers to connect and to engage in group learning activities. These ongoing connection meetings are also hosted for peer support supervisors.

During the 2019 legislative session several bills were passed to expand peer support services. The Medicaid Division added peer support as a covered service for individuals with a qualifying behavioral health condition. Senate Bill 2012 passed, creating a new section of century code to provide funding to implement the expansion of Free Through Recovery separate from the criminal justice system, and the Behavioral Health Division was given authority to write administrative rules for the certification of Peer Support Specialists.

The 1915i State Medicaid Amendment Plan includes reimbursement for Peer Support and Family Peer Support. There are currently 26 Peer Support Enrolled Group Providers, 74 Individual Enrolled Peer Supports, 13 Family Peer Support Enrolled Group Providers and 26 Enrolled Family Peer Support Specialists.

On July 1, 2020 the Behavioral Health Division Policy Team began certifying Peer Support Specialists. Since this time the division has certified 203 Peer Support Specialists. Certification aims to standardize training and improve and regulate reimbursement while meeting the growing demand for behavioral health support services in North Dakota.

On February 1, 2021 the Behavioral Health Division launched Community Connect. Community Connect was the expansion of Free Through Recovery beyond the criminal justice system. Community Connect is designed to assist individuals with meeting their needs and goals through the provision of peer support and care coordination. Community Connect currently is serving approximately 2471 participants and Free Through Recovery currently serves approximately 1510 program participants across North Dakota.

The North Dakota Substance Use Disorder (SUD) voucher continues to support funding for recovery support services, which include peer support as a reimbursable service.

Telephone Recovery Support: The Behavioral Health Division contracts with a vendor to provide telephone recovery support for individuals to call or text a peer support specialist twenty-four hours a day, seven days a week. The service is free, confidential, and individuals may remain anonymous. The program is currently being extended to allow for individuals to sign up and request contact by a peer support specialist on a regular basis as an additional tool to their recovery.

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 Integrated Team-based Treatment Care in each regional Community Behavioral Health Clinic. The core services offered through the Integrated Team-based Treatment teams, either directly or through public/private provider partnership or contracting include: outpatient services, SUD services, crisis services, case management, medication services, peer support, psychiatric and psychological services,

psychosocial rehabilitation delivered through integrated specialty care models and evidence-based models. There are also an array of clinical services including individual, group and family therapy as well as intensive case management. This same system also provides services for children diagnosed with a serious emotional disturbance. The Youth and Family Team is an Integrated Team that includes the following members: Team Lead, mental health counselor, addiction counselor, psychiatric provider (when necessary), psychologist (when possible), nurse (consulting with teams), case manager, skills trainer and skills integrator. Service planning is based on 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. There also exists within the Youth and Family Services delivery system, one evidence-based team, Multi-Systemic Therapy Psychiatric (MSTp), which targets youth and their families who are at high risk for out of home placement due to their psychiatric condition. The array of services provided through the Children and Family Team within the children's mental health system of care include skills training and integration, care coordination, case aide, flexible funding, crisis services, substance use/co-occurring services along with all the other services listed above.

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 be managed with additional community supports.

All individuals presenting for services at the regional Community Behavioral Health Clinics 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 as well as IV-E funded evidence-based care models.

The Department of Health and Human Services houses several divisions which play a key role in the children's system of care, including the Behavioral Health Division, Children and Family Services Division, and Medical Services Division (the state Medicaid agency). The Behavioral Health Division Policy Team 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 Integrated Children and Family Team 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.
- Skills Training: Skills trainers take the psychosocial rehabilitation recommendations from the treatment plan and teach skills relative to the youth's functional deficits until minimal mastery has been met (i.e. developing communication, social activities).
- Skills Integration: Skills integrator assists the youth/family in generalizing the skill from the treatment plan (i.e. model and prompt the use of skills in a generalized setting).
- Substance Use/ Co-occurring Services: When a child diagnosed with a severe emotional disturbance requires substance use treatment, a substance use provider becomes involved in the team process.
- 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.
- Individual Therapy: This service provides a child diagnosed with a severe emotional disturbance the opportunity to heal throughout the therapeutic process. Many therapists are trained in and utilize evidence-based care such as CBT, TF-CBT, DBT, and PCIT.
- Psychiatric Care: This service includes assessment and medication management services by a Licensed Psychiatric Provider.

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.
- 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.
- Other Supportive Services: Acute, Psychological Services, and psychiatric services are available through the regional human service centers.

Several legislative bills passed during the state's 2019 legislative session which supports the continued development of a system of care. One of these bills required 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 County Social Services have transferred to Human Service Zones, aligning with the state priorities of person-centered planning and access to community services.

North Dakota applied for the System of Care grant in April 2019 and was awarded. Unfortunately, North Dakota had to turn back the System of Care (SOC) grant award as we were unable to expand services and meet required deadlines and deliverables during the COVID-19 pandemic. North Dakota applied in early 2021 and did not receive the grant. The State applied again in 2022 and was awarded the grant. The purpose of the grant is to improve the mental health outcomes for children and youth, birth through age 21, with serious emotional disturbance (SED), and their families. This grant will support the implementation, expansion, and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative or CMHI). The Policy Team began implementation in two key catchment areas in the Lake Region and West Central portions of the state. A baseline study of gap areas has been completed, and a strategic plan outlined.

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. North Dakota County Social Services have transferred to Human Service Zones, aligning with the state priorities of person-centered planning and access to community services.

Homelessness continues to be an issue in North Dakota. The state lacks 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 permanent supportive housing are in very short supply. Housing subsidy funds are limited and waiting periods of six months to more than one 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. 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.

Four regionally based coordinators are funded under the Projects for Assistance in Transition from Homelessness (PATH) Grant. The grant aids individuals who are homeless, at risk of homelessness and diagnosed with a Serious Mental Illness (SMI) and/or SMI and co-occurring substance use disorder (SUD). Persons who are homeless and seriously mentally ill are provided outreach services and referrals for treatment services, housing services, health, education, and other available community-based programs. Coordinators are also trained in the SSI/SSDI

Outreach, Access and Recovery (SOAR) model, which is designed to increase access to disability income benefits for individuals who are experiencing or at risk of homelessness. Coordinators assist individuals with social security applications, utilizing the SOAR model.

HHS administers programs and services that help older adults with services 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. Home and community-based services (HCBS) are offered in North Dakota through several programs administered and funded by HHS. Priority for services is given to older individuals residing in rural areas; with greatest economic need (particular attention to low-income minority individuals and individuals residing in rural areas); with greatest social need (particular attention to low-income minority individuals and individuals residing in rural areas); with severe disabilities; with limited English proficiency; with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and caretakers of such individuals); and at risk for institutional placement.

SPECIAL TOPICS/POPULATIONS

Pregnant Women and Women with Dependent Children/ Intravenous Drug Users / Tuberculosis Services (SABG Priority Population)

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

The regional Community Behavioral Health Clinics 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 clinics offer treatment mall model of services and individuals can 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. Clinic regional 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. Regional Community Behavioral Health Clinics, upon reaching 90% of its capacity to admit pregnant women, shall provide written notification of that fact to Behavioral Health Division Policy Team within seven days. If the clinic 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, the clinic 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 Policy Team 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 Policy Team 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.

INTRAVENOUS DRUGS

Regional Community Behavioral Health Clinics have adopted open access assessment services and each individual seeking an assessment is triaged and screened for injection drug use. If an individual does identify as 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 clinics 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. Clinic regional directors and clinical directors sign a memorandum of understandings to stipulate priority population requirements are met.

TUBERCULOSIS

The regional Community Behavioral Health Clinics 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 clinics have nurses available with the ability to conduct a TB test and provide for the follow up appointments. Other clinics 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 Policy Team 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), Problem Gambling Advisory Council, Mental Health and Substance Abuse Planning Council and Olmstead Commission.

The Behavioral Health Division Policy Team allocates approximately 20% of the SUPTRS 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 use 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 Use Prevention System – longstanding collaboration with the tribes in the state.

The Policy Team has begun to manage contracts for treatment/recovery services with the Native American reservations in the state, which were previously managed through the Community Behavioral Health Clinics. Doing so respects the government-to-government relationship and allows the tribe to identify through data/assessment their highest priority needs. The Policy Division is continuing to further develop partnerships between prevention and treatment efforts funded through the SUPTRS 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.

LGBTQ2S+ POPULATIONS

The Behavioral Health Division Policy Team partners with the Community Engagement Office within the Department of Health and Human Services to address the needs of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Two-Spirit Community (LGBTQ2S+). An Advisory Board was created and is known as "BeYOU Health Board" (BYHB) to provide recommendations and ensure LGBTQ2S+perspectives are incorporated in planning and decisions for the state. The BeYOU Health Board is led by representation of the LGBTQ2S+ community; conducts consistent, structured meetings with an emphasis on planning, executing, and focusing on meaningful projects and topics to improve the well-being and eliminate health inequalities faced by the LGBTQ2S+ community. Through consultation between the Division and the Community Engagement Unit, we are working to identify populations currently underserved by behavioral health programs and initiatives, using this information to create strategies for promoting health equity for those underserved populations. The first objective is to identify populations that are potentially underserved, and to identify barriers to serving identify populations and strategies for ensuring greater health equity.

During 2023 the North Dakota Department of Health and Human Services, held listening sessions across North Dakota with behavioral health leaders in American Indian, New American/foreign-born/immigrant and refugee communities to understand and identify community specific strength, needs, priorities, and to identify opportunities to partner with

Health and Human Services. These listening sessions were compiled into a report which provided a summary of strengths, needs, priorities and opportunities for partnership and are utilized to guide next objectives and action steps.

PERSON-CENTERED PRACTICES FOR PEOPLE WITH ALL ABILITIES

The North Dakota Department of Health and Human Services applied and was awarded technical assistance through the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) to implement a statewide person-centered initiative to ensure appropriate person-centered principles are utilized in all policies, procedures, and practices for individuals of all abilities.

All North Dakota Department of Health and Human Services divisions are undergoing a person-centered assessment process to establish baselines, create actions plans, and measure progress towards building a more person-centered system. Initiatives are ensuring there is community inclusion, so people have full access to an array of individualized services in their community and are treated with dignity and respect. The initiative is also ensuring people are making their own choices about services and supports as well as decisions regarding their own health, well-being, and life goals while their desires are heard, honored, valued, and reflected in the services received.

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 Health and Human Services in partnership with local agencies and governments deliver coordinated and comprehensive services to people in the program. Using a 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.

Free Through Recovery continues to be a successful collaboration between ND DOCR and the Behavioral Health Division Policy Team. As of July 2023, there were 45 different agencies providing care coordination and peer support services to participants, which has grown from 11 at the program's start. Services are presently offered statewide, including participants residing in the most rural areas of North Dakota. Since February 1, 2018, there have been 5582 individual participants. The 2021 Senate bill 2015 expanded funding for Free Through Recovery.

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.

The 2018 HSRI study identified a need to expand access to services for Veterans in North Dakota. The eight regional community behavioral health clinics expanded their payer sources to include TriCare to assist in meeting this need.

North Dakota has been actively participating in the VA/SAMHSA Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families. The ND Behavioral Health Division has had multiple staff providing support for all three Governor's Challenge priority areas: Identifying and Screening, Promoting Connectedness and Care Transitions, Lethal Means Safety and Safety Planning. The ND Behavioral Health Division has also supported the Governor's Challenge by assisting in developing and growing Military Veteran peer support services in North Dakota; and linking ND Cares and the VA to North Dakota's Mental Health Registry, which provides contact information for nearly 200 Mental Health agencies across the state.

[i] North Dakota Youth Risk Behavior Survey, 2021

[ii] Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK587174/#:~:text=Nearly%2020%25%20of%20children%20and,in%20the%20decade%20before%202019.

[iii] Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). National Survey on Drug Use and Health.

[iv] North Dakota Department of Health Division of Vital Records. *North Dakota Fast Facts 2021*.
Retrieved from: https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Vital/ff2021.pdf

[v] North Dakota Youth Risk Behavior Survey, 2021

[vi] ND Cares. (n.d.). *North Dakota Military Data Book, 2020*.
Retrieved from: https://www.ndcares.nd.gov/sites/www/files/documents/Publications/DataBook%202020%20for%20Website%20-%20New.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 systems, 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 behavioral health system, including for 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. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

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

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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 use 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 and 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 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'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 SUPTRS primary prevention funds should be allocated: (1) Underage Alcohol Use; and (2) Adult Binge Drinking.

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

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 identified needs and gaps in community awareness and education, prevention and early intervention, outpatient and community-based mental health and substance use disorder treatment services, crisis and inpatient services, and behavioral health/criminal justice system initiatives. The HSRI report provided thirteen major recommendations for improvement based on 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 Health and Human Services and the Governor's office, North Dakota created 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 Strategic Goals to support focused systems change efforts.

To ensure North Dakota is addressing the identified needs and gaps, a team of stakeholders including members of the Behavioral Health Council, service users, families, advocates, providers, administrators, and others were assigned to each of the thirteen Strategic Goals. Each team is responsible to complete tasks and objectives within each goal to implement the recommendations to enhance the comprehensiveness, integration, cost-effectiveness, and recovery orientation of the behavioral health

system. Progress on each goal is provided quarterly to the Behavioral Health Planning Council and is also made available on a public website for system monitoring, continued planning, and improvement recommendations.

Additionally, during the 2021-2023 legislative interim, the Acute Psychiatric Committee commissioned a study on a long-term plan for acute psychiatric hospitalization. The "Acute Psychiatric and Residential Care" final report was published April 2022. The report identified the following recommendations:

- Build a modern and efficient state hospital.
- Develop and fund short term/emergency acute psychiatric beds in critical access hospitals.
- Clarify Administrative Code 33-07-01 that emergency stabilization of behavioral health can be provided in all emergency departments in all hospitals.
- Codify and update the purpose of the state hospital and human service centers.
- Create regulations defining behavioral health levels of care.
- Improve contracts with hospitals and providers to include the language of
    - no eject/no reject.
    - requiring the use of Medicaid funding when eligible.
    - expecting data when using public funding.
- Clarify and maximize the use of telehealth to bolster psychiatric services in all areas.
- Dedicate an implementation team to lead this project to completion.

The North Dakota Department of Health and 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 Health and Human Services' Behavioral Health Division also continues to assess and address needs and gaps within the SUPTRS 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.

UNMET SERVICE NEEDS AND CRITICAL GAPS IN THE CURRENT SYSTEM FOR UNDERSERVED COMMUNITIES, AS DEFINED UNDER EO 13985

The mission of the North Dakota Health and Human Services (HHS) Community Engagement (CE) Unit is to understand and reduce health disparities among all North Dakotans. The Behavioral Health Division collaborates with the CE Unit. The primary goal is to work alongside North Dakota communities in addressing health-related needs to reduce disease rates by providing opportunities for interventions and improving access to health care. This will ensure that all North Dakotans have the ability to reach their optimal health. The CE Unit Strategic Plan addresses the specific concerns expressed by underserved or marginalized North Dakotan populations. The CE Unit also recognizes that several individuals experience intersectionality, or the intersection of multiple underserved classes like homelessness and living with a disability.

The Strategic Plan serves as an ongoing, actionable guide, highlighting the HHS' commitment to achieving health equity for North Dakota residents of all backgrounds. Collaborations with the HHS Health Statistics and Performance section are paramount when using new or existing data to detect gaps and inequities. HHS continues to use performance management and quality improvement to ensure data

measures are meeting targets. Therefore, the CE Unit's first goal is to improve the overall data collection of various population groups. The Strategic Plan has the following goals, which include objectives and action steps.

- **Goal 1**-By December 31, 2023, HHS will improve data collection and tracking processes for health equity initiatives.
- ***Completed* -Goal 2**-By June 2020, HHS will have established a New American Foreign-Born Immigrant (NFI) Advisory Board
- ***Completed*-Goal 3**-By December 1, 2020, HHS will co-host a national indigenous Telehealth Conference
- ***Completed*-Goal 4-**By January 2021, HHS will launch a national Indigenous Maternal Child Health Learning Collaborative to strengthen the relationship between the Community Engagement Unit and the Indigenous Maternal Child Health Programming.
- ***Completed*-Goal 5**-By January 31, 2021, HHS will have established a LGBTQ2S+ Advisory Board focusing on the health needs of LGBTQ2S+.
- ***Completed*-Goal 6**-By February 2021, HHS will pilot the first participatory grant making session to position the Community Engagement Unit as leader in equitable funding strategies at HHS.
- ***Completed*-Goal 7-**By March 2021, HHS will administer a survey tool across Team ND to assess equity comfort and knowledge.
- ***Completed*-Goal 8**-By March 31, 2021, HHS will have established a youth advisory board, focusing on the health needs of ND youth.
- ***Completed*-Goal 9**-By December 2021, Inclusion, Diversity Equity, Access and Action (IDEAA) Project will launch.
- **Goal 10**-By December 31, 2023, the Health Equity Training Initiative series will be established.
- ***Completed* Goal 11**-By July 2021, HHS will have established or participate in regular New American, Foreign Born, Immigrant (NFI) Stakeholder meeting in at least six communities.
- ***Completed*-Goal 12**-By March 31, 2022, HHS, NDSU and the Indian Affairs Commission will have established a Tribal Health Board, focusing on the health needs of ND tribes.
- ***Completed*-Goal 13**-By December 31, 2022, HHS will have established a more extensive Community Engagement Unit to work collaboratively across HHS and other state agencies.
- ***Completed*-Goal 14**-By December 31, 2022, HHS will have begun engineering greater diversity and inclusion in their work and workforce.
- ***Completed*-Goal 15**-By December 31, 2022, HHS will have made concerted efforts to update its Community Engagement website an establish a recurring newsletter.

In addition to the CE Unit Strategic Plan there is also a North Dakota Health Equity Committee. The ND Health Equity Committee is a statewide leadership committee to address health inequities that include social, economic, and environmental disparities. Members are dedicated to increasing access to quality health care concerning affordability, availability, accessibility, accommodation, and acceptability.

The committee will promote cultural strengthening and safety while implementing strategies founded on collaboration, data, advocacy, policy, and resource alignment for all North Dakotans. Members will serve to educate, inform, and advise the North Dakota Health and Human Services agency, ensuring that social determinants of health and matters related to health equity are adequately addressed.

The Community Engagement Unit and the Behavioral Health Policy Division partner to address goals related to health equity.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention and Early Intervention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

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: 41.08%. Ages 26+: 25.99% (2021 NSDUH)

First-year target/outcome measurement: Increase statewide media efforts with the Speak Volumes media campaign.

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

Data Source:

Behavioral Health Division media evaluation for the number of impressions. The National Survey on Drug Use and Health (NSDUH) will be utilized to monitor adult consumption rates.

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

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

Baseline Measurement: 23.7 % of ND high school students reported alcohol use in the past 30 days (2021 YRBS)

First-year target/outcome measurement: Implement Kognito education module relating to substance use prevention within grades 6 -12.

Second-year target/outcome measurement: A 2% decrease in past 30 day alcohol use 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:

Quantitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Increasing availability of early intervention services for individuals with a marijuana related offense

Baseline Measurement: Increase the number of instructors for marijuana education

First-year target/outcome measurement: Develop a certification of evidence based marijuana education providers

Second-year target/outcome measurement: Have at least 1 certified provider in each of the 8 regions

Data Source:

ND Administrative Code, BHD

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Suicide Fatality Review Commission

Baseline Measurement: No statewide suicide fatality review commission

First-year target/outcome measurement: Establish the membership and processes and procedures for the statewide suicide fatality review commission

Second-year target/outcome measurement: Implement the processes and procedures and develop recommendations

Data Source:

Behavioral Health Division, Suicide Fatality Review Commission

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Community-Based Services

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

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

Goal of the priority area:

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

Strategies to attain the goal:

Increase services through education systems, CCBHC, crisis and system of care for children development.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand behavioral health services and supports in K-12 schools

Baseline Measurement: Limited behavioral health services and supports integrated with K-12 schools.

First-year target/outcome measurement: Increase number of schools utilizing funding programs with the Behavioral Health Division.

Second-year target/outcome measurement: Increase number of students served.

Data Source:

Behavioral Health Division, Contract Management and reports

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Enhance Statewide Crisis Services

Baseline Measurement: Mobile crisis services are limited to 45 mile radius of regional community clinics. Limited target efforts for specific popoulations.

First-year target/outcome measurement: Build capacity of behavioral health providers to respond to crises by providing training.

Second-year target/outcome measurement: Partner with rural law enforcement to enhance their ability to effectively respond to adult and youth behavioral health crises.

Data Source:

Behavioral Health Division, training documentation, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

none

Indicator #: 3

Indicator: Expand awareness of and access to Early Episode Psychosis Programming

Baseline Measurement: Increase awareness of First Episode Psychosis programs in the state and gather data of need in underserved areas.

First-year target/outcome measurement: Contract to provide outreach and education of First Episode Psychosis programs in the state

Second-year target/outcome measurement: Complete full fidelity reivew to ensure best practice of Coordinated Specialty Care model.

Data Source:

Program monthly reports, fidelity review and additional data as requested.

Description of Data:

Self-report by organizations: qualitative and quantitative

Data issues/caveats that affect outcome measures:

none

Indicator #: 4

Indicator: Build capacity to certify Certified Community Behavioral Health Clinics (CCBHC)

Baseline Measurement: No CCBHC clinics in North Dakota

First-year target/outcome measurement: Develop a CCBHC certification process and guidelines

Second-year target/outcome measurement: Certify one CCBHC

Data Source:

Behavioral Health Division

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Enhance system of care for children with a serious emotional disturbance

Baseline Measurement: Limited infrastucture and service providers for children's behahvioral health services.

First-year target/outcome measurement: Enter into contract with behavioral health provider to provide day treatment

Second-year target/outcome measurement: Enhance parent and youth peer support services

Data Source:

NOMS and Human Service Center data

Description of Data:

Qualitative and Quantitative

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Person-Centered Practice

Priority Type: SUP, SUT, MHS, ESMI, BHCS

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

Goal of the priority area:

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

Strategies to attain the goal:

Implement culturally-relevant services and supports for specific populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand awareness of American Indian culture among behavioral health providers

Baseline Measurement: Limited understanding of unique behavioral health needs of the American Indian population.

First-year target/outcome measurement: Facilitate listening sessions across North Dakota with tribal entities to identify strengths, needs, and opportunities.

Second-year target/outcome measurement: Develop and implement a training for behavioral health service providers to increase knowledge of American Indian culture

Data Source:

Behavioral Health Division, contract management and meeting and training records

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Expand awareness of behavioral health in aging services providers

Baseline Measurement: Adult and aging community providers have limited behavioral health needs of individuals who are aging and/or struggling with dementia including Alzheimer's Disease.

First-year target/outcome measurement: Identify and develop training specific for behavioral health needs of the aging population.

Second-year target/outcome measurement: Develop and implement a training plan for providers

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Expand access to behavioral health services for high risk professionals (i.e. Veterans, Law Enforcement, First Responders)

Baseline Measurement: Increase the number of behavioral health providers with population specific expertise in serving high risk populations.

First-year target/outcome measurement: Train providers in Critical Incident Stress Managment Training (CISM) and Accelerated Resollution Therapy (ART) best practices.

Second-year target/outcome measurement: Increase number of providers serving high risk populations within local communities.

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Expand culturally-relevant mental health services to North Dakota tribal areas and New American, foreign born immigrant (NFI) and refugee populations.

Baseline Measurement: Limited cultural knowledge in serving NFI / refugee community among behavioral health providers

First-year target/outcome measurement: Identify and develop training specific for behavioral health needs of the NFI / refugee

populations.

Second-year target/outcome measurement: Develop and implement a training plan for providers

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Increase Access to Targeted Services

Priority Type: SUT, SUR, BHCS

Population(s): BHCS, PWWDC, PWID, TB

Goal of the priority area:

Ensure quality services are available for individuals with a substance use disorder.

Strategies to attain the goal:

Implement efforts to increase evidence-based practices for women and women with dependent children, expand withdrawal management and awareness of residential treatment services.

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: No current residential treatment program specific for pregnant women and women with dependent children.

First-year target/outcome measurement: Conduct market research to potential vendors to identify barriers regarding providing residential addiction treatment programming for pregnant women and women with dependent children. Re-issue a request for proposals and implement a residential program for prengant women and women with dependent children.

Second-year target/outcome measurement: Serve at least 25 pregnant women and women with dependent children in a residential program.

Data Source:

Behaivoral Health Division, Contract Management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Withdrawal management

Baseline Measurement: Limited withdrawal management service systems in communities in the state.

First-year target/outcome measurement: Identify communities needing assistance with development of withdrawal management

strategic plans and withdrawal management services.

Second-year target/outcome measurement: Provide communities with training & technical assistance in developing withdrawal management strategic plans and increase withdrawal management services.

Data Source:

Behavioral Health Division, contract management, training & technical assistance documentation

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Expand awareness of and access to residential treatment services

Baseline Measurement: Currently limited ability for individuals and providers to know availability of treatment services across the state.

First-year target/outcome measurement: Idenfity a process for implementing a bed-management system in North Dakota

Second-year target/outcome measurement: Implement a bed-management system

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Workforce

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

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

Goal of the priority area:

Ensure a competent and trained behavioral health workforce to meet the behavioral health needs of North Dakotans

Strategies to attain the goal:

Implement efforts to increase substance use primary prevention workforce, peer support service and developing a single entity responsible for supporting behavioral health workforce implementation.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the infrastructure of the Substance Use Primary Prevention workforce in the State

Baseline Measurement: Number of individuals who complete a substance use prevention training and individuals who participate in a substance use prevention internship

First-year target/outcome measurement: Collaborate with a vendor to develop community level capacity assessments.

Second-year target/outcome measurement: Implementation of capacity building activities among new and existing community prevention workforce.

Data Source:

Behavioral Health Division, Contract Management

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Expand peer support services

Baseline Measurement: There is no specific training available in North Dakota for family peer support and culturally relevant peer support services

First-year target/outcome measurement: Determine specific training for family peer support and culturally relavant peer support

Second-year target/outcome measurement: Deliver peer support training tracks specific to culturally relavant peer support services and family peer support services.

Data Source:

Behavioral Health Division, Contract Management

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Designate a single entity responsible for supporting behavioral health workforce implementation

Baseline Measurement: No current single entity responsible for supporting behavioral health workforce implementation and current capacity is not sufficient to address needs.

First-year target/outcome measurement: Develop specifications for a single entity responsible for supporting behavioral health workforce implementation

Second-year target/outcome measurement: Develop and implement strategic plan to engage in targeted efforts to recruit and retain behavioral health workforce

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

None

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$9,912,908.00		$0.00	$3,250,000.00	$2,109,088.00	$35,292,109.00	$3,189,241.00		$2,953,557.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$1,416,661.00				$600,000.00		$1,000,000.00			
b. Recovery Support Services	$473,131.00				$1,509,088.00				$125,000.00	
c. All Other	$8,023,116.00			$3,250,000.00		$35,292,109.00	$2,189,241.00		$2,828,557.00	
2. Primary Prevention[d]	$3,332,021.00		$0.00	$10,500,000.00	$100,000.00	$0.00	$0.00		$1,074,336.00	$0.00
a. Substance Use Primary Prevention	$3,332,021.00			$10,500,000.00	$100,000.00				$1,074,336.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$320,323.00		$84,093.00		$2,379,084.00					
12. Total	**$13,565,252.00**	**$0.00**	**$84,093.00**	**$13,750,000.00**	**$4,588,172.00**	**$35,292,109.00**	**$3,189,241.00**	**$0.00**	**$4,027,893.00**	**$5,288,864.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]					$100,000.00						
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$343,310.00						$147,000.00		$250,000.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital					$4,418,142.00						
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$2,543,907.00	$21,126,540.00	$20,352,599.00	$138,213,134.00		$14,837,141.00	$995,000.00		$2,103,813.00	
10. Crisis Services (5 percent set-aside)[f]		$171,655.00					$1,867,500.00	$75,000.00		$125,000.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$21,079.00	$84,093.00		$2,076,209.00						
12. Total	**$0.00**	**$3,079,951.00**	**$21,210,633.00**	**$20,352,599.00**	**$144,807,485.00**	**$0.00**	**$16,704,641.00**	**$1,217,000.00**	**$0.00**	**$2,478,813.00**	**$124,521.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2,161	40
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	45,306	4,461
4. Persons who inject drugs	0	1,548
5. Persons experiencing homelessness	0	1,316

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

Whether or not a person has dependent children is not a datapoint that is recorded in the TEDS dataset defined by SAMHSA; therefore, it is not possible to determine the number of women with dependent children from TEDS data. BHD's electronic health record (EHR) also does not collect number of dependent children in a way that could be aggregated across all clients reliably at this time. Aggregate Number Estimated in Need totals were derived using a combination of state and national NSDUH data, CDC birth rates, and other data and should be considered rough estimates only given that data sources are not meant to be combined and there does not appear to be published SAMHSA data that would clearly or accurately estimate these categories. Total need for the populations of Women with Dependent Children, Persons who Inject Drugs, and Persons Experiencing Homelessness do not have reliable data sources at this time. Data from State of ND programs cannot be applied to the general population.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$5,044,928.00	$2,828,557.00	$661,108.00
2 . Substance Use Primary Prevention	$1,882,574.00	$1,074,336.00	$661,108.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$226,280.00	$125,000.00	
6 . Administration (SSA Level Only)	$376,514.00		
7. Total	**$7,530,296.00**	**$4,027,893.00**	**$1,322,216.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report 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 SUPTRS BG allotments to establish one or more projects to provide early intervention services 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$1,099,544	$322,301	$33,055
	Total	**$1,099,544**	**$322,301**	**$33,055**
2. Education	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$54,977	$53,717	$33,055
	Total	**$54,977**	**$53,717**	**$33,055**
3. Alternatives	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$54,977	$53,717	$33,055
	Total	**$54,977**	**$53,717**	**$33,055**
4. Problem Identification and Referral	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$73,303	$107,433	$99,167
	Total	**$73,303**	**$107,433**	**$99,167**
	Universal	$0	$0	$0

5. Community-Based Processes	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$183,257	$268,584	$231,388
	Total	**$183,257**	**$268,584**	**$231,388**
6. Environmental	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$366,516	$268,584	$231,388
	Total	**$366,516**	**$268,584**	**$231,388**
7. Section 1926 (Synar)-Tobacco	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$50,000	$0	$0
	Total	**$50,000**	**$0**	**$0**
8. Other	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,882,574**	**$1,074,336**	**$661,108**
Total SUPTRS BG Award[3]		**$7,530,296**	**$4,027,893**	**$1,322,216**
Planned Primary Prevention Percentage		**25.00 %**	**26.67 %**	**50.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct			
Universal Indirect			
Selected			
Indicated			
Column Total	**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]	**$7,530,296**	**$4,027,893**	**$1,322,216**
Planned Primary Prevention Percentage	**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☐	☐	☐
Marijuana	☐	☐	☐
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☐	☐	☐
Military Families	☑	☑	☑
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☑	☑	☑
African American	☐	☐	☐
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$80,000.00	$0.00	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00	$0.00	$0.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00	$0.00	$0.00
8. Total	**$80,000.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

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). Led by the Behavioral Health Planning Council and endorsed by the Department of Health and Human Services and the Governor's office, North Dakota has created 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 to support focused systems change efforts. Working with stakeholders – including service users and families, advocates, providers, administrators, and other North Dakotans – HSRI is continuing to assist the state set its course for ongoing system monitoring, planning, and improvements in the long term.

Through this process, the ND Department's Behavioral Health Division Policy Team has developed several programs to improve access to care for mental disorders, substance use disorders and co-occurring disorders. The Policy Team developed the Free Through Recovery and Community Connect programs to provide additional access to care coordination and recovery support services for individuals with behavioral health conditions.

The Policy Team assesses payment sources to improve access to care. North Dakota recently implemented a Medicaid 1915(i) State Plan Amendment which increases availability and access to services for individuals of all ages with serious emotional disturbances, serious mental illness, and/or substance use disorders. North Dakota is a Medicaid Expansion state which also assists improve access to behavioral healthcare. The Policy Team also administers a Substance Use Disorder Voucher program, which provides payment for addiction treatment for individuals without insurance.

The Policy Team implemented a Recovery Housing Assistance Program, a state-funded option for individuals wanting to initiate and sustain recovery efforts in a safe, stable living environment. Up to 12 weeks of an eligible individual's living expenses will be paid directly to a Recovery Housing Assistance Program provider. This program improved access to care for individuals with substance use disorders.

The Policy Team was awarded a four-year Substance Abuse and Mental Health Services (SAMHSA) System of Care (SOC) Expansion and Sustainability Grant to enhance mental health outcomes for children and youth. North Dakota will receive $3 million per year starting September 30, 2022 through September 30, 2026. The SOC grant is designed to enhance mental health outcomes for children and youth, birth through age 21. Through this grant, the Policy Team is building and expanding community-based behavioral health services and supports for children and youth with Serious Emotional Disturbances (SED) and their families.

A Mental Health Program Directory was launched by the Policy Team October 3, 2022 to assist North Dakotans in locating and accessing mental health services in the state. The new directory allows users to search for mental health programs by location, population served, type of mental health specialty and treatment and interventions options. Individuals can also search for programs that offer telehealth services. ?

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

North Dakota Medical Services Division within the Department of Health & Human Services submitted a State Plan Amendment (SPA) to change requirements aligning to Mental Health Parity and essential health benefits. The SPA was approved by the Department of Health & Human Services Centers for Medicare & Medicaid Services on March 24, 2022 with an effective date of January 1, 2022. The changes included discontinuing prior authorizations, referral requirements, dollar limits such aggregate lifetime dollar limits or annual dollar limits, and ending any quantitative treatment limitations such as limits on the frequency of treatment, number of visits, etc. limits on frequency of treatment, number of visits, days of coverage, etc. for behavioral health services. Currently Medicaid also provides for comprehensive and preventative health care services for children under age 21 including behavioral health. Any child recommended for a service, even if the service is not listed as a covered service will be allowable under the Early and Periodic Screening, Diagnostic and Treatment benefit.

Furthermore, the Legislative Health Care Committee will begin studying prior authorization in health benefits plans during the 2023-2025 interim. The study must include consideration of the extent to which prior authorization is used by health insurance companies in North Dakota including the types of services and procedures for which prior authorization is required; the impact of prior authorization on patient care, including the effects on patient health outcomes, patient satisfaction, health care costs, and patient access to care; the impact of prior authorization on health care providers and insurers, including the administrative burden, time, and cost associated with obtaining prior authorization, and the appropriate utilization of health care services. The study may include consideration of issues related to reasons time, retroactive denial, data reporting, clinical criteria and medical necessity, transparency, fraud and abuse, reviewer qualifications, exceptions, and an appeal process. The Department of Health & Human Services will collaborate with the committee to ensure an understanding of the essential aspects of Parity.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

The Policy Team supports integrated behavioral health and primary healthcare through multiple avenues. The North Dakota Department of Health and Human Services' Public Health Division has been implementing a Pediatric Mental Healthcare Access Grant and the Policy Team recently applied for the administration of the upcoming grant year to be transferred to the Policy Team. This grant program brings behavioral health consultation, training, and support to pediatric primary care and other providers so that children's mental health needs are met.

The state's public behavioral health system is moving to develop Certified Community Behavioral Health Clinics (CCBHC). Through the CCBHC development, integration between behavioral health and primary care services will be enhanced as identified in CCBHC required activities.

The Policy Team continues regular collaboration with healthcare providers throughout the state to identify opportunities for integration.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

The Policy Team has developed programs to ensure care coordination is available to populations with behavioral health conditions. Examples of these programs include Free Through Recovery and Community Connect which are funded by the state legislative assembly with a focus on individuals who are eighteen years of age or older and have a mental health or substance use disorder diagnosis impacting functionality in multiple domains such as employment, housing, physical health, parenting, and community connections. Care coordination is also available and funded through the state's Medicaid 1915(i) State Plan Amendment serving adults and children with serious behavioral health conditions. Within the eight regional community behavioral health clinics, citizens can receive screening for services through an open access model. Individuals are initially screened for needs and referred to community-based services, or to see a clinician for a full diagnostic assessment. The community behavioral health clinics prioritize service for individuals with SMI/SED or co-occurring disorders. There are several evidence-based models of care utilized for both youth and adults. For youth with a serious emotional disturbance, team-based care is available to include Multi-systemic therapy-psychiatric (MSTp), and rehabilitative-focused services such as therapy, case management, psychiatric care, and skills training. The state is also developing intensive-wrap around services for youth to better assist with navigation of behavioral health systems. Additionally, First Episode Psychosis programs were implemented in two of the eight regional community behavioral health clinics, serving youth and young adults who have experienced early episodes of psychosis within an evidence-based framework. For adults with co-occurring disorders, team-based care under the Integrated Dual Disorder Treatment model (IDDT) are provided. This includes a focus on stage-based care and motivational interviewing approaches within an integrated framework. Additionally, each community behavioral health clinic offers a variety of SUD services for adults along the continuum of care. ASAM Level 3.1 low-intensity residential is offered in most regions in addition to 24-hour crisis services and crisis residential units. Outpatient treatment groups and individual therapy is also included within the model, utilizing evidence-based approaches such as E-IMR, Seeking Safety, Motivational Interviewing, CBT, DBT, and connection to recovery-based community supports.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

All eight regional public community behavioral health clinics offer an open access clinic available Monday-Friday 8:00am-5:00pm for screening, triage, and assessment. Individuals may be triaged to a community service that fits their needs or seen by a licensed therapist who will complete an integrated diagnostic assessment. The information is reviewed by a multi-disciplinary team to substantiate the diagnosis and ASAM dimensions for any SUD level of care. In the interim, the individual is connected to the appropriate service. If the individual is assigned to an integrated team at the community behavioral health clinic, they may receive inter-disciplinary care in a team-based setting. This may include mental health individual and/or group therapy, SUD individual and/or group therapy, case management, rehabilitative services including skills training and integration, psychiatric treatment and further psychological assessment as clinically indicated. This process is available for adults and youth. Youth are served on integrated specialty teams for youth and family services which take place in-home and in-community. There are also several evidence-based teams individuals may be referred to including Integrated Dual Disorder Treatment (IDDT) for adults and Multi-Systemic Therapy-Psychiatric (MSTp). State also contracts with a vendor to provide statewide adolescent residential addiction treatment. The vendor is required to assess for co-occurring disorders and integrate services to address the youth's individual needs.

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

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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 status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. 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, LGBTQI+ 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

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?

The policy division has contracted with HSRI to provide technical assistance to create a strategic plan for addressing gaps in service, particularly for individuals who have been marginalized. Currently, contracts have been developed within our eight regional community behavioral health clinics for linguistic services as well as in our communications department. The policy division has also set aside block grant dollars to coordinate with the Department of Health for increasing culturally-relevant services for NFI populations and Native American populations, two demographics which are currently underserved in the system. North Dakota also recently implemented NOMS data collection in two of the eight regional human service centers with further implementation plans as we transition several of the community behavioral health clinics into Certified Community Behavioral Health Clinics (CCBHC's).

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:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ 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. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] 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)**[8] 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. Each 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

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 focused 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. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care (OnTrack)	2

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
175000	175000

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

North Dakota Medicaid and other private insurances currently reimburse for clinical services provided in ESMI/FEP. The State is exploring options for billing other components of the model.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

The State is funding two First Episode Psychosis (FEP) programs in the state, one located in Fargo at Southeast Human Service Center, and another located in Bismarck at West Central Human Service Center. The FEP programs help individuals who have recently experienced the first onset of psychotic symptoms by working with individuals and their families to help understand the illness and develop skills to help them live healthier and happier lives.

5. Does the state monitor fidelity of the chosen EBP(s)?

(•) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(•) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

The State has contracted with outreach provider to educate key stakeholders through statewide outreach and engagement activities. State is developing media campaigns to expand knowledge of psychosis within the state and increase number of individuals with psychosis to access services.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

State plans to expand FEP services to rural and tribal areas in FY 2024 & FY 2025.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, mood disorders with psychotic features and Post Traumatic Stress Disorder (PTSD) featuring psychosis.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

The North Dakota State Epidemiological Outcomes Workgroup does not currently have any statewide data on the incidence of individuals with a first episode psychosis. The regional community behavioral health clinics are developing processes to collect data within the Electronic Health Record.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

The state has contracted with an outreach provider, a licensed clinician, to engage with individuals in need of services and can provide referral and warm hand off to the FEP programs. This provider also educates key stakeholders through statewide outreach and engagement activities on how to access service. The contractor is providing information and education to key agencies who may interact with individuals experiencing a first episode psychosis hospitals, emergency rooms, colleges, high schools, psychiatric residential treatment facilities, human service centers, private providers, etc., across the state.

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

Identifying ways to identify the incidence of individuals with a first episode psychosis in the state.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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.

North Dakota’s Person-Centered Practices Initiative is a statewide, systemwide priority. The North Dakota Department of Health and Human Services (ND DHHS) Person-Centered Practices (PCP) have evolved for decades, however; the efforts have resulted in significant variation across the department specifically in policy, training, and practice. The DHHS Executive Leadership supported the development and implementation of a strong and consistent statewide vision and universal understanding of person-centeredness across all DHHS entities and community partners.

An active work group composed of team members from eight divisions and collaborating agencies continues to meet at least monthly to facilitate the development and implementation of a strong and consistent statewide vision and universal understanding of person-centeredness across all ND DHHS entities and community partners.?The cross-division workgroup has a technical assistance plan, detailing goals, activities, and timing to ensure statewide implementation and system change.

North Dakota’s Person-Centered Technical Assistance Plan has completed the following goals from Year 1-Year 4:

Goal One: By March 31, 2020, all members of the Department of Human Services executive leadership team will demonstrate understanding of and commitment to person-centered thinking, planning, and practice

Goal Two: Create a toolkit based on the Participant Engagement Guide and conduct trainings on the toolkit to engage diverse service user and family communities to inform systems change efforts.

Goal Three: Six ND DHHS Divisions will complete a person-centered practice self-assessment process resulting in action plans to increase person-centered practice for each division.

North Dakota’s Person-Centered Technical Assistance Plan for Year 5 includes:

Goal One: Develop materials and training content based on the Participant Engagement Guide to support DHHS staff and leadership in engaging culturally and linguistically diverse service user and family communities to inform systems change efforts.

Goal Two: ND DHHS will review, select, and implement a train-the-trainer process for person-centered practices that will include the development and utilization of resources and toolkits that will guide in the implementation of person-centered practices

In 2023 North Dakota hosted a five-part Person-Centered Practices Summit. This summit was an opportunity to highlight the accomplishments and resulting outcomes of the goals, activities, and statewide implementation of technical assistance plan. This summit provided an opportunity to raise awareness about ND DHHS person-centered practices initiatives and included participation from individuals receiving services, their families, stakeholders, and providers

During the 67th Legislative Assembly, a new section to NDCC was created and enacted as follows (Chapter 1-02): "Person-first language. The provisions of this code, unless the context otherwise requires, must be construed in person-first language and any new enactments of this code must be written in person-first language."?

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

To consistently include service recipients in decision making requires them to be in the room and at the table when decisions are being made. North Dakota developed a "Guide of Best Practices" that details five strategies and proven practices to directly involve people in workgroups and teams.

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.

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

North Dakota's Person-Centered Planning Process developed 8 guiding principles these principles include:

Emphasize Person First, with Customized Supports and Services – The person directs their plan and is at the center of the planning process, rather than the conditions/diagnosis, agency, or system. The person's desires and experiences should be heard, honored, prioritized, and reflected in the services received. People who are important in the person's life should be part of the planning process, helping to ensure the person's vision for their life is realized.

Focus on the Person's Strengths – Recognize the individual's positive attributes and what they can or hope to do. Listen to the person and those who know them well, to understand their talents, unique skills, gifts, competencies, and sources of pride. Utilize and build upon the person's strengths to support them in realizing their desires and to develop/enrich life-long skills.

Balance Choice and Risk – Show dignity and respect by identifying what is important to and for the person. What's important to the person is usually related to comfort, happiness, contentment, satisfaction, and often revolves around what is critical to maintain the individual's health and safety. People have the right to take risks which are essential for dignity and self-esteem, to learn from mistakes, and grow through these learning opportunities.

Meet the Person Where They Are – Seek to understand the person's values, beliefs, culture, and community to foster appreciation and respect for how the individual feels, works, and lives their life. This includes acknowledging how a person's past experiences impact their life today. To ensure a person's vision for their life is realized, listen to their story with humility. Humility—which is about personal reflection and being open to and thoughtful about other peoples' experiences—should be shared by everyone participating in the service process, including those receiving and providing services or supports. Many cultures see health, well-being, and community as one in the same. Respect and compassion for all people as valued community members are integral to success of the whole. Acknowledge cultural similarities and embrace the differences, but do not impose beliefs and values on others.

Regularly Review Goals – Recognize that desires and needs evolve over time and may change. Take the time to review the person's life goals to ensure that supports and services are designed to help realize the person's vision for their life is imperative. Supports and services should be flexible, and any changes/updates made timely.

Build Equity of Voice – Empower the person to actively participate and make decisions that are consistent with their goals and values and support the individual's voice. Create equity in engagement by reaching out to people who may not traditionally be engaged in self- and system-advocacy, and make sure underrepresented groups feel welcome and supported to engage.

Equip the Person to Make Informed Decisions – Clearly explain what options, education, and choices may be available to the person. Ensure that the person understands the options and has all necessary information, including potential benefits and consequences, to make informed decisions.

Be Kind – Take the time to show genuine care, concern

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.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

While the eight regional community behavioral health clinics do not formally utilize psychiatric advanced directives, the consideration of person-centered care is at the forefront of service delivery. Treatment plans are individualized with the client and

reviewed at regular intervals to ensure personalized service focused on the client's goals. Additionally, all staff within these clinics are trained in motivational interviewing approaches and person-centered safety planning. Inclusion of the client's family or support system is also incorporated into the treatment plan for improved outcomes.

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

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:

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?

   N/a

   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?

   The North Dakota Department of Health and Human Services' Behavioral Health Division Policy Team does not have a comprehensive process for tracking the number of consultation sessions the state has conducted with federally recognized tribes; however, the state regularly collaborates and works with the federally recognized tribes. Examples of this include quarterly prevention trainings which include tribal prevention grantees, quarterly Behavioral Health Planning Council of which there is tribal membership, and regular collaboration with the Department's Community Engagement Unit's Tribal Liaisons to identify gaps and opportunities for behavioral health service on federally recognized tribes. The Policy Team also consults with federally recognized tribes in the state in relation to the implementation of the System of Care grant.

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

   Throughout 2022 and 2023 there were conversations between the Policy Team and the Department's Tribal Liaisons and behavioral health leaders in tribal and Urban Indian Communities as part of a strategic plan objective related to "Meet with all behavioral health leaders at each tribe to understand strengths, needs, and priorities and identify opportunities to partner with the Department." Each tribal community identified strengths, needs and priorities, as well as opportunities for collaboration with the Department. Overall specific needs and priorities included: Transportation issues; Lack of behavioral health workforce; Training for non-Native providers on cultural humility, historical trauma, and implicit bias; Supports for people who are homeless; Providers who serve children;
   Crisis Support.

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

   The North Dakota Behavioral Health Division Policy Team 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 Policy Team heads 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 Policy Team allocates approximately 20% of the SUPTRS 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 use 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 Misuse Prevention System – long standing collaboration with the tribes in the state.?

The Policy Team contracts with three Affiliated Tribes for residential treatment programming. The Policy Team is continuing to further develop partnerships between prevention and treatment efforts funded through the SUPTRS grant to align and leverage resources.?

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

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)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [x] Other (please list)

Readiness

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [ ] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [ ] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [ ] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☑ Others (please list)

Uniform Crime Report
Crash Analysis
ND Violent Death Reporting System

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** 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 are called upon when needed.
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  Several of the CLAS standards are included in the assessment process that both the state and communities implement.
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  The state considers sustainability throughout all phases of the Strategic Prevention Framework.
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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;
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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 Planning

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

a) If yes, please describe.

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

a) 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.behavioralhealth.nd.gov/prevention. 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. The Division also contracts with external providers to assist in providing training and technical assistance to the prevention workforce in the state.

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

a) If yes, please describe mechanism used.

The Division (through contract with the Wyoming Survey and Analysis Center) has funded the implementation of a statewide community readiness survey. The survey was completed in 2015, 2017, 2019, and 2022. The completed community readiness reports can be found at https://www.hhs.nd.gov/behavioral-health/data. The Division also contracted with an external provider to assess community readiness specific to the Tribes in the state.

4. Does your state integrate the National CLAS Standards into the capacity building step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Several of the CLAS standards are included in the capacity process that both the state and communities implement.

5. Does your state integrate sustainability into the capacity building step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The state considers sustainability throughout all phases of the Strategic Prevention Framework.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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;
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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.

Planning

1. Does your state have a strategic plan that addresses substance use primary 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.

Plan is uploaded in Attachments Page.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Cultural competence component (i.e., National CLAS Standards)
- **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 SUPTRS BG 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 SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) 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 are called upon when needed.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) 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 are called upon when needed.

8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Several of the CLAS standards are included in the planning process that both the state and communities implement.

b) If no, please explain in the box below.

NA

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The state considers sustainability throughout all phases of the Strategic Prevention Framework.

b) If no, please explain in the box below.

NA

Narratve Question

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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.

Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The Behavioral Health Division actively disseminates information to communities and stakeholders. The Behavioral Health Division also implements evidence-based mass media/communication efforts targeting priorities set by the state's SEOW:
- Parents Lead
- Opioids: Fill with Care
- Speak Volumes

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 SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

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

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Several of the CLAS standards are included in the implementation process that both the state and communities implement.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

The state considers sustainability throughout all phases of the Strategic Prevention Framework.

b) If no, please explain in the box below

Narratve Question

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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.

Evaluation

1. Does your state have an evaluation plan for substance use primary 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 SUPTRS BG 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 SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy use

- **c)** ☑ Binge use
- **d)** ☑ Perception of harm
- **e)** ☐ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Several of the CLAS standards are included in the evaluation process that both the state and communities implement.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

The state considers sustainability throughout all phases of the Strategic Prevention Framework.

b) If no, please explain in the box below.

Footnotes:

NORTH DAKOTA PREVENTION RESOURCE & MEDIA CENTER

North Dakota Behavioral Health Division

SUBSTANCE ABUSE PREVENTION Strategic Plan 2016 – 2020

Increase implementation of effective prevention statewide

Decrease underage drinking

Decrease adult binge drinking and related consequences

Decrease prescription opioid misuse and related consequences

Goal 1: Increase implementation of effective prevention statewide	
Objective 1.1: Increase capacity of state-level prevention workforce to implement effective prevention	Strategy 1.1.1: Continually assess data trends, needs and resources *Activities: SEOW*
	Strategy 1.1.2: Receive ongoing training and consultation *Activities: TTA trainings/self-assessment; evidence-based practices and processes; CAPT*
	Strategy 1.1.3: Promote effective prevention to state-level stakeholders and policy-makers *Activities: GPAC; video; newspaper insert*
Objective 1.2: Increase the capacity of communities to implement effective prevention	Strategy 1.2.1: Enhance and promote effective prevention *Activities: prevention website/PRMC; newsletter; Increase the quantity and quality of resources; video; newspaper insert*
	Strategy 1.2.2: Promote and provide Training and Technical Assistance [TTA] services across the state *Activities: TTA methods*
	Strategy 1.2.3: Seek out and provide funding opportunities to support prevention efforts *Activities: PFS; BG contracts, SPF Rx application, providing support for DFC grant application*
Objective 1.3: Expand the prevention workforce	Strategy 1.3.1: Enhance effective prevention education opportunities at the college-level *Activities: Internship program; requiring prevention courses for different disciplines (i.e. addiction counseling)*
	Strategy 1.3.2: Develop credentialing processes for prevention specialists *Activities: become trainers of SAPST; offer SAPST on a regular basis; explore ways to move to credentialing; promotion of SAPST/credentialing*
Outcome Measures: capacity is difficult to measure and will be evaluated within the objectives and strategies, including process measures	

Goal 2: Decrease underage drinking	
Objective 2.1: Increase parental protective factors (role-modeling, communication, monitoring, engagement)	Strategy 2.1.1: Enhance and promote Parents Lead website *Activities: Parents Lead for Professionals (targeting selective populations)*
Objective 2.2: Increase community implementation of effective strategies targeting underage drinking	Strategy 2.2.1: Administer the Strategic Prevention Framework Partnership For Success Grant [PFS]
Objective 2.3: Prevent the onset of substance use disorders (SUD) among youth who do not yet meet criteria for a SUD, but are exhibiting early warning signs	Strategy 2.3.1: Enhance screening and brief intervention implementation across the state
	Strategy 2.3.2: Develop evidence-based first offender program to be implemented statewide
Outcome Measures: Decrease past month underage drinking by 7% and past month underage binge drinking by 5% as evidenced by the 2021 YRBS.	

Goal 3: Decrease adult binge drinking and related consequences	
Objective 3.1: Shift community norms and increase perception of risk for adult binge drinking	Strategy 3.1.1: Enhance and promote Speak Volumes
Objective 3.2: Increase community implementation of effective strategies targeting adult binge drinking	Strategy 3.2.1: Administer community grants
Objective 3.3: Prevent the onset of substance use disorders (SUD) among adults who do not yet meet criteria for a SUD, but are exhibiting early warning signs	Strategy 3.3.1: Enhance screening and brief intervention implementation across the state
	Strategy 3.3.2: Enhance evidence-based statewide first offender program
Outcome Measures: Decrease adult (age 26+) past month binge drinking by 4% as evidenced by the 2018-2019 NSDUH; Decrease the number of alcohol-related fatal crashes by 30% [34] as evidenced by the 2021 Crash Summary; Decrease the number of alcohol-related injury crashes by 10% [335] as evidenced by the 2021 Crash Summary	

Goal 4: Decrease prescription opioid misuse and related consequences	
Objective 4.1: Increase community implementation of effective strategies targeting prescription drug abuse and overdose	Strategy 4.1.1: Administer community grants
Objective 4.2: Decrease access to unused/unneeded prescription drugs	Strategy 4.2.1: Promote safe use and disposal of medication** *Activities: Enhance and promote Lock. Monitor. Take Back - targeted and statewide promotion of Take Back locations; NDSF; incorporate messages into Parents Lead*
	Strategy 4.2.2: Enhance prescription practices for prescription opioids** *Activities: include PDMP*
Objective 4.3: Increase implementation of evidence-based overdose prevention	Strategy 4.3.1: Increase awareness of risks and signs of overdose**
	Strategy 4.3.2: Increase awareness of overdose response** *Activities: naloxone, Good Samaritan*
Outcome Measures: Decrease high school lifetime prescription drug misuse by 2% as evidenced by the 2021 YRBS; Decrease past-year non-medical use of pain relievers (among ages 18+) by 1% as evidenced by 2018-2019 NSDUH; Decrease overdose deaths (because of fragmented data collection, trend data will not be able to obtained; this is in the process of being remedied)	

***links to BHD Opioid Strategic Plan*

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-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Policy Team has developed and implemented several programs to offer services and resources to individuals with behavioral health conditions to remain in their home community, these programs and funding sources are highlighted below: Collectively, these efforts provide a wide array of services to prevent individuals needing residential or inpatient setting.

Medicaid 1915(i) State Plan Amendment

The North Dakota Medicaid 1915(i) State Plan Amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions. The Care Coordinator develops a person-centered plan of care and assists in gaining access to needed 1915i services such as: Training and Support?for Unpaid Caregivers, Community Transition?Services, Benefits Planning, Non-Medical Transportation, Respite, Pre-Vocational Training, Supported Education, Supported Employment, Housing Support, Family Peer Support, and Peer Support.

Free Through Recovery and Community Connect

Free Through Recovery and Community Connect programs were designed to provide additional access to care coordination and recovery support services for individuals with behavioral health conditions. These programs have developed funding opportunities for private providers to engage in care coordination, case management, and peer support services.

Permanent Supportive Housing

During the 2021 legislative session State general funds were created to fund permanent supportive housing grants. The Grantees work to provide supportive services that tenants need to retain housing. The Grantee must ensure that tenants have access to 24/7 support, as needed. Services are designed to support individuals in solving predictable problems by proactive planning, relationship building, vigilant oversight of critical incidents, and communication and coordination with property managers.

System of Care

The Policy Team was awarded a four-year Substance Abuse and Mental Health Services (SAMHSA) System of Care (SOC) Expansion and Sustainability Grant to enhance mental health outcomes for children and youth. North Dakota will receive $3 million per year starting September 30, 2022 through September 30, 2026. The SOC grant is designed to enhance mental health outcomes for children and youth, birth through age 21. Through this grant, the Policy Team is building and expanding community-based behavioral health services and supports for children and youth with Serious Emotional Disturbances (SED) and their families.

Recovery Housing Assistance Program

The Recovery Housing Assistance Program (RHAP), is a state-funded program, administered by the Policy Team. RHAP provides an

option for individuals wanting to initiate and sustain recovery efforts in a safe, stable living environment. Up to 12 weeks of an eligible individual's living expenses will be paid directly to a Recovery Housing Assistance Program provider. This program improved access to care for individuals with substance use disorders.

Mental Health Program Directory

A Mental Health Program Directory was launched by the Policy Team October 3, 2022, to assist North Dakotans in locating and accessing mental health services in the state. The new directory allows users to search for mental health programs by location, population served, type of mental health specialty and treatment and interventions options. Individuals can also search for programs that offer telehealth services. ?

Community Behavioral Health Clinics

In addition to the private sector, North Dakota has eight regional community behavioral health clinics who provide 24-hour crisis service including mobile response, open access admissions including screening, triage, and diagnostic assessment, team-based behavioral health service delivery to include case management, individual and group therapy for MH and SUD, rehabilitative services, psychiatric and psychological services, and peer support as deemed clinically necessary. These community behavioral health clinics prioritize service for youth with SED and their families, as well as adults with SMI or co-occurring disorders with severe and extreme functional deficits related to a primary BH condition. The practice model of the HSC's includes several evidence -based programs including Multi-Systemic Therapy (MST), Integrated Dual Disorder Treatment (IDDT), Assertive Community Treatment (ACT), and First Episode Psychosis (FEP). In addition, a focus on community-based, wrap around care is essential to connecting individuals to their community resources.

Substance Use Disorder Voucher

The Substance Use Disorder (SUD) Voucher program was established to address barriers to treatment and increase the ability of people to access treatment and services for substance use disorders. Individuals 14 age and older who are eligible, can access treatment and recovery services at a private program involved in the voucher program.

Peer Support Specialists

Starting in January 2018 the Policy Team began training Peer Support Specialists. Since 2018, the Policy Team has trained over 900 peers and hosted 30+ trainings to support the provision of peer support services. In 2019, the Policy Team was authorized to establish and implement a certification for peer support specialists. Peer Support services are now reimbursable through Medicaid Expansion, 1915i State Medicaid Amendment Plan, Blue Cross Blue Shield Commercial and the Substance Use Disorder Voucher, and Free Through Recovery and Community Connect programs. Peer Support Specialists have lived experience in recovery which makes it possible to engage clients in building recovery by offering a level of credibility that can only come from that lived experience

Medicaid Expansion

When North Dakota accepted the Affordable Care Action Medicaid Expansion, the state was provided with federal funding in order to expand Medicaid coverage options. The ACA Medicaid expansion was passed and signed into North Dakota law in 2013.

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

a)	Physical Health	○ Yes	◉ No
b)	Mental Health	◉ Yes	○ No
c)	Rehabilitation services	◉ Yes	○ No
d)	Employment services	◉ Yes	○ No
e)	Housing services	◉ Yes	○ No
f)	Educational Services	◉ Yes	○ No
g)	Substance misuse prevention and SUD treatment services	◉ Yes	○ No
h)	Medical and dental services	○ Yes	◉ No

i)	Support services	(•) Yes	( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	( ) Yes	(•) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes	( ) No

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

The state of ND would like to see enhanced service coordination with primary care and other medical providers. The Policy Team will assist one community behavioral health clinic become certified within the next year as a Certified Community Behavioral Health Clinic (CCBHC) through SAMHSA. Additionally, the state of ND has several full-service community school systems; however, there still exist disparities among different schools across the state and the services they provide.

3. Describe your state's case management services

Currently, the eight regional community behavioral health clinics provide case management services as a part of a team-based service delivery model to youth with SED and their families, and adults with SMI or co-occurring disorders. The regional community behavioral health clinics prioritize individuals with severe or extreme functional deficits related to their behavioral health condition. In order to fill in gaps in service, the Policy Team has developed state programs such as Community Connect and Free Through Recovery to provide additional case management services. The Medicaid 1915i State Plan amendment also allows for additional case management services.

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

There are several activities implemented to reduce hospitalizations and hospital stays.

The implementation of 988 and expansion of mobile crisis response was implemented in direct response to an increase in calls and lack of services in rural regions. The Policy Team is also contracting with a healthcare partner to provide telehealth crisis response directly via law enforcement who respond to behavioral health crises in rural areas to reduce emergency department and hospital visits by resolving crisis and providing referral and follow-up.

The department is procuring a vendor to provide a behavioral health bed management registry program to track the availability of behavioral health beds statewide. The system will assist providers and consumers in identifying access to the appropriate services rather than resulting in unnecessary emergency department or hospital stays.

Additionally, the enhancement of evidence-based programs including Multi-Systemic Therapy, Integrated Dual Disorder Treatment, and Assertive Community Treatment as well as other community-based models have shown to assist in decreasing emergency department visits, the duration of hospital stays, and reduce out of home placement. Over the next two years, the eight regional community behavioral health clinics plan to enhance evidence-based service provision through the addition of Functional Family Therapy (FFT).

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

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	42,087	7,901
2.Children with SED	18,313	1,992

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 Calculations

Statewide prevalence for Adults with SMI was calculated using the prevalence percentage estimate from the 2021 National Survey on Drug Use and Health Model-Based Prevalence Estimates published by SAMHSA as well as US Census population estimates for North Dakota. The estimated prevalence of 7.06% was applied to the July 1, 2022 Census estimated population of adults (59,6134.665 * .0706 = 42,087.11).

Statewide prevalence for Children with SED was calculated using the prevalence percentage of 10%. This percentage was applied to the estimated population for people under 18 based on July 1, 2022 US Census estimate data (183,126.335 * .10 = 18,312.63). Prevalence estimates for Children with SED are more difficult to calculate given the broad range of estimates available. References utilized include:

URS Table 1 by State 2021 published by SAMHSA/Hendall (lower limit 9%/upper limit of 11% for North Dakota).

Williams, Scott, and Aarons (2018) Prevalence of Serious Emotional Disturbance Among US Children: A Meta-Analysis (10%).

Incidence Calculations

Incidence calculations were based on the last two fiscal years (FY2022 and FY2023) of BCI data reported to SAMHSA regarding adults with SMI and Children with SED that were served by the State of North Dakota behavioral health system. The incidence rate is based on an estimated number of people we expect to be served by the state behavioral health system over the 2-year grant period. It should be noted that the comparison of total prevalence to incidence rates will likely show that the state system will serve a small percentage of the total populations impacted by SMI/SED in the state.

Incidence for Adults with SMI and Children with SED were calculated using the average counts from BCI data for reporting years FY2022 and FY223 and then multiplied by two to estimate the number anticipated over the 2-year grant period.

(Adults with SMI Count FY2022 + Adults with SMI Count FY2023) / 2 = Average Adults with SMI Served * 2 Years = Estimated Incidence for Adults with SMI

(Children with SED Count FY2022 + Children with SED Count FY2023) / 2 = Average Children with SED Served * 2 Years = Estimated Incidence for Children with SED

Generally speaking, the State behavioral health system is serving an average of 3,951 adults with SMI and 996 children with SED each BCI reporting period. There is carryover from year-to-year, as individuals will receive services in more than one reporting period. However, assuming the question is attempting to estimate the number of individuals expected to be served in the grant period with SMI/SED, the carryover was included.

References

SAMHSA. (2022). 2021 adults-with-smi-and-children-with-sed-prevalence-in-2021. This was emailed to us, not sure where it is published on SAMHSA's website.

Substance Abuse and Mental Health Services Administration. (2023). 2021 National survey on drug use and health: Model-based prevalence estimates (50 states and the District of Columbia). 2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia) (samhsa.gov).

United States Census Bureau. (2023, August). QuickFacts North Dakota. U.S. Census Bureau QuickFacts: North Dakota.

Williams, N.J., Scott, L., Aarons, G.A. (2018). Prevalence of serious emotional disturbance among U.S. children: A meta-analysis. Psychiatric Services, 69, 32-40. doi:10.1176/appi.ps.201700145

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

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 IDEA	( ) Yes	(•) No
c)	Juvenile justice services	(•) Yes	( ) No
d)	Substance misuse preventiion 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 systems	( ) Yes	(•) No

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

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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. **See SAMHSA's Rural Behavioral Health page for program resources**

The Policy Team contracts with mental health providers to facilitate and conduct outreach in rural areas of the state designed to increase knowledge of statewide behavioral health resources. Funding was awarded to a private mental health program to open a new clinic location in an underserved area of that state as well as to assist individuals with accessing appropriate services. In addition to funding the Policy Team also hosts monthly webinar sessions designed to increase knowledge and awareness of behavioral health conditions and treatment options.

North Dakota's Behavioral Health Strategic Plan goal 9.3 is to identify populations underserved by behavioral health programs and initiatives, and strategies for promoting health equity for those underserved populations or areas. Rural population has been identified and a report is being completed to better identify the barriers as well as strategies to improve health equity.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

The eight Regional Human Service Centers provide support to individuals who are experiencing homelessness. The case managers specialize in outreaching to, engaging, and advocating for those who are most vulnerable and provide critical services that mainstream mental health programs may not support.

The Behavioral Health Policy Team is a participating member of North Dakota's Continuum of Care, a requirement of Housing and Urban Development (HUD).

The Policy Team also participates in the North Dakota Housing Finance Agency Services Collaborative workgroup that has an action plan designed to fill gaps regarding housing supportive services.

The Policy Team provides grant funding for Permanent Supportive Housing providers designed to support the provision of supportive services to those that have experienced homelessness and often have serious mental illness.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

The Policy Team and Adult and Aging Services in collaboration are building a training plan designed to improve the early identification and treatment for aging adults who may be experiencing behavioral health symptoms or preventing, when possible. Part of the training plan is to ensure that all providers that are working with the aging population are trained to identify and respond appropriately to older adults experiencing behavioral health symptoms. In addition to this plan the Adult and Aging Services administers additional programs and services designed to support older adult populations.

The North Dakota Adult and Disability Resource Link (ADRL) is a resource link/hotline to assist individuals, professionals, caregivers, and families with finding in-home and community services and supports to maintain or improve quality of life.

North Dakota's Long-Term Care Ombudsman Program speaks on behalf of people living in assisted living homes, basic care homes, hospital swing beds, transitional units or nursing homes. The ombudsmen work to resolve complaints to the resident's satisfaction and offer information and resources on long-term care homes. Residents of long-term care homes may have concerns about the quality of their care or that their rights as a resident are not being honored.

North Dakota Health and Human Services administers a Money Follows the Person Grant program to enable Medicaid members with disabilities to transition from institutions to community living. As of May 2022, CMS had awarded North Dakota $47 million to help move eligible individuals from institutions to community settings.

Home and Community Based Services (HCBS) provide opportunities for people to receive services in their own home or community, delivered by a Qualified Service Provider (QSP).

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

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.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

In planning for allocation of the Mental Health Block Grant funding in North Dakota, the Behavioral Health Division Policy Team 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 Policy Team plans to allocate the Mental Health Block Grant funds in the following way:

Peer Support: The Division is continuing to develop mental health peer support services throughout the state including peer support certification, peer support supervision training and expanding the types of peer support training available for peer support specialists.

Care Coordination: The Division is expanding care coordination and recovery support services for pregnant women, families, caregivers, and individuals with a SMI which impacts functionality in multiple domains including housing, employment, parenting, physical health, and/or community connections.

Crisis Services: The Division is continuing to expand behavioral health crisis service delivery throughout the state.

First Episode Psychosis Treatment Program: The Division is providing First Episode Psychosis (FEP) services in two Human Service Centers in the state and will expand this service to the Western part of the state. The Division provides services to a core population of individuals with serious mental illness including schizophrenia, schizoaffective, schizophreniform, brief psychotic disorder, trauma-related and mood disorders. Division staff will provide evidence based FEP treatment services to individuals between 15 and 25 years of age through the Coordinated Specialty Care program.

Advocacy: The Division provides funding to support a consumer-run advocacy program to more effectively respond to the needs of children, youth, and young adults with serious emotional disturbances (SED) and their families by providing information, referrals, and support, increase the quality and access to mental health services, assist consumers to ensure 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 provides funding to a program to support, provide resource, referral and advocacy for adults with SMI and their families. The program maintains a statewide council, coordinates a statewide conference, and staffs a call line to provide resources and referrals to assist families with accessing mental health services in the state. The agency also has a staff member trained in the SSI/SSDI Outreach, Access and Recovery (SOAR) model to assist adults with SMI to apply for social security benefits.

Aging and Mental Health: The Division plans to assist with training for long term care and home and community-based service 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. The Division plans to provide workforce

trainings to enhance services for children with SED and adults with SMI. Trainings planned include the following topics: LGBTQ+ Affirming Psychiatric Residential Treatment Facilities, LGBTQ+ Adult Behavioral Health, Motivational Interviewing, Compassion Fatigue, Developing Agri-Cultural Competence for Mental Health Professionals, and Building Successful Initiatives in Rural Communities to Build Resilience. In addition, the annual Behavioral Health Conference hosted by the Behavioral Health Division, plans to collaborate with the Child and Family Services to provide additional training and professional development.

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.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Currently, the state utilizes a HIPAA-compliant platform associated with the electronic health record to provide services via telehealth. All eight regional community behavioral health clinics offer diagnostic assessment via a hub and spoke model utilizing telehealth. Additionally, several psychiatric providers who are located out of state are connected to patients utilizing the telehealth platform. Telehealth services are also offered at several additional locations in rural areas within each regional behavioral health clinic service area including several county jails. These services may include psychiatric care, SUD or MH counseling. Currently, the state plans to expand telehealth services to rural areas by contracting with an entity who will utilize tablets to connect law enforcement with licensed behavioral health staff to assist in crisis. The state is also contracting with a separate entity to provide additional telehealth psychiatric services within county jails.

In August 2022 North Dakota completed a Telebehavioral Health Study, the purpose of the study was to examine what telebehavioral health services were offered across the state of North Dakota and look at the demographic and payer factors of such programs. The study identified that were currently at least 36 facilities providing telebehavioral health services to North Dakota. Of those 36, 17 provided mental health services, 14 provided both mental health and substance use services, and five provided substance use services only. Provider facilities were most likely operating out of an outpatient mental health facility. Of the 58 survey respondents, 18 did not report providing telebehavioral health services, most indicated that they did not plan to utilize in the future or were unsure due to lack of behavioral health providers and lack of familiarity with equity or technology needed to provide services.

North Dakota's Behavioral Health Strategic Plan, AIM 8 is to continue to expand the use of tele- behavioral health services. To expand the State has two goals and eight objectives related to expansion, by increasing the types of services available through tele-behavioral health and enhancing capacity of community providers to provide tele-behavioral health services through education and awareness.

In May 2023 the North Dakota Medical Services Division hosted webinars and discussion sessions designed to enhance providers knowledge of telehealth. In July 2023 the ND Medicaid Division updated and issued a behavioral health services provider manual, which indicates what services can be delivered via telehealth.

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

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

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/residential)	(•) 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:

i)	Prioritized services for veterans?	( ) Yes (•) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

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.

Programs receiving funding from block grant become scheduled for a compliance visit from the Behavioral Health Division Policy Section. During the compliance visit, requirements for PWWDC are reviewed including policies, procedures, chart reviews, staff training logs, as well as interviews with individuals being served by the program and team members. A compliance report is written and submitted to the program identifying areas of non-compliance and the Policy Section will work to provide training and technical assistance. This relates to all treatment programs including those specific to pregnant and parenting women.

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, if applicable — (●) 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, LGBTQI+, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites 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.

Programs receiving funding from block grant become scheduled for a compliance visit from the Behavioral Health Division Policy Section. During the compliance visit, requirements for PWID are reviewed including policies, procedures, chart reviews, staff training logs, as well as interviews with individuals being served by the program and team members. A compliance report is written and submitted to the program identifying areas of non-compliance and the Policy Section will work to provide training and technical assistance.

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.

Programs receiving funding from block grant become scheduled for a compliance visit from the Behavioral Health Division Policy Section. During the compliance visit, requirements for TB are reviewed including policies, procedures, chart reviews, staff training logs, as well as interviews with individuals being served by the program and team members. A compliance report is written and submitted to the program identifying areas of non-compliance and the Policy Section will work to provide training and technical assistance. ?

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 such 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 SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 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 SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

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 memebers, 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)** MOUD — (●) 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 including 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.

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

There will be approximately two compliance reviews equaling 25% of block grant sub-recipients.?

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.

Licensure Requirements for Public Mental Health Service Program:

Human Service Center Licensure: https://ndlegis.gov/information/acdata/pdf/75-05-00.1.pdf

Administration and Center Management: https://ndlegis.gov/information/acdata/pdf/75-05-01.pdf

Clinical Services: https://ndlegis.gov/information/acdata/pdf/75-05-03.pdf

Client Management: https://ndlegis.gov/information/acdata/pdf/75-05-04.pdf

Licensure Requirements for all Substance Use Disorder Treatment Programs: https://ndlegis.gov/information/acdata/pdf/75-09.1-01.pdf

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

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 2022-FFY 2023? ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *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 guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	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
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No

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

The Behavioral Health Division's values include Trauma-Informed principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. This is evident in the practice model among the eight regional behavioral health clinics. Trainings provided by the State also focus on equity amongst NFI, Native American and LGBTQ+ populations, which are marginalized in the state. All eight regional community behavioral health clinics require trauma-informed training upon hire and regularly review trauma-informed practices through

policy and clinical supervision.

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

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☑ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☑ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☑ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☑ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☑ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☑ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☑ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☑ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☑ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☑ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☑ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☑ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☑ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☑ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☑ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ◉ Yes ○ No

The North Dakota Department of Corrections and Rehabilitation (DOCR) collects and publicizes data regarding individuals residing in a correctional facility including the identification of race, gender, and age. The DOCR further utilizes the data to create efforts toward a more rehabilitative criminal justice system.

The North Dakota Department of Corrections and Rehabilitation is also partnering with Restoring Promise to focus on restorative housing units for young adults, with a special focus on Native American and Black youth. Restoring Promise transforms prison culture by designing spaces for young adults (Ages 18-25) that focus on healing, fairness, and respect. Every Restoring Promise housing unit is designed and driven by incarcerated people and corrections staff, empowering them to create a supportive community.

3. 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

4. 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.? Since 2017, Free Through Recovery has received support during each legislative session for continued funding.

Free Through Recovery continues to be a successful collaboration between ND DOCR and the Policy Team. As of August 2023, there were 54 different agencies providing care coordination and peer support services to participants, which has grown from 11 at the program's start. Services are presently offered statewide, including participants residing in the most rural areas of North Dakota.? Since February 1, 2018, there have been 5,582 individual participants.

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

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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 the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ( ) Yes (●) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, 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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ( ) Yes (●) No

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

The state is purchasing naloxone with SUPTRS BG funds in alignment with plans for achieving naloxone saturation.

The state plans to update regulations for SUD treatment providers to require that individuals with a opioid use disorder receive education on MOUD treatment options that are available.

North Dakota's rural nature results in many barriers for individuals to access all FDA approved medications for opioid use

disorder.

Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Citizens of North Dakota can access crisis services through several methods. The rollout of 988 in ND allows for individuals to contact a live person via call or text through a vendor for crisis intervention. The 988-call center is available to all ND citizens statewide. If the crisis cannot be resolved via the phone encounter, the vendor connects to a behavioral health professional available twenty-four seven at one of the eight regional community behavioral health clinics. Each region has a behavioral health team available for mobile outreach during the crisis within a forty-five-mile radius. Citizens may also walk into the community behavioral health clinic to receive screening, triage, assessment and crisis intervention during business hours. In six of the eight regions, the community behavioral

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☑	☐	☐
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

In the 2023 legislative session, North Dakota set aside additional funding to enhance the 988 crisis line. While any citizen may talk or text someone via 988, mobile crisis response remains limited, particularly in rural areas outside of a 45-mile radius of the eight regional community behavioral health clinics. Crisis residential units are operational in six of the eight regions.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The current crisis system requires enhancements to appropriately respond to crisis in rural parts of the state. The Policy Team is in the process of contracting with a tele-behavioral health entity to provide access to tele-behavioral health to law enforcement professionals and other agencies in rural areas of the state to utilize when responding to an individual experiencing a behavioral health crisis. When law enforcement responds to a call and the individual is in crisis, the officer will connect the individual to a licensed behavioral health professional to assess and resolve the crisis, via a tablet. If the crisis cannot be resolved in the moment, the licensed behavioral health professional will assist law enforcement in accessing the appropriate level of care. Additionally, the licensed

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The eight regional community behavioral health clinics and the behavioral health policy team work together to identify systemic needs for statewide behavioral health crisis response services. In this collaboration the mobile crisis behavioral health care response team identified the need to increase capacity of statewide crisis teams by utilizing the evidence based Brief Cognitive Behavioral Therapy (BCBT) and Crisis Response Planning (CRP). BCBT training is geared towards mental health professionals seeking to acquire entry-level information and training on the assessment, management, and treatment of suicide risk. CRP is a brief procedure used to reduce an individual's risk for suicidal behavior. The policy team will utilize the five percent set aside to provide training and technical assistance

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

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

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining 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- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. 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)	Use 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.

North Dakota provides recovery and recovery support services for adults with SMI through employing peer support specialists at the eight regional community behavioral health clinics that serve a core population of individuals with SMI or co-occurring disorders.?This includes screening and referral, crisis services, integrated diagnostic assessment, integrated team-based care including individual and group therapy (MH and SUD), case management, rehabilitative services, and psychiatric care and medication management. Community providers are also employing peer support specialists in urban and rural North Dakota communities to provide recovery support services through several community-based programs. Other services include: targeted case management and care coordination, skills training, and other rehabilitative services, supported employment, peer support, family peer support, residential services, supported housing, medication management, and Recovery Centers for socialization activities.

North Dakota implemented a certification process for peer support specialists in 2019. In 2021, the state expanded these services through the approval of the Medicaid 1915(i) State Plan Amendment allowing for eligible adults and children to access recovery and recovery support services closer to home. The state continues to host peer support trainings, peer support supervision trainings, and continuing education for peer support specialists. 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. i.e., RCOs, RCCs, peer-run organizations

As one of its foremost priorities, the Behavioral Health Division Policy Section promotes a recovery-oriented service system. The Policy Section 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 Policy Section is also working closely with the First Lady's office to host the seventh annual Recovery Reinvented event scheduled for October 2023.?

The Behavioral Health Division Policy Section provides funding to support a consumer-run advocacy program to more effectively respond to the needs of children, youth, and young adults with serious emotional disturbances (SED) and their families by providing information, referrals, and support, increase the quality and access to mental health services, assist consumers to ensure they are the catalyst for transforming the mental health system, and increase positive messaging while reducing the stigma associated with mental health diagnosis.? The Policy Section has provided funding to Mental Health America of North Dakota to administer the North Dakota Consumer Family Network (CFN) which 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.???

Eight Recovery Centers (one in each region throughout the state) employ peer staff and are contracted through the Community Behavioral Health Clinics or run by the local clinics. 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. They have connected with peer supports within each Community Behavioral Health Clinic to expand membership and offer collaborative opportunities.?

Peer Support: The North Dakota Behavioral Health System study recommendation,7.6 included establishing training/credentialing program for peer services and recommendation, 7.8 included supporting a robust peer workforce through training, professional development, and competitive wages.??

Since 2018 the Behavioral Health Division Policy Section in conjunction with Appalachian Consulting has facilitated 39 peer support trainings, training over 900 individuals as Peer Support Specialists. The Division offers ongoing continuing education opportunities for peers, peer supervisors and behavioral health providers that are working towards integrating peer support services.???

The Division offers peer support endorsements, endorsements are a continuing education training that is available to peer support specialists to help promote the professional development of a peer support specialist, current endorsements include criminal justice setting endorsements and brain injury endorsements. The Division will be adding peer support endorsements to enhance training for peers related to New American, Foreign Born Immigrants and Refugees and American Indians.???

The Division hosts ongoing peer support connection meetings for peers, these connection meetings offer an opportunity for peers to connect and to engage in group learning activities. These ongoing connection meetings are also hosted for peer support supervisors.????

During the 2019 legislative session several bills were passed to expand peer support services. The Medicaid Division added peer support as a covered service for individuals with a qualifying behavioral health condition. Senate Bill 2012 passed, creating a new section of century code to provide funding to implement the expansion of Free Through Recovery separate from the criminal justice system, and the Behavioral Health Division was given authority to write administrative rules for the certification of Peer Support Specialists.??

The 1915i State Medicaid Amendment Plan includes reimbursement for Peer Support and Family Peer Support. There are currently 26 Peer Support Enrolled Group Providers, 74 Individual Enrolled Peer Supports, 13 Family Peer Support Enrolled Group Providers and 26 Enrolled Family Peer Support Specialists.??

On July 1, 2020 the Behavioral Health Division Policy Section began certifying Peer Support Specialists. Since this time the division has certified 203 Peer Support Specialists. Certification aims to standardize training and improve and regulate reimbursement while meeting the growing demand for behavioral health support services in North Dakota.??

On February 1, 2021 the Behavioral Health Division launched Community Connect. Community Connect was the expansion of Free Through Recovery beyond the criminal justice system. Community Connect is designed to assist individuals with meeting their needs and goals through the provision of peer support and care coordination. Community Connect currently is serving approximately 2471 participants and Free Through Recovery currently serves approximately 1510 program participants across North Dakota.??

The North Dakota Substance Use Disorder (SUD) voucher continues to support funding for recovery support services, which include peer support as a reimbursable service.??

Telephone Recovery Support:? The Behavioral Health Division contracts with a vendor to provide telephone recovery support for individuals to call or text a peer support specialist twenty-four hours a day, seven days a week.? The service is free, confidential, and individuals may remain anonymous. The program is currently being extended to allow for individuals to sign up and request contact by a peer support specialist on a regular basis as an additional tool to their recovery.???

5. Does the state have any activities that it would like to highlight?

Not at this time.

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:

1. 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

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

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

The 2019 North Dakota Legislative Assembly approved a study directive into issues related to the Olmstead Commission and services for individuals with behavioral health issues. 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.

The North Dakota Olmstead Commission's goal is?to move North Dakota forward towards greater integration and inclusion for persons with disabilities with respect to community services and supports, employment, education, health care, housing and transportation. The Technical Assistance Collaborative, Inc. completed an assessment of services and systems in the state that support individuals with disabilities. A summary report was presented to the Olmstead Commission December of 2022.

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

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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).

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

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

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

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

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	(•) Yes	( ) No
b) The resilience of children and youth with SED?	(•) Yes	( ) No
c) The recovery of children and youth with SUD?	(•) Yes	( ) No
d) The resilience of children and youth with SUD?	(•) Yes	( ) No

2. 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:

a) Child welfare?	(•) Yes	( ) No
b) Health care?	(•) Yes	( ) No
c) Juvenile justice?	(•) Yes	( ) No
d) Education?	(•) Yes	( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?	(•) Yes	( ) No
b) Costs?	(•) Yes	( ) No
c) Outcomes for children and youth services?	(•) Yes	( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?	(•) Yes	( ) No
b) Mental health treatment and recovery services for children/adolescents and their families?	(•) Yes	( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?	(•) Yes	( ) No
b) for youth in foster care?	(•) Yes	( ) No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	( ) Yes	(•) No
d) Does the state have an established FEP program?	(•) Yes	( ) No
Does the state have an established CHRP program?	( ) Yes	(•) No
e) Is the state providing trauma informed care?	(•) Yes	( ) No

6. 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 was awarded a System of Care Grant September 2022. Through the initial grant implementation, the Policy Team has assessed gaps in service delivery among the behavioral health, child welfare, school, and community systems. The Policy Team is in the early stages of implementation in two catchment areas, Lake Region and West Central regions of ND. The public community

behavioral health clinics at these locations have started to collect National Outcome Measures (NOMS) data on their triage, assessment, treatment, and referral processes. Additionally, connections have been made with the tribal areas as well as the schools. The Policy Team plans to contract with additional behavioral health providers to provide intensive wrap around services, day treatment services, respite, and enhance in-school behavioral health services. The Policy Team has also established steering committees in each of the catchment areas. The steering committees will provide guidance on local strengths, barriers to services, and opportunities for change. The steering committees are made up of professionals serving youth and families in the region including licensed providers, schools, family-run agencies, human service center representatives, tribal representatives, juvenile justice representatives, disability advocates and persons with lived experience including youth, children, young adults, and parents/caregivers/families.

North Dakota's Dual Status Youth Initiative (DSYI) was a collaborative effort between several state agencies to address the issue of dual status youth (youth involved in the juvenile justice system and child welfare system) in our state. This collaborative effort explored how to prevent youth in the child welfare system from formally entering the juvenile justice system and more effectively serve youth that touch both systems. The DSYI promotes interagency information sharing, policy and practice changes, child and family centered multidisciplinary teams and designated dual status youth liaisons. The Dual Status Youth Initiative is an example of a cross-system partnership that addresses the needs of youth in the juvenile justice and child welfare systems.

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 a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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:

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 Policy Team partners with several organizations throughout the state to lead suicide prevention efforts. The Policy Team focuses on shared risk and protective factors and recognizes that work to increase access to behavioral health care is suicide prevention.

Other efforts include:
- Statewide implementation of 988 suicide and crisis lifeline
- Statewide, multi-media marketing and awareness campaign to promote the 988 suicide and crisis lifeline to the general population. Specific messaging to high-risk populations is anticipated to begin in the next year.
- All schools in North Dakota, public and private, have the option to participate in a virtual simulation suicide prevention training for teachers and staff.
- Funding opportunities for local government organizations, nonprofits, and tribal communities in suicide prevention training, awareness, planning, and implementation.
- Suicide prevention training for Care Coordinators and Peer Support Specialists.
- The 2023 ND legislative session authorized the state to create a Suicide Fatality Review Commission.
- Parents Lead is an evidence-based prevention program that provides parents and caregivers with a wide variety of tools and resources to support them in creating a safe environment for their children that promotes behavioral health.

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

If yes, please describe how barriers are eliminated.

The 988 suicide and crisis call center in North Dakota provides follow up calls to individuals transitioning out of acute psychiatric units; however, this only occurs at the psychiatric hospitals that contract with the call center for this service.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

Through 988 implementation and promotional efforts the state prioritized efforts for individuals who are experiencing a behavioral health crisis.

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 SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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 Policy Team continuously assesses the need to develop new partnerships within the North Dakota Department of Health and Human Services, other state agencies, and private/non-profit organizations. The Policy Team currently works closely with a number of entities to ensure that quality, efficient, and effective evidence-based 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 and Children's Cabinet.

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 Policy team works with multiple private behavioral health providers through various contracts to provide specific services to

youth and families. For example, one contract in the southeastern part of the state focuses on youth-specific crisis intervention. This agency also collaborates with local schools within the region for screening, triage, and crisis services. Two of the eight regional human service centers are piloting National Outcome Measures (NOMS) data collection for youth services as well. The Policy division also works closely with other child-serving entities such as Child and Family Services to collaboratively enhance therapeutic foster care and services to assist with re-entry into their home communities with wrap-around supports, often provided by one of the eight regional community behavioral health clinics. The state of North Dakota is also working on building a system of care focused on enhancing navigation of services, increasing the number of services available including partial hospitalization programming and intensive wrap-around care and in-school services. School behavioral health grants are also available through the state of North Dakota to enhance behavioral health services within the schools. One area of continued development is the education platform, Kognito, which assists educational professionals in better screening, understanding, and teaching around behavioral health. Partnerships and collaboration with our family advocacy organizations such as the ND Federation of Families for Children's Mental Health (NDFFCMH), Family Voices and Consumer Family Network are also critical for service coordination. The Policy Team also continues to partner with our tribal representatives including our tribal liaisons to ensure quality, efficiency and effective evidence-based behavioral health services are available statewide.

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

None

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder 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 SUPTRS BG, 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.**[1]

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.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Council meets quarterly to discuss community-based public behavioral health services. The Council's input is requested prior to submission of the combined block grant application. On July 19th, the policy team provided a presentation on the draft priority areas to be included in the combined application. A draft of the application will be provided to the Council prior to submission to SAMHSA. The final, submitted application will be posted on the ND HHS website with information on how to provide feedback at any time.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The Policy Team provides quarterly updates of the state plan to the Behavioral Health Planning Council (BHPC) and requests ongoing feedback of goals. The BHPC provides testimony during legislative session to educate legislators of gaps of services within the state's behavioral health system and works with legislators in members' respective regions to familiarize lawmakers with the need for appropriate behavioral health services.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. 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

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The North Dakota Behavioral Health Planning Council's (BHPC) objective is to monitor, review and evaluate the allocation and adequacy of mental health and substance abuse services in North Dakota. The council has a focus and vision on wellness and recovery that is consumer and family driven.

The BHPC requests quarterly presentations from behavioral health stakeholders to identify gaps in the state's system and uses information to provide recommendations for improvements in services, programs, or facilities. The council receives quarterly updates of the North Dakota Behavioral Health Plan from the Human Services Research Institute (HSRI), which provides progress of the plan's goals.

The BHPC reviews status of the combined behavioral health assessments and plan at least annually, recommends ways in which identified needs can be met by the Department of Health and Human Services. The council serves forum for meetings with governing boards of other public and private human service agencies that are brought to the council by the Department of Health and Human Services for the purpose of promoting greater understanding, efficiency and effectiveness in the working relationships among local and regional service providers. The council reviews the progress in the development and monitoring of the goals and objectives of the North Dakota Department of Health and Human Services, Behavioral Health Division and promotes clear lines of communication between the Department of Health and Human Services, the Governor's office, and the BHPC.

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

None

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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Meeting Notice

Behavioral Health Planning Council Meeting
Wednesday, July 19, 2023
Job Service ND Office – Dakota Room
1601 East Century – Bismarck, ND
Or via video conference option
Click here to join the meeting

10:00 AM – 4:00 PM, CT

AGENDA

10:00 AM **Welcome and Call to Order**: Carlotta McCleary, Chairperson
Roll Call of Council Members via Electronic Sign-in/Quorum Established
Meeting Minutes Review and Approval-May 17,2023
Agenda Approval-July 19, 2023

10:10 AM **BHPC Updates** – Membership & Bylaws Update-Tami Conrad/DHS

10:20 AM **State Hospital Update,** Dr. Eduardo Pelayo Yabut/Interim Superintendent & Medical Director

- Next Steps following legislative decisions.
- Challenges/Opportunities

10:50 AM **North Dakota Pediatric Mental Health Care Access Program Update** –Jenn Faul/Program Director/Sanford Health and Lyndsi Engstrom/Program Director, ND Full-Service Schools Consortium

Implications of the Rollback of Public Health Emergency on Tele-behavioral Health, Dr. Gabriela Blaf and or Courtney Koebel of ND Medical Association***this presentation will be rescheduled for a future meeting***

11:20 AM **1915(i) Provider Status & Clients Served Update**- Monica Haugen/Administrator Behavioral Health 1915(i)

12:00 PM **LUNCH BREAK**

1:00 PM **Mental Health Block Grant (MHBG) & Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG),** Lacresha Graham/ Manager, Addiction & Recovery Program and Policy, DHHS and Tami Conrad, Behavioral Health Administrator, DHHS

- Review grant application draft
- Review/update on contracts

1:40 PM **Behavioral Health Division Update-**– Pam Sagness/Executive Director Behavioral Health Division, DHHS

- Highlights from the *Behavioral Health in North Dakota Databook 2023*
- Data reporting improvements recommended.
- Legislative Studies Approved with BH Implications

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2:25 PM **BHPC Discussion re: Interim Study Positional Statements**

2:40 PM **Summary Report of ND Behavioral Health Strategic Plan and Future Activities**, Bevin Croft, Human Services Research Institute

- Updates on the Strategic Plan

3:10 PM **Crisis Response Units Update**, Dan Cramer

- Regional team update
- Dispositional data
- Impact of 988
- Specialized population group response

3:40 PM **Lightning Round Resource Sharing**

3:45 PM **Public Comments**

3:55 PM **Next Steps**

Next Meetings Scheduled. All meetings will be held onsite at the Job Service ND Office – Dakota Room; 1601 East Century; Bismarck, ND, and online via videoconference link.

- OCTOBER 18 (ANNUAL MEETING)/ DECEMBER 13

4:00 PM **Adjourn**

Optional Videoconference Connections*

Microsoft Teams meeting

Click here to join the meeting

Meeting ID: 251 285 967 41
Passcode: nFZ9X5

Join with a video conferencing device

teams@join.nd.gov

Video Conference ID: 114 374 001 5

Or call in (audio only)

+1 701-328-0950,,734839068# United States, Fargo

Phone Conference ID: 734 839 068#

ND Behavioral Health Planning Council (BHPC)
Quarterly Business Meeting
July 19, 2023
Meeting Minutes

Meeting Attendance
Council Members in Attendance: Kurt Snyder (Consumer, Individual in Recovery); Daniel Cramer (DHS Behavioral Health Delivery System); Mandy Dendy (Principal State Agency: Medicaid); Christina Bond (ND National Guard); Melanie Gaebe (Consumer, Individual in SUD Recovery); Matthew McCleary (Mental Health America of ND); Carlotta McCleary (ND Federation of Families for Children's Mental Health); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Pamela Sagness (Principal State Agency: DHHS Mental Health); Lisa Peterson (Consumer, Family Member of a Veteran); Brad Hawk (Indian Affairs Commission); Michelle Masset (Principal State Agency: DHHS Social Services); Emma Quinn (Consumer, Individual in Recovery Mental Health); Jennifer Henderson (ND Housing Finance Agency); Paul Stroklund (Consumer, Family Member of an Adult with SMI); Carl Young (Consumer, Family Member of a Child with SMI)**;** Camille Redmann (private mental health provider);Tania Zerr – parent of child with SMI
Staff: Tami Conrad (DHHS, Behavioral Health); James Knopik (DHHS, Behavioral Health); Kelli Ulberg (DHHS, Behavioral Health); Leah Jangula (DHHS, Behavioral Health), Shauna Eberhardt (DHHS, Behavioral Health);
Other: Chaz Brost (CFN President); Dr. Eduardo Yabut (ND State Hospital)

Call to Order
Chairperson McCleary called the meeting to order at 10:02 AM CT.

Approval of Minutes
Chairperson McCleary called for the approval of the May 17, 2023; meeting minutes as presented. MELANIE GAEBE MADE A MOTION AND CARL YOUNG SECONDED THE MOTION TO APPROVE THE MAY 17, 2023, MEETING MINUTES. THE MOTION WAS PASSED UNANIMOUSLY.

Approval of Agenda
Chairperson McCleary called for the approval of the agenda as presented. CHRISTINA BOND MADE A MOTION AND MATTHEW MCCLEARY SECONDED THE MOTION TO APPROVE THE JULY 19, 2023, AGENDA. THE MOTION WAS PASSED UNANIMOUSLY.

BHPC Updates
Tami Conrad provided the Behavioral Health Planning Committee updates and welcomed two new council members: Camille Redmann and Tania Zerr. Deb Jendro has resigned her position from the council and the Governor's office will be appointing a new member. Tami encouraged council members to share the open position with interested individuals and stated all applications for the council must be completed online on the governor's website.

North Dakota State Hospital Update
Dr. Eduardo Pelayo Yabut provided updates on the ND State Hospital.

North Dakota Pediatric Mental Health Care Access Program Update
Jenn Faul (Program Director, Sanford Health) provided updates on the ND Pediatric Mental Health Care Access Program.

Chairperson McCleary recessed the Council at 11:14 AM CT for a brief break and reconvened at 11:21 AM CT.

1915(i) Provider Status & Clients Served Update
Monica Haugen (DHHS, Behavioral Health Administrator for the 1915(i) program) provided data updates related to 1915(i) clients served and providers.

Chairperson McCleary recessed the Council at 11:52 PM CT for a lunch break and reconvened at 1:00 PM CT.

Mental Health Block Grant (MHBG) & Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG) Update
ND DHHS Behavioral Health Division staff members, Lacresha Graham, Laura Anderson, Shauna Eberhardt, James Knopik, Kelli Ulberg, Tami Conrad, and Heather Brandt provided updates on the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS) initiatives and discussed the upcoming combined application process. Council members provided feedback regarding gaps of behavioral health services in the state. The council was encouraged to continue to provide feedback of the combined application at any time. The application is available on the ND DHHS website at Community Mental Health Services Block Grant and Substance Use Prevention, Treatment and Recovery Services Block Grant | Health and Human Services North Dakota. Feedback can be provided by email to dhsbhd@nd.gov. The council will also receive the combined application draft when completed by email.

Behavioral Health Division Update
Pamela Sagness (Executive Director Behavioral Health Division, DHHS) provided updates on the Behavioral Health Division Updates.

BHPC Discussion Regarding Interim Study Positional Statements
Chairperson McCleary would like to schedule an Executive Committee meeting to prioritize which studies the council would like to focus on.

Summary Report of ND Behavioral Health Strategic Plan and Future Activities
Bevin Croft (Human Services Institute) provided updates on the Behavioral Health Strategic Plan and Future Activities.

Crisis Response Units Updates
Daniel Cramer provided an update on the regional team, dispositional data, impact of 988, and specialized population group response.

Lightening Round Resource Sharing
Kurt Snyder shared the open house for the new Heartview facility in Dickinson will be July 26, 2023.

The Behavioral Health and Children and Family Services Conference will be held October 24, 25, and 26 in Bismarck or virtually.

Public Comments
Chairperson McCleary called for any public comments. None were provided.

Next Meeting
The next BHPC meeting is scheduled for **October 18,, 2023**, via videoconference or in person at the Bismarck Office of Job Service, located at 1601 East Century.

Adjournment
Having completed all agenda items and hearing no further comments from BHPC members, Chairperson McCleary declared the meeting adjourned at 4:06 PM CT.

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August 28, 2023

Grants Management Specialist
Substance Abuse Mental Health Services Administration
Office of Financial Resources, Division of Grants Management
5600 Fishers Lane, 17E25D
Rockville, Maryland 20857

Dear SAMHSA:

On behalf of the North Dakota Behavioral Health Planning Council, I am pleased to submit to you this letter specific to the Combined Community Mental Services Block Grant and the Substance Use Prevention, Treatment, and Recovery Services Block Grant application.

The Council met to review the combined Block grant on July 19, 2023. Council members spent much of the day going over each section of the application, inquiring on details and providing suggestions to the Behavioral Health Division within the North Dakota Department of Health and Human Services. Council members were also given time to email any further recommendations to the Behavioral Health Division.

Since 2014, North Dakota has received several studies on North Dakota's behavioral health system. The most recent studies were the 2022 Schulte Report and the 2020 Human Services Research Institute (HSRI) Report. Both reports focused on the acute psychiatric needs of North Dakota. The studies responded to the perceived need for more acute psychiatric hospitalization options and beds. Both the Schulte report and the HSRI report found that there are certainly concerns with access to and monitoring of available hospital beds, but neither report endorsed the idea that North Dakota needed a substantial increase in the number of beds in the state. Instead, North Dakota did need to provide acute psychiatric service options in western North Dakota and provide more access to psychiatric stabilization services at community hospitals. These recommendations would serve to enhance North Dakota's crisis response system. Prior to this, North Dakota had relied on information gleamed from two reports: the 2014 Schulte Report and the 2018 HSRI Report. Both reports had many recommendations to end the North Dakota behavioral health systems "crisis" that Schulte had first outlined. These early studies warned that North Dakota did not have adequate community-based behavioral health services as outlined by federal law and that North Dakota needed to make a series of changes to meet federal standards of care throughout the continuum.

The North Dakota Behavioral Health Planning Council has been working with HSRI to guide and monitor the implementation of its 2018 study recommendations. There has been much progress made in the 13 major recommendations for improvement. Those recommendations are as follows:

1. Develop and implement a comprehensive strategic 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 with complex needs and their families
6. Continue to implement and refine the current criminal justice strategy
7. Engage in targeted efforts to recruit and retain a qualified and competent behavioral health workforce
8. Continue to expand the use of telebehavioral health interventions
9. Ensure the system reflects its values of person-centeredness, health equity, and trauma informed approaches
10. Encourage and support communities to share responsibility with the state for promoting high-quality behavioral health services
11. Partner with tribal nations to increase health equity for American Indian populations
12. Diversify and enhance funding for behavioral health
13. Conduct ongoing system-wide data-driven monitoring of need and access

While there has been much progress, much remains to be done. An area of focus that has consistently been a priority for the Council is Recommendation 5: "Enhance and streamline System of Care for children with complex needs and their families." Here many gaps remain. It is believed the System of Care grant will help us move the children's system in a more positive direction. Many of the activities in this aim are currently related to the System of Care Grant. While this grant is for two regions in the state, it is believed that we will be able to roll out further improvements to the other six regions. In addition, the Council has been focused on improving North Dakota's crisis response system. North Dakota has had a fairly successful launch of 988, thanks to FirstLink's prior experience with its 211 call center (which provided resources, referral, and crisis call support). In recent years, North Dakota has had to design and implement a crisis response system from the ground up. There are areas of improvement that the Council is advocating for including: enhancing service availability for rural communities, ensuring that all regions have crisis beds for adults, further improving mobile crisis teams, and developing a crisis bed system for children across all regions of the state.

Last year the Council welcomed several new council members: Paul Stroklund (representing consumer/family member), Mandy Dendy (representing Medicaid), Melanie Gaebe (Consumer, individual in Recovery for SUD, also employed through ND Alzheimer's Association), Dan Cramer (DHHS Behavioral Health Delivery System), Tania Zerr (Family member of a child with SED). The Council currently has three positions that need to be filled: Private Mental Health Provider, Adult with SMI, and the ND National Guard.

The North Dakota Behavioral Health Planning Council has been active in providing advice and guidance to the North Dakota Department of Health and Human Services and has been active in educating policymakers such as the North Dakota legislature about the status and needs of the state's behavioral health system. The Council oversees the HSRI Study Implementation process. Further, each of the 13 recommendations has a named Council member serving as a liaison between DHHS, HSRI, and the Council on the status of implementing that recommendation. The Council has received updates on the System of Care grant for children's mental health that North Dakota received. The Council has been actively monitoring the implementation of the state's 1915(i) State Plan Amendment; giving feedback about potential barriers for providers and consumers and family members alike. The Council has also provided substantial support for increasing the prominence and availability of peer support services and the peer support workforce throughout the state.

The Council has taken positions on critical issues facing the state regarding behavioral health system reform. The Council took a position in support of the building of a new State Hospital that is designed for best practices (e.g., ensuring that the architecture is safe and therapeutic). The Council intensely studied the issue of IMD Exclusion and IMD Exclusion Waivers, taking the position that North Dakota should not pursue an IMD Exclusion Waiver,

but should instead ensure North Dakotans have ample access to community-based behavioral health services. The Council was instrumental in advancing the importance of ensuring the state of North Dakota funded 988 services after federal funding decreased. Lastly, the Council has also supported the creation of Certified Community Behavioral Health Clinics in North Dakota.

The Council understands that the block grant programs are used for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. ND's objectives toward achievement of this overall goal are generally determined by the Department of Health and Human Services itself. The Council is becoming more educated in its role in this regard and will work with the Department of Health and Human Services to ensure that the Council is meeting its role.

Sincerely,

Carlotta McCleary

Carlotta McCleary
Behavioral Health Planning Council, Chair

Environmental Factors and Plan

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.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Brenda Bergrud	Providers	Consumer Family Network ND		
Christina Bond	Providers	North Dakota National Guard		
Dan Cramer	State Employees			
Lorraine Davis	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Mandy Dendy	State Employees			
Melanie Gaebe	Others (Advocates who are not State employees or providers)			
Michelle Gayette	State Employees			
Denise Harvey	State Employees			
Brad Hawk	State Employees			
Jennifer Henderson	State Employees			
Cheryl Hess-Anderson	State Employees			
Andrea Hochhalter	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Deb Jendro	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Glenn Longie	Providers			
Michelle Masset	State Employees			
Carlotta McCleary	Others (Advocates who are not State employees or providers)			
Matthew McCleary	Providers			

Dr. Lisa Peterson	Others (Advocates who are not State employees or providers)			
Amanda Peterson	State Employees			
Emma Quinn	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Camille Redmann	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Pamela Sagness	State Employees			
Michael Salwei	Others (Advocates who are not State employees or providers)			
Mark Schaefer	Others (Advocates who are not State employees or providers)			
Kurt Snyder	Others (Advocates who are not State employees or providers)			
Paul Stroklund	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Dr. Amy Veith	State Employees			
Tim Wicks	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Carl Young	Parents of children with SED			
Tania Zerr	Parents of children with SED			

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	5	
Parents of children with SED	2	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	6	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**15**	**50.00%**
State Employees	11	
Providers	4	
Vacancies	0	
Total State Employees & Providers	**15**	**50.00%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	2	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**30**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

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:

https://www.hhs.nd.gov/publications-behavioral-health-division

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes: