North Dakota

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/29/2025 11.02.22 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	GSKXYGKGX6A4

I. State Agency to be the SUPTRS BG 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 SUPTRS BG Grantee of the Block Grant

First Name	Lacresha
Last Name	Graham
Agency Name	North Dakota Department of Health & Human Services - Behavioral Health Division
Mailing Address	600 E Boulevard Ave
City	Bismarck
Zip Code	58505
Telephone	701-328-8922
Fax	701-328-8969
Email Address	lgraham@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	Tiffany
Last Name	Pinckney
Agency Name	ND Dept. of Health & Human Services - Behavioral Health Division
Mailing Address	600 E Boulevard Ave
City	Bismarck
Zip Code	58505
Telephone	701-328-7946
Fax	701-328-8969
Email Address	tpinckney@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	Laura
Last Name	Anderson
Telephone	701-328-8918
Fax	
Email Address	lauranderson@nd.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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: Pamela Sagness

Signature of CEO or Designee[1]: _____

Title: Executive Director, Behavioral Health Division

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: 05/28/2025 Expires: 01/31/2028

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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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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: North Dakota

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

Signature of CEO or Designee[1]:

Title: Executive Director

Date Signed: 07/21/2025

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: 05/28/2025 Expires: 01/31/2028

Footnotes:

NORTH Dakota | Office of the Governor

Be Legendary.™

March 7, 2025

Ms. Odessa Crocker
Manager of the Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Crocker:

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 Executive Director of the Behavioral Health Division of the North Dakota Department of Health and Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to Ms. Sagness at the Department of Health and Human Services' Behavioral Health Division, 600 E Blvd Ave, Bismarck, ND 58505 Dept. 328.

Sincerely,

Kelly Armstrong
Governor

State Information

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

Fiscal Year 2026

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Executive Director, Behavioral Health Division

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: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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 II of the Public Health Service Act		
Section	**Title**	**Chapter**
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.

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.

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]:

Title: Executive Director Date Signed: 07/21/2025

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: 05/28/2025 Expires: 01/31/2028

Footnotes:

NORTH Dakota | Office of the Governor

Be Legendary.™

March 7, 2025

Ms. Odessa Crocker
Manager of the Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Crocker:

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 Executive Director of the Behavioral Health Division of the North Dakota Department of Health and Human Services.

All correspondence regarding the above-mentioned grants should continue to be sent to Ms. Sagness at the Department of Health and Human Services' Behavioral Health Division, 600 E Blvd Ave, Bismarck, ND 58505 Dept. 328.

Sincerely,

Kelly Armstrong
Governor

North Dakota

BSCA funding plan 2026

September 1, 2026, to September 30th, 2028

Crisis 5%:
North Dakota will utilize BSCA supplemental funds to expand behavioral health crisis services through a primary focus on enhancing services for youth. The State will collaborate with agencies to provide crisis response trainings with a youth-focus to providers identified in the statewide plan. Funding will also be utilized to enhance existing workforce and additional infrastructure associated with our system of care initiatives to focus on someone to talk to, someone to respond, and a safe place to be.

FEP 10%:
The 10% set-aside supporting interventions for individuals with mental illness, particularly youth with SMI/SED, will continue to support expansion of North Dakota's First Episode Psychosis teams. Funding will be used for on-going evidence-based training and consultation for service providers working with young adults and youth with SMI/SED, including attendance at a national conference and expanding upon workforce.

Remaining funds will also be used to support youth crisis supports and expansion of workforce.

Crisis 5%	Training for HSC crisis staff on youth-specific interventions	6,293.00
FEP 10%	FEP staff training and consultation, workforce expansion	12,586.00
Remaining	Workforce and infrastructure enhancements for youth crisis services	106,981.00
Total		**125,860.00**

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: 05/28/2025 Expires: 01/31/2028

Footnotes:
Not applicable. ND HHS does not engage in lobbying activities.

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 prevention system (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 behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. 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."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

On September 1, 2022, the North Dakota Department of Health and the North Dakota Department of Human Services merged to become the North Dakota Department of Health and Human Services (HHS). 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, State-Operated Community Behavioral Health Clinics (previously known as the Human Service Centers), and the State Hospital.

The Policy Team within the Behavioral Health Division (NDCC 50-06-01.4) is 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 State-Operated Community Behavioral Health Clinics and State Hospital function was 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 (both youth and adults) with behavioral health disorders, and rehabilitative services designed to restore functioning and quality of life.

There are eight State-Operated Community Behavioral Health Clinics, accredited by the Council on Accreditation, with 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.

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 years 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.

There are several differences between the child and adult system, although they both operate within the eight State-Operated Community Behavioral Health Clinics. For children, outpatient services in the public sector are provided via a team-based model within the clinics, utilizing several evidence-based models including Functional Family Therapy (FFT), and Multi-Systemic Therapy (MST). Outpatient adult services are team-based and there are several residential options for adults including Crisis Residential Units, Transitional Living, and ASAM Level 3.5 and 3.1, which are subsequently licensed by the Behavioral Health Division's Policy Team. Crisis services are operated within the state-operated behavioral health centers; however, children do not currently have access to the Crisis Residential Units (CRU), and specialized mobile crisis services for youth are not available outside of the mobile response teams within the clinics.

In the past several years the public behavioral health system has focused on expanding the twenty-four-hour crisis services available. Crisis stabilization facilities for adults 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 receive short-term, recovery-focused services with the goal of resolving the crisis. Services also include withdrawal management, supportive therapy and referral to any additional services needed. Trained mobile crisis staff members

partner with 988 and are deployed to meet a person in crisis where they are, assess for risk of harm to self/others, help problem-solve the crisis situation, and assist the individual in accessing the least restrictive level of care needed. The current goal for crisis service enhancement is to support these mobile crisis teams in youth and family-specific interventions and support.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

The vision of HHS is to make North Dakota the healthiest state in the nation. HHS is an umbrella agency headed by Interim Commissioner Patrick Traynor who was appointed by Governor Kelly Armstrong on June 2, 2025. 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 behavioral health services and the state institution for individuals needing inpatient psychiatric services.

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).

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

A theme that emerged from the 2018 North Dakota Behavioral Health System Study is that North Dakota's behavioral health system, like many others throughout the country, was dedicating a majority of its resources into residential, inpatient, and other institution-based services, investing relatively fewer dollars 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 System Study: (1) support the full continuum of care; (2) increase community-based services; and (3) prevent criminal justice involvement.

The full continuum of care for individuals in need of services for substance use disorders and mental health is supported through services provided by North Dakota's network of public and private local providers at local, county, regional, and tribal levels.

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, and coalitions supported by the SUPTRS, State Opioid Response (SOR) grant and other funding sources. The SSA directly provides a combination of direct services, funding for community prevention efforts, training and technical assistance, and media/communication to communities across the state. Both state and community-based processes are guided by the Strategic Prevention Framework.

Through the previous Strategic Prevention Framework-State Incentive Grant (SPF-SIG) and Strategic Prevention Framework-Partnership For Success (SPF-PFS) awards and current PFS and SUPTRS prevention set aside, substance use prevention has been integrated into local public health units and Tribes across the state. This integration has been beneficial to the state's community-level prevention system in building a sustainable infrastructure through continued support by the SUPTRS.

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. Under this decentralized approach, the units are required to meet state standards and follow state laws and regulations as they exercise their own administrative authority to make decisions to meet their local needs.

North Dakota tribal nations operate prevention programs and tribal public heath units with financial support through SUPTRS via NDDHHS. 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 demonstrates one of the strengths of the ND Substance Use Prevention System – longstanding collaboration with the tribes in the state.

During the 2021 legislative session, North Dakota lawmakers passed Senate Bill No. 2161 allowing for 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 237 organizations, with 313 locations registered in the mental health program directory.

North Dakota Century Code requires the Behavioral Health Division Policy Team to license substance use disorder treatment programs in operation in the state. Currently 104 programs are licensed throughout the state (programs may be licensed for treatment and/or early education [ASAM 0.5]). The requirement that all substance use disorder programs operating in the state be licensed assists the Division to identify the levels of care available in various areas of the state and to identify gaps.

Attention to the MHBG and SUPTRS BG priority populations

SMI

Through the public behavioral health service delivery system in North Dakota, individuals diagnosed with a serious mental illness (SMI) are typically provided services through Integrated Team-based Treatment Care at a regional Community Behavioral Health Clinic. All individuals presenting for services at the regional Community Behavioral Health Clinics are screened during their intake process or multidisciplinary case staffing to determine service needs. The process begins with the completion of a screening and triage, or risk assessment, followed by the Daily Living Activities (DLA-20), a functional assessment, with transition into a full diagnostic assessment.

The State is currently in the planning grant stage of rolling out Certified Community Behavioral Health Clinics (CCBHC). Up to four of the state-operated community behavioral health clinics will become certified in the next several years. As such, there are several areas targeted for enhancement and focus, including serving justice-involved individuals, Veterans, and the increase utilization of care coordination.

Core services at the regional Community Behavioral Health Clinics are offered through the Integrated Team-based Treatment teams and follow integrated specialty care and evidence-based models. They are provided either directly at the clinics or through public/private provider partnerships or contracts. Core services include SUD services, crisis services, case management, medication services, peer support, psychiatric and psychological services, and psychosocial rehabilitation. There are also an array of clinical services available at the clinics, including individual therapy, group and family therapy, and intensive case management. The clinics utilize several evidence-based modalities such as Assertive Community Treatment (ACT) and Integrated Dual Disorder Treatment (IDDT). Other adopted best practices and evidence-based interventions utilized at the clinics include Cognitive Behavioral Therapy, Motivational Interviewing, Accelerated Resolution Therapy (ART), Eye-Movement Desensitization and Reprocessing (EMDR), and behavioral interventions.

Additional community-based support is available for individuals with SMI through the Community Connect program, which was designed as a low-barrier service to prevent deeper system involvement. Services offered by provider agencies include care coordination, peer support, and recovery support. Individuals may utilize Community Connect as stand-alone services, or in conjunction with other professional services.

To better serve those residing at a North Dakota Department of Corrections and Rehabilitation (DOCR) facilities, NDDHHS currently contracts with a telehealth provider who assists with psychiatric medications. Additionally, the state-operated community behavioral health clinics provide both telehealth and in-person assessments, therapy, and psychiatric services in jails. Individuals on North Dakota parole or probation may be eligible to receive community-based supportive services through Free Through Recovery, a program designed to divert individuals from returning to the criminal justice system simply due to a mental health disorder or a substance use disorder that could be managed with community-based support. Through a network of participating providers, Free Through Recovery offers justice-involved individuals an ongoing source of connection, assistance with accessing treatment and recovery support services, and care coordination and peer support to address barriers to their success.

Lastly, North Dakota law enforcement agencies can access Avel eCare virtual crisis services through an effort funded in the 2023 and 2025 North Dakota Legislative Sessions. AVEL provides law enforcement with 24/7 access to behavioral health professionals who can assist in responding to people experiencing a mental health crisis. The program virtually connects law enforcement with behavioral health professionals to assist with de-escalation, stabilization and safety assessment during crisis situations regardless of location. The regional state-operated behavioral health clinics are also provided information for people who have utilized this service and follows up within 24-48 hours to provide support and information for regional mental health services. This service is extremely beneficial to rural law enforcement agencies, often resulting in the person staying safety in the community and not needing a higher level of care.

North Dakota was approved to implement a 1915(i) Medicaid State Plan Amendment, increasing access to home and community-based services for both youth and adults. Since 2021, services 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 employment, supported education, housing support services, family peer support, and peer support.

SED

North Dakota's public community behavioral health system provides services for children diagnosed with serious emotional disturbance (SED.) The State Operated Behavioral Health Clinics offer an array of services for children such as outpatient individual, group, and family therapy, psychiatric care, case management, and rehabilitation services. 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 system two evidence-based programs. Multi-Systemic Therapy (MST) targets youth and their families who are at high risk for out-of-home placement due to their behavioral health. Functional Family Therapy provides intensive, in-home services for youth and their families. The State's First Episode Psychosis Program, Healing, Empowering, and Learning about Psychosis (HELP) also serves youth and young adults experiencing a first or early episode of psychosis. This program aligns with the Coordinated Specialty Care Model.

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, which involves comprehensive assessment, care planning, and ongoing connection to services and support for children and youth with complex needs as well as Title 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 of transforming the behavioral health system of care in the state.

Other support/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.
• Partial Hospitalization Program (PHP): This service is an intensive outpatient mental health treatment option that provides structured, daily therapy sessions without requiring overnight stays. PHP involves daily treatment sessions, typically lasting six to eight hours for five days a week. This short-term, intensive day treatment is designed for youth with behavioral health and co-occurring substance use conditions, providing a structured environment that prioritizes recovery and connection to local resources. The average length of stay in PHP is 3-4 weeks. The program will include integrated educational services, comprehensive care and discharge planning with community mental health providers, schools and other child serving systems.
• Psychiatric Residential Treatment Facilities: A facility or a distinct part of a facility that provides children and adolescents with a twenty-four hour per day 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 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.
• 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 are not limited to, skills training and counseling.
• Other Supportive Services: Acute, Psychological Services, and psychiatric services are available through the regional state-operated behavioral health clinics.

Several legislative bills passed during the state's 2019 legislative session supported 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 the Protection and Advocacy Project. The purpose of this cabinet is to assess, guide, and coordinate the care for children across the state branches of government and tribal nations. The Children's Cabinet was also intended to assist with the coordination of payment structures for services designed to support children with SED and their families. This cabinet assures cross-department communication and opportunities to creatively braid funding for comprehensive supports and services.

North Dakota was awarded a Substance Abuse and Mental Health Services (SAMHSA) System of Care (SOC) Expansion and Sustainability Grant in September 2022 to enhance mental health outcomes for children and youth. The purpose of the grant is to build and expand a comprehensive set of community-based behavioral health services and supports for children and youth with serious emotional disturbances (SED), birth – age 21, and their families. The grant focuses on two geographical catchment areas: Lake Region Community Behavioral Health Clinic (Devils Lake) partnering with both public and private providers in six counties in the region and West Central Community Behavioral Health Clinic partnering with both public and private providers in 10 counties in the region. These two regions include four tribal nations: Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians and Mandan Hidatsa Arikara Nation.

North Dakota System of Care grant initiative aligns with the Behavioral Health Strategic Plan, AIM 5 - to enhance and streamline a system of care for children with complex needs and their families. The two primary goals include: (1) to increase access to high-quality and culturally appropriate services and supports for children with SED and their families in the identified regions and (2) to develop a sustainable infrastructure to support the System of Care approach for North Dakota children with SED and their families.

In the current Grant Year 3, service implementation includes partial hospitalization/intensive day treatment, Functional Family Therapy, Parent and Caregiver Peer Support, and expansion of both school and community-based, evidence-based treatment and care coordination.

Service Highlights include:
-The opening of a Child and Adolescent Partial Hospitalization Program in Bismarck (April 2025)
-The launch of Parent and Caregiver Peer Support training and integration of parent peers in Community Behavioral Health Clinics.
-Investments in local service expansion including community and school-based services:
-Group evidence-based treatments (SPARCS, Seeking Safety)
-Expanding the number of clinical providers in rural and tribal communities
-Training and workforce development in evidence-based practices
-Early childhood interventions including Child Parent Psychotherapy (CPP), Parent Child Interaction Therapy (PCIT), and Child Parent Relationship Therapy (CPRT)
-Care coordination
-Supporting the expansion of FamilyFirst Prevention services including Functional Family Therapy (FFT), Family Check Up, and Healthy Families

Through the SOC grant, the Department has developed a contract with University of Connecticut Innovations to develop a roadmap for North Dakota to implement High Fidelity Wraparound for children with complex needs and at risk for out of home placement.

The System of Care initiative has prioritized developing partnerships locally, regionally, and statewide across child-serving systems. SOC Regional Steering Committees have convened since April 2023 and bring together stakeholders from Human Service Centers, private behavioral health providers, hospitals, child welfare, juvenile justice, schools, tribal communities, family organizations, and youth and parents with lived experience. The steering committees guide and advise grant implementation and develop local priorities and action planning. Each of the regional steering committees have created working groups related to the youth crisis continuum, care coordination, and service array.

ESMI
There are two First Episode Psychosis programs within North Dakota, entitled "Healing, Empowering, and Learning about Psychosis (HELP)" operating within the State-Operated Community Behavioral Health Clinics. One operates in the southeast region and the other in the south central region. These programs serve individuals age 15-35 with the experience of early psychosis. Referrals to the program are managed through an outreach and engagement position funded by mental health block grant. The southeast program currently includes all elements of the coordinated specialty care model, while the south central program has most elements with the exception of supportive education and employment, which is referred through community partnerships.

BHCS (crisis services)
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 FirstLink for crisis intervention. FirstLink, the 988-call center (crisis contact center), is available to all ND citizens statewide. If the crisis cannot be resolved via the phone/text encounter, the crisis contact center connects to a behavioral health professional available twenty-four seven at one of the eight regional state-operated behavioral health clinics. Each region has a behavioral health team (mobile crisis response team) available for mobile outreach during the crisis within a forty-five-mile radius. The Southeast community behavioral health clinic also contracts with a private provider to expand mobile crisis response in the city and surrounding areas. The state is collaborating with the private provider to determine their capacity to expand their mobile crisis response to other areas of the state. Citizens may also walk into the community behavioral health clinic to receive screening, triage, assessment and crisis intervention during business hours. In seven of the eight regions, the community behavioral health clinics have crisis residential units (CRU or Crisis Receiving and Stabilization Facilities) that provide varying levels of crisis stabilization services offered twenty-four seven. Lake Region community behavioral health clinic is the only region that does not have a crisis residential unit due to workforce. Lake Region collaborates with other regions to assist individuals needing that level of service and continues to identify resources for support.

North Dakota law enforcement agencies can access Avel eCare virtual crisis services through an effort funded in the 2023 and 2025 North Dakota Legislative Sessions. AVEL provides law enforcement with 24/7 access to behavioral health professionals who can assist in responding to people experiencing a mental health crisis. The program virtually connects law enforcement with behavioral health professionals to assist with de-escalation, stabilization and safety assessment during crisis situations regardless of location. The regional state-operated behavioral health clinics are also provided information for people who have utilized this service and follows up within 24-48 hours to provide support and information for regional mental health services. This service is

extremely beneficial to rural law enforcement agencies, often resulting in the person staying safety in the community and not needing a higher level of care.

North Dakota also continues to work to build infrastructure, provide training opportunities and education to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances.

The Department contracted with FirstLink, the 988-call center (crisis contact center) to provide trainings to agencies for assistance in training on the Columbia- Suicide Severity Rating Scale, a screening for suicide risk. Going forward, the Department will be working with Emergency Medical Services to provide these trainings across North Dakota.

The Department contracted with an entity to provide Accelerated Resolution Therapy (ART). Approximately 210 public and private mental health clinicians have been trained in ART. ART is recognized as an evidence-based treatment for psychological trauma and depression, often effective in one to two sessions. The Department focused statewide trainings for rural mental health providers and those providing crisis services. Special populations addressed through the trainings were tribal communities and mental health clinicians working with youth. Monthly consultation services are provided by an ART master level trainer to enhance ART services after training is completed.

The Department has continued to work on enhancing Critical Incident Stress Management (CISM) services within the state by supporting several events to integrate first responder agencies and mental health services. ND provided four statewide Critical Incident Stress Management (CISM) trainings, which included first responder and public and private mental health professionals as attendees. The Department has continued to collaborate with the ND CISM team and provides additional support for licensed mental health clinicians to attend CISM defusing and debriefing events. The contracted CISM trainer is also providing consultation services for technical assistance to enhance services of staff working in the community behavioral health clinics. The Department has held two first responder cultural competency for mental health clinician events in the state to enhance mental health clinician's knowledge of first responder mental health needs.

The Department continues to support first responder mental health needs by contracting with ten mental health clinicians across the state to provide agency engagement activities with local, regional and state first responders. These clinicians are trained in CISM and trauma informed treatment modalities effective with first responders. The clinician's also block one hour of clinical time weekly to provide first responders with access to services within 72 hours of request.

The Department provides statewide rural mental health outreach services by a licensed mental health clinician who also conducts Question, Persuade, Refer (QPR) trainings in each region. The clinician provides several free webinars on various mental health topics, along with information on resources and supports in the state. The webinars are recorded and accessible on the Department website.

The Department is also working to provide training and technical assistance on 988 and the connection to crisis mobilization services regionally. Regional efforts have included training school, child welfare, and other child-serving professionals on What Happens When You Call 988 and introducing Crisis Mobilization Teams in-person. The training and partnership building aims to increase the utilization of the crisis continuum for behavioral health needs and reduce law enforcement involvement and emergency room visits when a child can be stabilized in the community.

PPW
North Dakota ensures pregnant individuals seeking outpatient addiction treatment services are given priority status at all eight regional State Operated Behavioral Health Clinics. At the point of initial contact, individuals are screened for pregnancy and, if confirmed, are provided with priority status for treatment and services.

Since 2019, North Dakota has not had a residential addiction treatment program exclusively serving pregnant and parenting women. Despite issuing three separate Requests for Proposals (RFPs) that focused on and aligned with best practices for serving pregnant and parenting women and their dependent children, no proposals were received.

To address this critical gap in service, the Policy Team requested and was allocated one-time funding during the 2023 Legislative Session to aid a provider with construction and/or renovation costs to secure a location for residential addiction treatment specifically for pregnant and parenting women. North Dakota entered into a grant agreement with a provider in 2024, and the funding to support the construction of a new purpose-built facility dedicated to residential addiction treatment program for pregnant and parenting women and their children has since been expended.

The new residential addiction treatment program for pregnant and parenting women and their children is set to be fully operational by September 1, 2025, with the capacity to serve 16 women and their children. This family-centered model will allow pregnant and parenting women to have their children reside with them at the treatment program while they receive comprehensive addiction treatment services. This approach supports overall wellness, maternal recovery and family stability, promoting healthier outcomes for women, children, and families.

To ensure long-term sustainability of the program, North Dakota intends to utilize a combination of SUPTRS block grant funding

and allocated state general funds to support ongoing operations, maintenance, and ancillary services once the program is fully operational.

PWID
The State Operated Behavioral Health Clinics have adopted open access assessment services and each individual seeking an assessment receives triage and screening for injection drug use. If an individual does identify as using drugs intravenously, they are given priority status and an assessment is completed that day. If an assessment is not possible that same day, it is completed within 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 receives priority placement on the wait-list and is offered interim services to include engagement group, case management and/or a referral to education-based programming.

TB
The State Operated Behavioral Health Clinics have incorporated TB 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 reviews are completed by the Behavioral Health Division Policy Team to ensure the programs are complying with this requirement.

PRSUD (tx)
As one of its foremost priorities, the Behavioral Health Division Policy Team promotes a recovery-oriented service delivery system. The Policy Team continually strives to address the needs of people over time and across different levels of ability, 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. Several items within North Dakota's current substance use disorder service delivery system are worth noting:
Advocacy: The Behavioral Health Division Policy Team provides funding to support a consumer-run advocacy program to assist in more effectively responding to the needs of children, youth, and young adults with serious emotional disturbances (SED) and their families; provide information, referrals, and support; increase the quality of and access to mental health services; assist consumers to be the catalyst for transforming the mental health service system; and increase positive messaging while reducing the stigma associated with a mental health diagnosis.

Recovery Centers: Eight Recovery Centers (one in each region throughout the state) employ peer staff and are contracted through the State Operated Community Behavioral Health Clinics or operated 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 both structured and unstructured activities including job coaching, wellness groups, educational programs, and skills training as well as volunteer opportunities. They have connected with Peer Support Specialists within each Community Behavioral Health Clinic to expand membership and offer collaborative opportunities.

Peer Support: The 2018 North Dakota Behavioral Health System study recommendation 7.6 related to establishing a training/credentialing program for peer services, and recommendation 7.8 related to supporting a robust peer workforce through training, professional development, and competitive wages.

Since 2018, the Behavioral Health Division Policy Team has facilitated 54 Peer Support trainings in partnership with Appalachian Consulting, training over 1,400 individuals as Peer Support Specialists. The Division offers ongoing continuing education opportunities for peers, peer supervisors and behavioral health providers working towards integrating peer support services into their service delivery model.

During the 2019 legislative session, several bills were passed to expand peer support services. North Dakota Medicaid added Peer Support Specialists as covered service providers for individuals with a qualifying behavioral health condition. Senate Bill 2012 created a new section of century code to provide funding to implement the expansion of Free Through Recovery separate from the criminal justice system, paving the way for the launch of the Community Connect program in February 2021. The Behavioral Health Division was also given authority to write administrative rules for the certification of Peer Support Specialists.

On July 1, 2020, the Behavioral Health Division Policy Team began certifying Peer Support Specialists. As of June 2025, there are 514 Certified Peer Support Specialists in North Dakota. Certification ensures standardized training and improved regulation of reimbursement while helping to meet the growing demand for behavioral health support services in North Dakota.

The 1915(i) Medicaid State Plan Amendment includes reimbursement for Peer Support Specialists and Family Peer Support Specialists.

Community Connect: 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 assists individuals to meet their needs and goals through the provision of peer support and care coordination. Throughout North Dakota, Community Connect is

currently serving approximately 1,462 participants, and Free Through Recovery is currently serving approximately 1,500 participants. Community Connect serves individuals with mental health disorders as well as substance use disorders.

SUD Voucher: North Dakota has administers a Substance Use Disorder (SUD) treatment voucher program since 2016. The SUD Voucher increases access to quality addiction treatment services and allow individuals to choose where they receive services. SUD Voucher funding continues into the 2025-2027 State Biennium to support individuals ages 12 and older who meet the income eligibility requirement and need substance use disorder treatment. During the 2025 legislative assembly, authority and funding was granted to expand the SUD Voucher program to pay for medical costs for individuals whose Medicaid is suspended due to accessing a program deemed an Institute for Mental Disease (IMD). The North Dakota Substance Use Disorder (SUD) voucher, which funds recovery support services, also includes peer support as a reimbursable service.

Telephone Recovery Support: The Behavioral Health Division contracts with a vendor to provide telephone recovery support called Recovery Talk, which allows individuals to call or text a Peer Support Specialist twenty-four hours a day, seven days a week. The service is free and confidential, and individuals may remain anonymous. The program also allows individuals to request outreach from a Peer Support Specialist on a regular basis for additional support in their recovery.

Recovery Housing Assistance Program: During the 2019 legislative assembly, the State established the Recovery Housing Assistance Program (RHAP) through dedicated state funding. RHAP supports individuals in early recovery by reducing financial barriers to accessing recovery housing. The program aims to expand access to supportive, best-practice recovery environments and improve health and stability outcomes.

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Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of 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 should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, 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, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Over the past decade, 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. 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. In July 2025, the Human Services Research Institute and Behavioral Health Planning Council conducted a thorough review of progress and re-prioritized needs and gaps. This will lead to revised strategic goals to come out in the fall of 2025.

North Dakota has a 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'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).

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.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

The 2018 HSRI report on the North Dakota behavioral health system 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 with additional information provided on the links to the MHBG and SUPTRS BG priority populations.

1. Develop a comprehensive implementation plan.
2. Invest in prevention and early intervention. [SUPTRS Priority Population: Individuals in Need of Primary Substance Use Prevention (PP)]
3. Ensure all North Dakotans have timely access to behavioral health services. [SUPTRS Priority Populations PWWDC, PRSUD, Co-occurring; MHBG Priority Populations SMI, SED, BHCS]
4. Expand outpatient and community-based service array. [SUPTRS Priority Populations PRSUD, Co-occurring, Persons experiencing homelessness; MHBG Priority Populations SMI, SED, ESMI]
5. Enhance and streamline system of care for children and youth. [MHBG Priority Population SED]
6. Continue to implement/refine criminal justice strategy. [SUPTRS Priority Population PRSUD]
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. [MHBG Priority Populations SMI, SED]
11. Partner with tribal nations to increase health equity. [SUPTRS Primary Population PRSUD]
12. Diversify and enhance funding for behavioral health.
13. Conduct ongoing, system-wide, data driven monitoring of need and access

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans

should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Invest in prevention and early intervention [SUPTRS Priority Population: Individuals in Need of Primary Substance Use Prevention (PP)]

North Dakota utilizes SUPTRS primary prevention set-aside to support local implementation of substance use primary prevention efforts through contracts with Local Public Health Units and Tribes. 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 use prevention priorities of underage drinking and adult binge drinking.

All prevention providers funded with SUPTRS must follow the SPF process where the first step is to complete a needs assessment. They collect and review data to determine local priority areas, priority populations and any unmet needs. Prevention providers are then contractually required to complete a strategic plan, build capacity, implement evidence-based prevention strategies and evaluate their efforts. All local efforts are aligned with the state's strategic plan including the priority populations and activities.

The state provides support to local prevention providers through capacity building efforts in the form of training and technical assistance. Training and technical assistance is focused on supporting the State's prevention strategic plan including the identified priority populations and any unmet service needs. Several training events occur with this focus and are required events for all prevention providers funded with SUPTRS prevention set-aside.

Ensure all North Dakotans have timely access to behavioral health services [SUPTRS Priority Populations PWWDC, PRSUD, Co-occurring; MHBG Priority Populations SMI, SED, BHCS]

Pregnant & Parenting Women program
To address unmet service needs and close critical behavioral health gaps identified in the 2018 HSRI report, North Dakota is aligning Block Grant-funded initiatives with the recommended system improvements and priority population needs. A key component of North Dakota's strategy to address behavioral health service gaps is the establishment of a new residential treatment program for pregnant and parenting women and their children. Scheduled to be fully operational in Fall 2025, the new facility will serve up to 16 women and their children, providing trauma-informed, family-centered care that promotes recovery while preserving the parent-child bond and keeps families together. This initiative aligns with North Dakota's broader strategy to ensure timely access to behavioral health services, expand the community-based service array, and uphold person-centered, culturally competent and equitable care. In partnership with local providers, the program also supports workforce development and reflects principles outlined in the 2018 HSRI recommendations. By addressing the complex needs of individuals with co-occurring conditions and other behavioral health challenges, this residential treatment program for pregnant and parenting women and their children directly supports the SUPTRS Block Grant priorities for serving vulnerable and underserved populations.

Residential services through public clinics
Through targeted funding of public residential addiction treatment programming for individuals with high-intensity needs, the Block Grant has removed financial barriers to ensure these critical services remain accessible, support long-term recovery for vulnerable populations, and fill the residential gaps in the continuum of care. These residential programs prioritize populations most at risk, including pregnant women, individuals who use intravenous drugs, and those without the financial means to access treatment.

Crisis support for first responders
The expansion of crisis support has been a primary area of focus for the State, specifically for first responders who are at high risk of trauma-related disorders and suicide. Over the past several years, the Department has allocated funding to support cultural competence training for providers specific to the needs of first responders. Additionally, funding was utilized to support contracts with those providers to set aside time to support individual therapy opportunities for first responders. Critical Incident Stress Management training was also provided to multiple private and public clinicians across the state and these trained providers are available to provide Critical Incident Stress Debriefs with first responders across the state who experience difficult calls.

Expanding youth crisis supports
Youth crisis remains an area of growth for the State. Over the past biennium, the Department has supported several training opportunities for clinicians to expand their practice towards youth-specific needs. Accelerated Resolution Training specifically for youth providers was facilitated to promote evidence-based intervention, providing brief relief to youth who have experienced traumatic stress. Additionally, the Treatment Collaborative for Traumatized Youth was provided additional funding to expand their trainings of Trauma-Focused Cognitive-Behavioral Therapy for youth providers in the state, treating individuals with Severe Emotional Disturbance (SED) in outpatient and psychiatric residential treatment settings. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) trainings have been provided to train community-based clinicians and school personnel to co-facilitate groups in community and school settings. An on-going initiative is to address the youth mobile crisis response service to enhance providers understanding of MRSS best practices.

The Department is working to provide training and technical assistance on 988 and the connection to crisis mobilization services regionally. Regional efforts have included training school, child welfare, and other child-serving professionals on What Happens When You Call 988 and introducing Crisis Mobilization Teams in-person. The training and partnership building aims to increase the utilization of the crisis continuum for behavioral health needs and reduce law enforcement involvement and emergency room visits when a child can be stabilized in the community.

Expand outpatient and community-based service array [SUPTRS Priority Populations PRSUD, Co-occurring, Persons experiencing homelessness; MHBG Priority Populations SMI, SED, ESMI]

To address service gaps identified in the statewide needs assessment and support the expansion of outreach and community-based care, North Dakota continues to fund a Fargo-based mobile outreach program (MOP), targeting individuals with substance use disorders, co-occurring conditions, and those experiencing homelessness which are all key priority populations under the SUPTRS Block Grant. The Fargo MOP program operates during peak usage times, utilizing a staffed mobile unit to provide on-site engagement, transportation, education and crisis intervention for individuals in need of intoxication or withdrawal management services. This program is designed to reduce reliance on emergency services, the program ensure recovery-oriented, trauma informed, and person-centered care. Services that are provided include overdose prevention, naloxone distribution and direct connection to treatment and recovery resources. The program is guided by a community advisory committee and adheres to all applicable state and federal regulations and requirements. Data collection, outcome reporting and sustainability planning are integral components of the program, supporting transparency, continuous improvement and long-term effectiveness. This program strengthens the community-based service array, reduces system strain, and enhances access for underserved populations.

Over the past biennium, the Department has continued to utilize MHBG funds to support the First Episode Psychosis programs to screen and provide services to individuals experiencing an early episode of psychosis. The state-operated community behavioral health clinic in the Southeast region currently serves 22 individuals and the clinic in the Southcentral region is currently receiving training and technical assistance to start a partial program. The Department has also continued to fund a contract to provide a fidelity review and participate in the strategic plan through the University of North Dakota. Additional funding has been used to support on-going clinical consultation, training, and technical assistance through Dr. Tully. This contract includes a training curriculum offered to all licensed mental health professionals in the state to build capacity for providing services to individuals with psychosis in rural areas not served by a FEP program. Lastly, MHBG funds have been utilized to contract an outreach and engagement position to target stakeholder agencies for education regarding early episode psychosis and the need for early intervention. This individual also supports the referrals directly to the teams. Additional efforts are currently being made to support expansion to the Western part of the state.

Enhance and streamline system of care for children and youth [MHBG Priority Population SED]
Psychiatric residential treatment facilities (PRTF) serve youth with SED whose needs cannot be safely managed at a lower level of care. These facilities are required to admit youth both emergently and planned when a recommendation is received from a psychologist or psychiatrist. The Department licenses these facilities and promotes quality clinical care through funding additional supports and trainings. Over this past grant cycle, the MHBG was utilized to support facility grants for sensory needs to support youth in crisis, shifting away from seclusion and restraint procedures. Additional funding has been provided to support training for staff in trauma-informed methods of care including Accelerated Resolution Therapy (ART) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Efforts to leverage funding towards supporting the full continuum of care will continue to support youth with complex behavioral health needs who may require more intensive levels of service.

Continue to implement/refine criminal justice strategy [SUPTRS Priority Population PRSUD]
Through partnerships with the Department of Corrections & Rehabilitation and support for treatment services provided in treatment courts, the SUPTRS BG funding will support increased access to quality services for individuals involved in the criminal justice system, particularly those involved in treatment and solution courts. These efforts have also prioritized access for pregnant and parenting women, individuals who use intravenous drugs, and those unable to otherwise pay for addiction treatment services, ensuring the most vulnerable populations receive the care and support they need for successful recovery and reintegration.

Encourage and support the efforts of communities to promote high-quality services [MHBG Priority Populations SMI, SED]
The Department has contracted with an agency to provide statewide administration of an advocacy network to effectively respond to the needs of adults with serious mental illness in the state. The agency maintains a statewide council focused on advocacy for adults with SMI and their families, a support line to provide resources and referrals to assist families with accessing mental health services and a website with resource information and links available to mental health services, supports and resources. The agency establishes relationships with public and private agencies across the state, promotes consumer engagement, and holds an annual event to provide education of mental health conditions and treatment options, networking opportunities, promotion of current statewide behavioral health services and advocacy skills training.

Partner with tribal nations to increase health equity [SUPTRS Primary Population PRSUD]
To advance health equity and address unmet behavioral health needs among tribal populations, North Dakota maintains two contracts with tribal partners to provide culturally responsive residential addiction services on the Fort Berthold Indian Reservation and surrounding areas. The program integrates a cultural model of addiction recovery informed by community and Tribal leaderships, ensuring services are both trauma-informed and culturally relevant. Services that are provided include

educational programming, cultural awareness activities, social skills and nutrition guided by Tribal community specialists. Additionally, the program has enhanced its clinical capacity by hiring a Licensed Addiction Counselors licensed in North Dakota to provide addiction evaluations, conduct outreach and offer ongoing case management. Collaborative referral partnerships are maintained to support comprehensive care coordination. Data collection and reporting are aligned with Block Grant requirements to ensure accountability and continuous quality improvement in providing services.

Footnotes:

Planning Tables

Table 1: Priority Area 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 (Initial data collected prior to and during 2026): Ages 18-25 = 38.01%; Ages 26+ = 25.30% (2022-2023 NSDUH)

First-year target/outcome measurement (Progress to the end of 2026): Provide training and technical assistance to local prevention providers around evidence-based practices.

Second-year target/outcome measurement (Final to the end of 2027): 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:

No issues

Indicator #: 2

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

Baseline measurement (Initial data collected prior to and during 2026): 19.5% of ND high school students reported alcohol use in the past 30 days (2023 YRBS)

First-year target/outcome measurement (Progress to the end of 2026): Provide training and technical assistance to local prevention providers around evidence-based practices.

Second-year target/outcome measurement (Final to the end of 2027): 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:

No issues

Indicator #: 3

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

Baseline measurement (Initial data collected prior to and during 2026): Increase the number of instructors for marijuana education

First-year target/outcome measurement (Progress to the end of 2026): Develop a certification of evidence based marijuana education providers

Second-year target/outcome measurement (Final to the end of 2027): Have at least 1 certified provider in each of the 8 regions

Data Source:

ND Administrative Code, Behavioral Health Division certification tracking

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #: 4

Indicator: Increase utilization of 988

Baseline measurement (Initial data collected prior to and during 2026): 148 individuals died by suicide in 2024 (preliminary)

First-year target/outcome measurement (Progress to the end of 2026): Increase messaging and communication about 988

Second-year target/outcome measurement (Final to the end of 2027): Increased utilization of 988

Data Source:

Behavioral Health Division, North Dakota's 988 crisis line

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Priority #: 2

Priority Area: Community-Based Services

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

Population(s): SMI, SED, ESMI, BHCS, PWID, PRSUD

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 (Initial data collected prior to and during 2026): Limited behavioral health services and supports integrated with K-12 schools. 22 school districts/special education units provided behavioral health services and supports.

First-year target/outcome measurement (Progress to the end of 2026): Increase number of schools utilizing funding programs with the Behavioral Health Division.

Second-year target/outcome measurement (Final to the end of 2027): 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:

No Issues

Indicator #: 2

Indicator: Enhance Youth Crisis Services

Baseline measurement (Initial data collected prior to and during 2026): Currently only one region in the state with youth-specific mobile crisis

First-year target/outcome measurement (Progress to the end of 2026): Train existing mobile crisis teams in youth-specific interventions in alignment with MRSS.

Second-year target/outcome measurement (Final to the end of 2027): Youth-specific crisis services available in two regions.

Data Source:

Behavioral Health Division, training documentation, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #: 3

Indicator: Expand Early Episode Psychosis Programming

Baseline measurement (Initial data collected prior to and during 2026): Currently FEP programming is available in two regions of the state.

First-year target/outcome measurement (Progress to the end of 2026): Identify vendor for FEP programming expansion.

Second-year target/outcome measurement (Final to the end of 2027): FEP programming is available in three regions of the state.

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:

No issues

Indicator #: 4

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

Baseline measurement (Initial data collected prior to and during 2026): No CCBHC in North Dakota

First-year target/outcome measurement (Progress to the end of 2026): Develop a CCBHC certification process and guildelines

Second-year target/outcome measurement (Final to the end of 2027): Certify one CCBHC

Data Source:

Behavioral Health Division

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #: 5

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

Baseline measurement (Initial data collected prior to and during 2026): Limited infrastucture and service providers for children's behahvioral health services. Three Partial Hospital Programs (PHP) programs operating in the state.

First-year target/outcome measurement (Progress to the end of 2026): Enter into contract with behavioral health provider to provide PHP/day treatment

Second-year target/outcome measurement (Final to the end of 2027): Four PHP programs operating in the state.

Data Source:

Behavioral Health Division contract data

Description of Data:

Qualitative and Quantitative

Data issues/caveats that affect outcome measures:

No issues

Priority #: 3

Priority Area: Person-Centered Practice

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

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

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:	Enhance capacity of behavioral health providers serving Native American populations with evidence-based practices
Baseline measurement (Initial data collected prior to and during 2026):	Limited access to culturally-nuanced evidence-based treatments.
First-year target/outcome measurement (Progress to the end of 2026):	Behavioral health providers trained in Accelerated Resolution Therapy (ART) and Honoring Children Mending the Circle
Second-year target/outcome measurement (Final to the end of 2027):	Increase the number of behavioral health providers trained.

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:

No Issues

Indicator #:	2
Indicator:	Expand access to behavioral health services for high risk professionals (i.e. Veterans, Law Enforcement, First Responders)
Baseline measurement (Initial data collected prior to and during 2026):	Ten providers trained and contracted to provide behavioral health services and support to high risk professionals.
First-year target/outcome measurement (Progress to the end of 2026):	Train providers in Critical Incident Stress Managment Training (CISM) and Accelerated Resollution Therapy (ART) best practices.
Second-year target/outcome measurement (Final to the end of 2027):	Increase utilization of services.

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #:	3
Indicator:	Expand culturally-relevant behavioral health services in North Dakota
Baseline measurement (Initial data collected prior to and during 2026):	Limited cultural knowledge in serving special populations among behavioral health providers.
First-year target/outcome measurement (Progress to the end of 2026):	Survey private and public behavioral health providers to determine training needs for special populations.
Second-year target/outcome measurement (Final to the end of 2027):	Develop training to assist with training gaps/needs identified from the survey.

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Priority #: 4

Priority Area: Increase Access to Targeted Services

Priority Type: SUT, SUR

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

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 and expand withdrawal management.

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 (Initial data collected prior to and during 2026): No current residential treatment program specific for pregnant women and women with dependent children.

First-year target/outcome measurement (Progress to the end of 2026): Enter into contract with one provider.

Second-year target/outcome measurement (Final to the end of 2027): Enter at least 25 pregnant women and women with dependent children in a residential program.

Data Source:

Behavioral Health Division, Contract Management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #: 2

Indicator: Withdrawal Management

Baseline measurement (Initial data collected prior to and during 2026): Limited withdrawal management service systems in communities in the state.

First-year target/outcome measurement (Progress to the end of 2026): Identify opportunities to expand medically-managed withdrawal management

Second-year target/outcome measurement (Final to the end of 2027): Plan is developed to expand medically-managed withdrawal management

Data Source:

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

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #: 3

Indicator: Expand access to behavioral health inpatient level of care.

Baseline measurement (Initial data collected prior to and during 2026): Inpatient level of behavioral health care not available in all regions of the state

First-year target/outcome measurement (Progress to the end of 2026): Enter into contracts with three hospital facilities.

Second-year target/outcome measurement (Final to the end of 2027): Five new inpatient behavioral health facilities available in the state.

Data Source:

Behavioral Health Division, contract management

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #: 4

Indicator: Expand access to diversion models including treatment courts.

Baseline measurement (Initial data collected prior to and during 2026): Currently six drug courts in five regions, one Veterans Court and two youth drug courts in two regions.

First-year target/outcome measurement (Progress to the end of 2026): Develop clinical best practices for courts.

Second-year target/outcome measurement (Final to the end of 2027): Expand mental health courts and drug court participation.

Data Source:

Behavioral Health Division, contract management, DOCR partnership

Description of Data:

Quantitative and Qualitative

Data issues/caveats that affect outcome measures:

No issues

Priority #: 5

Priority Area: Workforce

Priority Type: SUP, SUT, SUR, MHS

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

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, and peer support service.

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 (Initial data collected prior to and during 2026):	Limited substance use prevention training opportunities
First-year target/outcome measurement (Progress to the end of 2026):	Increase number of ND trainers on SAPST Core Competencies and prevention ethics.
Second-year target/outcome measurement (Final to the end of 2027):	Continued implementation of capacity building activities among new and existing community prevention workforce. Explore prevention certification options.

Data Source:

Behavioral Health Division, Contract Management

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #:	2
Indicator:	Expand parent and caregiver peer support services
Baseline measurement (Initial data collected prior to and during 2026):	Minimal parent and caregiver support specialists integrated into behavioral health delivery systems in the state.
First-year target/outcome measurement (Progress to the end of 2026):	Continue to deliver parent and caregiver peer support trainings
Second-year target/outcome measurement (Final to the end of 2027):	Train 100 parent and caregiver peer support specialists

Data Source:

Behavioral Health Division, Contract Management

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures:

No issues

Indicator #:	3
Indicator:	Behavioral Health Workforce
Baseline measurement (Initial data collected prior to and during 2026):	Inconsistency among program offerings at higher ed institutions, ensure alignment with current needs related to behavioral health workforce shortages.
First-year target/outcome measurement (Progress to the end of 2026):	Convene a summit of stakeholders to identify and develop a strategic plan.
Second-year target/outcome measurement (Final to the end of 2027):	Implementation of strategic plan.

Data Source:

Behavioral Health Division

Description of Data:

Quantitative and qualitative

Data issues/caveats that affect outcome measures:

No issues

Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$9,536,701.00		$0.00	$5,250,000.00	$33,739,056.00	$0.00	$25,344,481.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$2,400,000.00				$600,000.00			
b. All Other	$7,136,701.00			$5,250,000.00	$33,139,056.00		$25,344,481.00	
2. Recovery Support Services[c]	$944,472.00				$1,368,131.00			
3. Primary Prevention[d]	$3,493,725.00			$8,000,000.00	$5,000.00			
4. Early Intervention Services for HIV[e]								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]								
13. Administration[g]	$1,085,694.00			$221,437.00	$4,807,095.00		$12,028.00	
14. Total	**$24,597,293.00**		**$0.00**	**$18,721,437.00**	**$73,658,338.00**	**$0.00**	**$50,700,990.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] 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.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Current table does not include Medicaid budget numbers - including Medicaid expenditures in the Plan is new for our agency and we are still working through information to get the most accurate budget numbers.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$341,948.00						$25,172.00
7. State Hospital			$2,004,083.00		$64,681,003.00		$13,541,592.00	
8. Other Psychiatric Inpatient Care					$6,962,014.00			
9. Other 24-Hour Care (Residential Care)					$750,000.00		$14,480,000.00	
10. Ambulatory/Community Non-24 Hour Care		$2,906,561.00	$20,875,470.00	$27,174,326.00	$206,656,757.00		$36,280,737.00	$213,962.00
11. Crisis Services (5 percent Set-Aside)[c]		$170,974.00						$12,586.00
12. Other Capacity Building/Systems Development								
13. Administration				$221,437.00	$4,807,095.00		$12,028.00	
14. Total		**$3,419,483.00**	**$22,879,553.00**	**$27,395,763.00**	**$283,856,869.00**	**$0.00**	**$64,314,357.00**	**$251,720.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **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 B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	1722	43
Women with Dependent Children	13923	209
Individuals with a co-occurring M/SUD	47742	4414
Persons who inject drugs	2000	1741
Persons experiencing homelessness	3528	1894

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

Estimates of people in treatment were derived from the State's EHR system data based on calendar year counts of people served with SUD. There are limitations around pregnancy and women with dependent children data, making these counts lower than expected. Aggregate Number Estimated in Need totals were derived using a combination of state and national NSDUH data, CDC birth rates, Census and ACS data, Point-in-time homeless counts, and other sources. It should be noted that estimates of injection drug use and homelessness are problematic given the national data sources available for those specific issues.

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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$5,033,998.00
2 . Recovery Support Services[b]	$236,118.00
3 . Substance Use Primary Prevention[c]	$1,882,184.00
4 . Early Intervention Services for HIV[d]	
5 . Tuberculosis Services	
6 . Other Capacity Building/Systems Development[e]	
7 . Administration[f]	$376,436.00
8. Total	$7,528,736.00

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[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]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.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	0.00
1b. Crisis Services for Adults	128230.50
1c. CSC/ESMI program for Adults	341948.00
1d. Other outpatient/ambulatory services for Adults	1716478.20
1e. *Other Direct Services for Adults	0.00
2. Subtotal of Services for Adults	2186656.70
3. Services for Children	
3a. EBPs for Children	0.00
3b. Crisis Services for Children	42743.50
3c. CSC/ESMI program for Children	0.00
3d. Other outpatient/ambulatory services for Children	1144318.80
3e. *Other Direct Services for Children	0.00
4. Subtotal of Services for Children	1187062.30
5. Other Capacity Building/Systems Development[a]	45764.00
6. Administrative Costs[b]	0.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**3419483.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$1,099,310
	Total	**$1,099,310**
2. Education	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$54,966
	Total	**$54,966**
3. Alternatives	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$54,966
	Total	**$54,966**
4. Problem Identification and Referral	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$73,287
	Total	**$73,287**
	Universal	$0
	Selective	$0

5. Community-Based Processes	Indicated	$0
	Unspecified	$183,218
	Total	**$183,218**
6. Environmental	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$366,437
	Total	**$366,437**
7. Section 1926 (Synar)-Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$50,000
	Total	**$50,000**
8. Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Budget		**$1,882,184**
Total Award [a]		**$7,528,736**
Planned Primary Prevention Percentage		**25.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	
2. Universal Indirect	
3. Selective	
4. Indicated	
5. Column Total	**$0**
6. Total SUPTRS Award[a]	**$0**
7. Primary Prevention Percentage	

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☐
Prescription Medications	☑
Cocaine	☐
Heroin	☑
Inhalants	☐
Methamphetamine	☐
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☐
Military Families	☑
American Indian/Alaska Native	☑
African American	☐
Hispanic	☐
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☐
Asian	☐
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00

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a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$0.00**	**$0.00**	**$0.00**

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00
3. Partnerships, Community Outreach, and Needs Assessment	$0.00	$0.00
4. Planning Council Activities	$45,764.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00
7. Training and Education	$0.00	$0.00
8. Total	**$45,764.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **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 health 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: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

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 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 details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

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 Free Through Recovery program serves individuals with SMI or SUD who are connected with the justice system. They are provided care coordination, access to recovery resources, and peer support. Similarly, the Community Connect program targeted individuals with SMI, SUD, or co-occurring disorders to provide additional access to care coordination and recovery support services with the goal of preventing further cross-system involvement.

In regard to pregnant and/or parenting women with dependent children with substance use disorders. North Dakota's Department of Health and Human Services Behavioral Health Division (HHS BHD) has made targeted efforts to improve access to care for individuals with mental health disorders, substance use disorders, and co-occurring conditions, with a specific focus on pregnant and parenting women with dependent children. BHD has continued to develop infrastructure to fill this critical gap. A provider in North Dakota is currently finalizing construction of a dedicated residential addiction treatment facility for pregnant and parenting women, anticipated to open in Fall 2025. A key component of the program is the ability for women to reside in treatment with their children, promoting family unity and allowing mothers to continue parenting while receiving care. This facility will expand access to high-quality specialized services for women and their children across the state. This program is designed to increase access to comprehensive, trauma-informed, and person and family-centered care. Additionally, the program will ensure access to a full continuum of behavioral health services that support both maternal recovery and child well-being.

The eight regional state-operated behavioral health clinics also prioritize team-based care for adults with SMI, SUD or co-occurring disorders, and youth with SED, SUD or co-occurring disorders. These individuals are provided an array of services including outpatient therapy, psychiatric and medication management, case management, rehabilitative services, with potential for psychological testing, and access to 24-hour crisis services. For adults, these crisis services may also include short-term placement at a Crisis Residential Unit (CRU), Transitional Living, or access to ASAM Level 3.1 or 3.5, provided at several of the local state-operated clinics and through partnerships with local private providers. Services at the state-operated behavioral health clinic begins with a screening to include screening for TB and HIV who are then referred to public health or primary care settings for additional care as needed. Risk assessment during the screening process is conducted to ensure individuals who are at highest risk of suicide, overdose, or those who are pregnant, or using via IV are prioritized for the appropriate level of care.

Payment for services have also been expanded through a collaboration between the Division and Medicaid. 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 as well as expanding the definition of eligibility for Targeted Case Management to include individuals with SUD. North Dakota is a Medicaid Expansion state which also assists improve access to behavioral healthcare. Lastly, the Division also administers a Substance Use Disorder Voucher program, which provides payment for addiction treatment for individuals without insurance, offering choice and expansion of service options.

Within the last several years, the Division 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 who are in need of additional living support.

In regard to expanding services for youth, North Dakota was awarded a Substance Abuse and Mental Health Services (SAMHSA) System of Care (SOC) Expansion and Sustainability Grant in September 2022 to enhance mental health outcomes for children and youth. The purpose of the grant is to build and expand a comprehensive set of community-based behavioral health services and supports for children and youth with serious emotional disturbances (SED), birth – age 21, and their families. The grant focuses on two geographical catchment areas: Lake Region Community Behavioral Health Clinic (Devils Lake) partnering with both public and private providers in six counties in the region and West Central Community Behavioral Health Clinic partnering with both public and private providers in 10 counties in the region. These two regions include four tribal nations: Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians and Mandan Hidatsa Arikara Nation. North Dakota System of Care grant initiative aligns with the Behavioral Health Strategic Plan, AIM 5 - to enhance and streamline a system of care for

children with complex needs and their families. The two primary goals include:
1. To increase access to high-quality and culturally appropriate services and supports for children with SED and their families in the identified regions.
2. To develop a sustainable infrastructure to support the System of Care approach for North Dakota children with SED and their families.

In the current Grant Year 3, service implementation includes partial hospitalization/intensive day treatment, Functional Family Therapy, Parent and Caregiver Peer Support, and expansion of both school and community-based, evidence-based treatment and care coordination. Service Highlights include:
-The opening of a Child and Adolescent Partial Hospitalization Program in Bismarck (April 2025)
-The launch of Parent and Caregiver Peer Support training and integration of parent peers in Human Service Centers
-Investments in local service expansion including community and school-based services:
a. Group evidence-based treatments (SPARCS, Seeking Safety)
b. Expanding the number of clinical providers in rural and tribal communities
c. Training and workforce development in evidence-based practices
-Early childhood interventions including Child Parent Psychotherapy (CPP), Parent Child Interaction Therapy (PCIT), and Child Parent Relationship Therapy (CPRT)
-Care coordination
-Supporting the expansion of FamilyFirst Prevention services including Functional Family Therapy (FFT), Family Check Up, and Healthy Families

Through the SOC grant, the Department has developed a contract with University of Connecticut Innovations to develop a roadmap for North Dakota to implement High Fidelity Wraparound for children with complex needs and at risk for out of home placement.

The Department also provides grants to schools to provide behavioral health services and supports to address student behavioral health needs. The purpose of the grants is to address and identify gaps along the behavioral health continuum of care. During the last 24-25 school year, over $4 million dollars were awarded to 22 eligible school districts or special education units with almost $3 million of those dollars to provide direct services in the schools. The Department also developed a pilot to demonstrate improvement to children's behavioral health in a school setting and learn how to fully integrate a continuum of supports in a school. Toolkits were developed to assist schools in ND in creating Tier 1, 2 and 3 supports.

The Department contracts with the Treatment Collaborative for Traumatized Youth (TCTY) which is a network of clinicians whose mission is to implement, evaluate, and sustain the practice of evidence-based mental health treatments for children who have experienced traumatic life events.

This collaboration provides funding for the training of clinicians in both the public and private behavioral health service delivery system. The specific focus of the training is Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT). The funding provided by the Department also supports a minimum of six months of case staffing and consultation calls with the TF-CBT trainer and other clinicians who have received the training.

A separate collaborative effort between the Department and TCTY is Project HEAL. Project HEAL aims to expand resources to address gaps and improved access to culturally relevant trauma services for Native American children. The three primary goals of the project are to: (1) Educate child-serving professionals on the incidence and consequences of historical trauma on Native American youth and communities, (2) Train mental health clinicians in culturally-informed trauma treatment enhancements, and (3) Increase access to culturally-informed trauma treatments for Native American youth in the state.

Lastly, a goal to increase navigation of services derived from recommendations from the Behavioral Health Planning Council and Child Fatality Review panel led to several efforts in the state. A Mental Health Program Directory was launched to assist North Dakotans in locating and accessing 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 interventions options. Individuals can also search for programs that offer telehealth services. Over the past biennium, this has expanded to include several specialized search options for various populations and evidence-based best practices. The Department was also granted funding in the 2023 legislative session for a Behavioral Health Navigator, which was filled in October of 2023. This individual assists individuals in accessing services and provides community education to a variety of stakeholders across the state.

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 completed a study on prior authorization in health benefits plans during the 2023-2025 interim. The study included 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 also included 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. This report will assist in further identification of areas of collaboration and consistency.

3. 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.

All eight regional state-operated 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.

a. Please describe how this system differs for youth and adults.

Within the public behavioral health clinics, all individuals who come into care receive several mandatory screenings including the PHQ-9 and the GAD-7, as well as the DLA-20 for functional impairment. Once an individual is assigned to a multidisciplinary team, additional assessments and screenings may differ depending upon need, clinical indication, and evidence-based best practice utilized.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Currently, only two of the eight regional behavioral health clinics continue to operate IT-COD with fidelity measures; however, this may change based upon community needs assessment associated with the State's implementation of CCBHC.

c. How many IT-COD teams do you have? Please explain.

There are 4 total IT-COD teams within the public behavioral health system. Three of those teams are located in the Southeast region.

d. Do you monitor fidelity for IT-COD? Please explain.

The State contracted with the Center for Excellence through Case Western to complete fidelity reviews.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. 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

d) How the state provides integrated treatment for individuals with co-occurring disorders

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, which is administered through 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 continues 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.

5. 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 (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Free Through Recovery is a community-based behavioral health program designed to increase recovery support services to individuals involved with the criminal justice system who have behavioral health concerns. Free Through Recovery participants work with local providers to receive access to care coordination, peer support, and access to recovery support services. During the 69th North Dakota legislative assembly House Bill 1012 expanded funding for Free Through Recovery.

Community Connect is a community based behavioral health program designed to increase recovery support services. Community Connect program participants work with local providers to receive access to care coordination, peer support, and access to recovery support services. This program focuses 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. During the 69th North Dakota legislative assembly House Bill 1012 expanded funding for Free Through Recovery.

The North Dakota Medicaid 1915i program offers home and community-based services to individuals ages 0+ with diagnosed behavioral health conditions. North Dakota's 1915i Medicaid Plan requires care coordination for all 1915i members.

The eight regional community behavioral health clinics began implementing care coordination services. Within the eight regional clinics, citizens can receive screening for services through an open access model. Individuals are initially screened for needs and referred to a care coordinator and community-based services, or to see a clinician for a full diagnostic assessment. The community behavioral health clinics prioritize service for children and adults with SMI/SED or co-occurring disorders. The eight regional community behavioral health clinics receive state appropriated funding through the North Dakota legislative assembly, bill insurance, and receive different state and federal funds to operate. However, all care coordination services are currently funded through state appropriated funding for positions.

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.

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.

Each regional 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.

6. 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 state-operated 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.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Within the last several years, the Developmental Disabilities and Behavioral Health Systems separated. Despite this separation, the state operated behavioral health clinics and Developmental Disabilities Program Managers continue to collaborate on a case by case level. Legislation in 2025 also brought about the opportunity for Applied Behavior Analysts (ABA) from the residential program for individuals with IDD/DD needs could provide cross-assistance with the state-operated Psychiatric Residential Treatment Facility, Ruth Meyers. This has also led to discussions about how to partner on a policy level in regard to improving co-occurring services. One area in which this is currently being developed is through the Cross Disabilities Advisory Council.

8. Please indicate areas of **technical assistance needs** related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
First Episode Psychosis Coordinated Specialty Care	2.00
	0.00
	0.00
	0.00

	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
175,000.00	175,000.00

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

The components of the Coordinated Specialty Care model include: outreach and engagement, individual, group, and family therapy, case management, peer support, supported education and employment, and psychiatric services. Currently all are billable within Medicaid except for the outreach and engagement service, which is provided through a contracted position, funded with Mental Health Block Grant.

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

There are two First Episode Psychosis programs within North Dakota, entitled "Healing, Empowering, and Learning about Psychosis (HELP)" operating within the State-Operated Community Behavioral Health Clinics. One operates in the southeast region and the other in the south central region. These programs serve individuals age 15-35 with the experience of early psychosis. Referrals to the program are managed through an outreach and engagement position funded by mental health block grant. The southeast program currently includes all elements of the coordinated specialty care model, while the south central program has most elements with the exception of supportive education and employment, which is referred through community partnerships.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

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

The outreach and engagement contract funded through MHBG is responsible for community outreach and education in addition to referral management. This contractor currently outreaches to clinics, hospitals, schools, and community members through in-person education, webinar, and booth activities to provide information about the program and how to refer. Once an individual is referred into the program, they meet with the FEP team for assessment and education. Services provided include individual, family, and group therapy, supported education and employment, case management, psychiatric services, peer support, and referral to natural community supports and other specialty services as needed. Fidelity is monitored through a contract with the University of North Dakota who meets with each team on an annual basis to provide a fidelity review and assist with strategic planning and outcome improvement.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

Planned activities for FFY2026 and 2027 include expansion of First Episode Psychosis programs to the Western part of the state. Additionally, expansion of current services due to increased volume in existing programs is also being explored. Prevalence of first episode psychosis is not well-known in North Dakota, so the State also seeks to better understand incidence and prevalence. Funding will also be utilized to continue to support existing service providers with education, training, and technical assistance, as well as the continued funding of the fidelity review process.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

All state programs utilize the same diagnostic criteria for eligibility which includes: Psychosis, Bipolar Disorder with psychotic features, Major Depressive Disorder with psychotic features, Brief Psychotic Disorder, Schizophrenia, and Schizoaffective Disorder.

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

While the national statistics indicate a prevalence between 0.25 and .64 percent, the prevalence in North Dakota is not known.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

The contracted Outreach and Engagement Specialist is tasked with providing the State data on outreach and education to each community served. Additionally, outreach and education is built into the current FEP model within the community behavioral health clinics so clinic staff are also able to provide outreach and education in their local communities.

12. Please indicate area of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process 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. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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.

The Behavioral Health Division completed their person-centered practice assessment in April 2025. A working group was identified that includes team members from prevention, addiction and recovery, peer support, treatment, adult mental health, children and family services, and behavioral health workforce. This working group will develop goals and action steps to further implement person-centered practices within the policy division.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances 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 **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.

6. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic 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. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based 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 behavioral health 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

   N/a
4. Please indicate areas of technical assistance needs related to this section.

   N/a

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve 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):

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

The state conducts a Community Readiness Survey.

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)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☐ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☑ Other (please list)

The state collaborates with each of the Tribal communities to conduct a Tribal Community Readiness and Substance Use survey.

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) ☑ Other (please list)

The state also uses data from the Uniform Crime Report, Crash Analysis, and Violent Death Reporting System.

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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

The state uses data to determine priority areas and strategies to implement.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders on individuals families and communities.
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

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

a) If yes, please describe.

The state does not have a formal licensing or certification program however, similar requirements through the contracting process occur with local prevention providers.

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 state 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: https://www.hhs.nd.gov/behavioral-health/prevention. The state also contracts with external providers to assist in providing training and technical assistance to the prevention workforce in the state. Technical Assistance provided by the state includes:
• Monthly Q&A Sessions – These are virtual networking meetings where state staff and local prevention providers get together. State staff answer questions, discuss barriers and provide updates.
• In-Person Quarterly Meetings – These training events are hosted by the state. Training topics have included: Assessment, Capacity Building, Strategic Planning, Implementation, Evaluation, Prevention Media 101, Action Planning, etc.
• Virtual Quarterly Prevention Provider Presentations – This is a virtual meeting where prevention providers present on the work they are doing locally. They discuss the activities they are implementing, any successes or barriers, etc. This is a way for local providers to network and learn from each other.
• Substance Use Prevention Community of Practice: This is a group of prevention professionals across the state who meet to discuss specific topics in prevention. The goal is to share knowledge, increase capacity and problem solve. Some of the topics have included “An Environmental Strategy to Combat Underage Drinking” and “How to Gain Community Buy-in

Before a Tragedy Happens." More information can be found here: https://www.hhs.nd.gov/behavioral-health/prevention/community-of-practice.

• SPF Application for Prevention Success Training (SAPST) – This training is a required training for prevention providers and is hosted annually. The goal is to increase prevention provider knowledge and skills.

• Prevention Core Competencies – This training was provided to our local prevention providers to enhance skills and knowledge. This training was very well received by both long-term and new providers.

• Prevention Ethics – This training is offered to our local prevention providers.

• Regional Prevention Events – These local capacity building events are being implemented by prevention providers with the goal to increase readiness amongst their partners such as coalition members, local policy makers, law enforcement, etc. These events include virtual presentations, in-person conferences, learning sessions, etc.

• State Prevention Conference – This conference took place in December 2024 with the goal to increase state-level readiness for prevention.

• Statewide Media Campaigns and Materials – The state creates, promotes and provides resources to support the work of local prevention providers. These resources can be found here: https://behavioralhealth.x-shops.com/.

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 state (through contracts 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 state also contracted with an external provider to assess community readiness specific to the Tribes in the state.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 WebBGAS

The state's strategic 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?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

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)** [ ] 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

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) 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.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 state actively disseminates information to communities and stakeholders. This is done in several ways including emails, websites, resource centers, etc. The state implements evidence-based mass media/communication efforts targeting priorities set by the state's SEOW. These efforts include Parents Lead, Opioids: Take Care be Aware, and Speak Volumes. Information Dissemination is also supported through contracts with local prevention providers with are Public Health Units and Tribes across the state. Training and technical assistance is provided on information dissemination best practices.

b) Education:

Education strategies are funded through community and tribal contracts. Training and technical assistance is also 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 state 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) Yes (if so, please describe)

All local prevention providers who receive SUPTRS funding are required to report monthly to the state on the activities they are implementing. These reports are reviewed prior to providing reimbursement ensuring all listed activities are primary prevention focused. The state provides communication to local prevention providers describing what duplication is and how it is not allowed. Strong partnerships with other state agencies have assisted the state in identifying needs/strategies to focus SUPTRS dollars in a way that will supplement and enhance current efforts without duplicating.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 WebBGAS

The state does not have an evaluation plan currently however, we are in the beginning stages of development.

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 prioritized benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes 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 describe):
- **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):

The state collects information on the type and number of strategies implemented, number of resources disseminated, number of new partnerships, etc.

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 alcohol use
- **c)** ☑ Binge alcohol 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):

The state collects data on lifetime use, age of initiation, perception of use, etc.

Footnotes:

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

In North Dakota, there are eight regional state-operated behavioral health clinics. These clinics provide an open-access model of assessment, 24-hour mobile crisis services, therapy, SUD counseling, psychological testing, psychiatric care and medication management, case management, and rehabilitative services. These clinics serve youth and their families as well as adults, primarily utilizing multi-disciplinary, team-based services. They also utilize several evidence-based models and interventions including Integrated Dual Disorder Treatment (IDDT), First Episode Psychosis (FEP), Multi-Systemic Therapy (MST), and Functional Family Therapy (FFT), as well as cognitive behavioral therapies, Eye-Movement Desensitization and Reprocessing, motivational interviewing, and Accelerated Resolution Therapy. North Dakota is also in a planning phase of CCBHC implementation.

In addition, The Department 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.

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, 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. These individuals 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 Department 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 continue to receive $3 million per year, which began 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.

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.

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.

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.

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 use prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	○ Yes	● No
i)	Recovery 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 services listed above are primarily carried out within the state-operated behavioral health clinics; however, there are additional programs funded by the State that assist in providing necessary services. For example, the Free Through Recovery and Community Connect programs fund private providers to enhance care coordination and peer support services for individuals with Serious Mental Illness, or those connected to the justice system. Areas of enhancement include the integration of physical health, supportive education, and employment through the development and certification of CCBHC's. 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

Targeted case management is provided through the state-operated behavioral health clinics and also is reimbursable through Medicaid. the 1915i addendum also opened TCM services as a reimbursable service through the expansion of private providers. TCM may be provided to any individual with a Serious Mental Illness, Substance Use Disorder, or Serious Emotional Disturbance with at least moderate severity of functional deficit related to their condition. This service includes comprehensive assessment and periodic reassessment, care planning, referral and related activities, monitoring and follow-up activities, and collateral contacts.

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

The development of a robust continuum of care is necessary to reduce hospitalizations. Investment in the continuum of care in North Dakota is a primary method of reducing the need for higher levels of care. This includes the investment in a crisis

continuum which includes 988, mobile crisis through the eight regional behavioral health clinics, and rural enhancement through a contract with a telehealth provider connected directly with law enforcement. Additionally, North Dakota has funded the enhancement of youth services including partial hospitalization programs in the last two years. The work towards certification of the regional behavioral health clinics in becoming CCBHCs is also designed to enhance community-based services.

5. Please indicate areas of technical assistance needs related to this section.

N/A

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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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	42,078	7,901
2.Children with SED	18,313	1,992

2. 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

3. Please indicate areas of technical assistance needs related to this section.

N/A

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

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

2. Please indicate areas of technical assistance needs related to this section.

[1] *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.*

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 tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The eight regional state-operated behavioral health clinics are each responsible for multiple counties in their jurisdiction which can include both urban and rural areas. Mobile crisis teams and behavioral health teams operate within these catchment areas to provide services. In-person services are also enhanced via telehealth in both crisis and standard service provision. This includes telehealth capability for psychiatry and medication management, therapy, SUD therapy, case management and care coordination. The State also contracts a provider to provide outreach and education in rural communities as to behavioral health services available in the state.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

The State receives PATH grant funding which supports staff within the regional behavioral health clinics who outreach individuals with SMI experiencing homelessness to provide housing assistance, documented through the HMIS portal. Several of the clinics also outreach homeless shelters in the area to provide crisis risk assessment, behavioral health screening, case management, therapy, and care coordination to additional services such as withdrawal management and SUD treatment. Several of the state-operated community behavioral health clinics operate transitional living services which assist individuals in establishing skills through rehabilitative interventions to promote housing maintenance.

The State also administers Permanent Supportive Housing state funds. 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

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

The State partners with the Aging Services unit within the Department of Health and Human Services to partner on education opportunities for DSPs regarding mental health services. The North Dakota State Hospital also coordinates care for individuals needing specialized geropsychiatric services with community partners. 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).

d. Please indicate areas of technical assistance needs related to this section.

N/A

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

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

Criterion 5

1. Describe your state's management systems.

In planning for allocation of the Mental Health Block Grant funding in North Dakota, the state takes many considerations into account, including needs and gaps identified in the 2018 North Dakota Behavioral Health Systems Study and corresponding strategic plan, which is continued to be assessed through a contract with the Human Services Research Institue (HSRI). The North Dakota Behavioral Health Planning Council, working with stakeholders - including service users and families, advocates, providers, administrators, and other North Dakotans provides additional feedback, which is used in connection with data to inform on-going planning decisions.

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 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 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 federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. 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.

The State currently has a database with public access which outlines provide providers for mental health services with search features to allow telehealth availability as a search criteria (https://www.hhs.nd.gov/behavioral-health/program-registry). Additionally, the eight state-operated, behavioral health clinics utilize telehealth for assessment within their open access model, to quickly connect an individual with the first available clinician and within the clinic's daily operations for service provision of telepsychiatry and teletherapy. Mobile crisis services have also been expanded utilizing State general fund to contract with a tele behavioral health entity who law enforcement in rural areas encountering individuals in crisis can connect with directly for crisis risk assessment and crisis intervention services.

3. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for 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 (with medications for addiction treatment included in v-x):

i)	Screening	(●) Yes	( ) No
ii)	Education	(●) Yes	( ) No
iii)	Brief intervention	(●) Yes	( ) No
iv)	Assessment	(●) Yes	( ) No
v)	Withdrawal Management (inpatient/residential)	(●) Yes	( ) No
vi)	Outpatient	(●) Yes	( ) No
vii)	Intensive outpatient	(●) Yes	( ) No
viii)	Inpatient/residential	(●) Yes	( ) No
ix)	Aftercare/Continuing Care	(●) Yes	( ) No
x)	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. Does your state 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.

Treatment programs receiving funding from block grant become scheduled for a compliance visit that includes an onsite visit and review of policies, procedures, chart reviews, staff training logs, as well as interviews with staff and individuals being served by the program. If the program is found to be out of compliance with any requirements, a corrective action plan is required to become compliance. 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)** Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached? ( ) Yes (●) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement? ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support? (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? (●) Yes ( ) No

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

Treatment programs receiving funding from block grant become scheduled for a compliance visit that includes an onsite visit and review of policies, procedures, chart reviews, staff training logs, as well as interviews with staff and individuals being served by the program. If the program is found to be out of compliance with any requirements, a corrective action plan is required to become compliance. This relates to all treatment programs including those specific to PWID.

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.

Treatment programs receiving funding from block grant become scheduled for a compliance visit that includes an onsite visit and review of policies, procedures, chart reviews, staff training logs, as well as interviews with staff and individuals being served by the program. If the program is found to be out of compliance with any requirements, a corrective action plan is required to become compliance. This relates to all treatment programs including those specific to TB.

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

Hypodermic Needle Prohibition

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 for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? ● Yes ○ No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered 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 system, adult criminal justice system, 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

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

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

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[1] (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) SMI Adviser ● Yes ○ No

c) Addiction TTC? ● Yes ○ No

d) State Opioid Response Network? ● Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ● Yes ○ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ● No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

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

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

North Dakota reports data through the CLD data set. This is currently client-level data for those who are involved in our public behavioral health system.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

All of the data comes out of the State’s Electronic Health Record including all eight regional behavioral health clinics and the ND State Hospital. It is independent of other state agencies.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

   Currently, the State does not have ability to link data within our reporting systems. The State does have a warehouse project that will allow for some data sharing.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

   The Electronic Health Record does include Care Pathways in which clients receiving First Episode Psychosis programming, allowing for data to be pulled at the individual level. Additionally, there are dedicated forms for crisis services.

5. Briefly describe the limitations of the SMHA 's existing data system.

   The primary limitation of the data collecting system is the data siloing from other state agencies.

6. What strategies are being employed by the SMHA to enhance data quality?

   The State is working on a warehousing project currently, building a new comprehensive assessment and ASAM form to better meet the federal reporting requirements including CCBHC standards. The State is also working on referral forms to track internal and external referrals.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

   The State has limitations on funding for external resources to assist as our IT infrastructure serves all areas of State Government.

8. Please indicate areas of technical assistance needs related to this section.

   N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

There is a mandatory 5 percent set-aside within 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 evidence-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 fund 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 expending 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 has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, 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 services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, 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 the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis 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 FirstLink for crisis intervention. FirstLink, the 988-call center (crisis contact center), is available to all ND citizens statewide. If the crisis cannot be resolved via the phone/text encounter, the crisis contact center connects to a behavioral health professional available twenty-four seven at one of the eight regional state-operated behavioral health clinics. Each region has a behavioral health team (mobile crisis response team) available for mobile outreach during the crisis within a forty-five-mile radius. The Southeast community behavioral health clinic also contracts with a private provider to expand mobile crisis response in the city and surrounding areas. The state is collaborating

with the private provider to determine their capacity to expand their mobile crisis response to other areas of the state. Citizens may also walk into the community behavioral health clinic to receive screening, triage, assessment and crisis intervention during business hours. In seven of the eight regions, the community behavioral health clinics have crisis residential units (CRU or Crisis Receiving and Stabilization Facilities) that provide varying levels of crisis stabilization services offered twenty-four seven. Lake Region community behavioral health clinic is the only region that does not have a crisis residential unit due to workforce. Lake Region collaborates with other regions to assist individuals needing that level of service and continues to identify resources for support.

North Dakota law enforcement agencies can access Avel eCare virtual crisis services through an effort funded in the 2023 and 2025 North Dakota Legislative Sessions. AVEL provides law enforcement with 24/7 access to behavioral health professionals who can assist in responding to people experiencing a mental health crisis. The program virtually connects law enforcement with behavioral health professionals to assist with de-escalation, stabilization and safety assessment during crisis situations regardless of location. The regional state-operated behavioral health clinics are also provided information for people who have utilized this service and follows up within 24-48 hours to provide support and information for regional mental health services. This service is extremely beneficial to rural law enforcement agencies, often resulting in the person staying safety in the community and not needing a higher level of care.

North Dakota also continues to work to build infrastructure, provide training opportunities and education to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances.

The Department contracted with FirstLink, the 988-call center (crisis contact center) to provide trainings to agencies for assistance in training on the Columbia- Suicide Severity Rating Scale, a screening for suicide risk. Going forward, the Department will be working with Emergency Medical Services to provide these trainings across North Dakota.

The Department contracted with an entity to provide Accelerated Resolution Therapy (ART). Approximately 210 public and private mental health clinicians have been trained in ART. ART is recognized as an evidence-based treatment for psychological trauma and depression, often effective in one to two sessions. The Department focused statewide trainings for rural mental health providers and those providing crisis services. Special populations addressed through the trainings were tribal communities and mental health clinicians working with youth. Monthly consultation services are provided by an ART master level trainer to enhance ART services after training is completed.

The Department has continued to work on enhancing Critical Incident Stress Management (CISM) services within the state by supporting several events to integrate first responder agencies and mental health services. ND provided four statewide Critical Incident Stress Management (CISM) trainings, which included first responder and public and private mental health professionals as attendees. The Department has continued to collaborate with the ND CISM team and provides additional support for licensed mental health clinicians to attend CISM defusing and debriefing events. The contracted CISM trainer is also providing consultation services for technical assistance to enhance services of staff working in the community behavioral health clinics. The Department has held two first responder cultural competency for mental health clinician events in the state to enhance mental health clinician's knowledge of first responder mental health needs.

The Department continues to support first responder mental health needs by contracting with ten mental health clinicians across the state to provide agency engagement activities with local, regional and state first responders. These clinicians are trained in CISM and trauma informed treatment modalities effective with first responders. The clinician's also block one hour of clinical time weekly to provide first responders with access to services within 72 hours of request.

The Department provides statewide rural mental health outreach services by a licensed mental health clinician who also conducts Question, Persuade, Refer (QPR) trainings in each region. The clinician provides several free webinars on various mental health topics, along with information on resources and supports in the state. The webinars are recorded and accessible on the Department website.

The Department is also working to provide training and technical assistance on 988 and the connection to crisis mobilization services regionally. Regional efforts have included training school, child welfare, and other child-serving professionals on What Happens When You Call 988 and introducing Crisis Mobilization Teams in-person. The training and partnership building aims to increase the utilization of the crisis continuum for behavioral health needs and reduce law enforcement involvement and emergency room visits when a child can be stabilized in the community.

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 published 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 published 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.*

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

	Exploration	Installation	Early Implementation	Partial Implementation	Majority Implementation	Program

	Planning		Less than 25% of counties	About 50% of counties	At least 75% of counties	Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to be	☐	☐	☐	☑	☐	☐

3. 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 somewhat limited based on staffing availability. Crisis residential units are operational in seven of the eight regions.

North Dakota law enforcement agencies can access Avel eCare virtual crisis services through an effort funded in the 2023 and 2025 North Dakota Legislative Sessions. AVEL provides law enforcement with 24/7 access to behavioral health professionals who can assist in responding to people experiencing a mental health crisis. The program virtually connects law enforcement with behavioral health professionals to assist with de-escalation, stabilization and safety assessment during crisis situations regardless of location. The regional state-operated behavioral health clinics are also provided information for people who have utilized this service and follows up within 24-48 hours to provide support and information for regional mental health services. This service is extremely beneficial to rural law enforcement agencies, often resulting in the person staying safety in the community and not needing a higher level of care.

There are gaps and limitation to youth specific crisis services. While there is 988 and limited mobile crisis response as identified above, only one region in the state currently offers Multisystemic therapy and a contract for expanded youth specific mobile crisis. Limited behavioral health workforce remains a challenge and there are no youth crisis residential programs currently available. There is also no acute hospitalization safety net.

While there is a safe place to be for adults, there are very limited safe places to be for youth/adolescents.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Currently, the crisis continuum follows best practices by utilizing a call center for 988 talk and text opportunities who also dispatch mobile crisis teams when in-person assessment and crisis intervention is needed. Mobile crisis teams are available in all eight regions across the state through the state-operated community behavioral health clinics. Mobile crisis staff can respond in a timely manner based on staffing availability. In the last biennium, the Department contracted 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 connects 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 behavioral health professional will connect to the regional community behavioral health clinic in the individual's area for follow up with the individual in crisis. This contract has enabled the expansion of crisis services to rural areas where individuals were previously transported by law enforcement to an emergency room for assessment. Data collection continues to evaluate effectiveness and ensure promotion of utilization.

The state-operated behavioral health clinics also operate crisis residential units in 7 of the 8 regions for adults. Several of these crisis units operate in a sit-stand capacity, allowing individuals to walk in or be dropped off for crisis assessment, intervention, and services up to and including admission to the unit. Individuals at the CRU may receive additional support such as therapy, psychiatry and medication management, case management, rehabilitative services, and care coordination.

Significant gaps in youth-specific crisis services in alignment with the MRSS model best practices continue to exist. Within the last biennium, the Department focused funding efforts on specialty training in evidence-based interventions for youth with Serious Emotional Disturbance (SED) including Accelerated Resolution Therapy and TF-CBT. Planning continues to increase specialized youth crisis response in alignment with the MRSS model.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

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 public safety first responder structures (police, paramedic, fire): 0

b. Integrated with public safety first responder structures (police, paramedic, fire): 0

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 47

b. Number of Emergency Departments that operate a specialized behavioral health component: 0

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 7

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The Department of Health and Human Services' Behavioral Health Division consists of program and policy, clinic, and hospital leadership within the public system. Data across the Division is analyzed to identify systemic needs for statewide behavioral health crisis response services as well as overall gaps in the behavioral health continuum of care. Currently, the State is in a planning grant phase for CCBHC, completing community needs assessments and finalizing criteria. Although the Behavioral Health Division remains responsible for 24-hour crisis services, carried out through the clinics, CCBHC criteria mirrors this by identifying crisis services as a necessary component of certification. Expansion of mobile crisis competencies in youth-specific interventions is a priority for the 5% set-aside this next biennium. The Division plans to contract with an agency to provide training and consultation support to mobile crisis staff in youth-specific interventions and best practices. An additional area of need includes a “safe place to be” for youth. The Division continues to work with community partners including the psychiatric residential treatment facilities and acute hospitals for opportunities to expand the current service provision to include crisis assessment and short-term crisis stabilization.

7. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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 funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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 and children with SMI and SUD through employing peer support specialists and parent and caregiver peer supports 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 also employ peer support specialists and parent and caregiver peer supports in urban and rural North Dakota communities to provide recovery support services through community-based programs and system of care funding. Other services include targeted case management, care coordination, skills training, and other rehabilitative services, supported employment, residential services, supported housing, medication management, and each region has Recovery Centers for socialization activities.

The state 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.

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 training, peer support supervision training, and continuing education for peer support specialists. In 2024 the state began hosting parent and caregiver peer support training, and parent and caregiver supervision training.

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 Governor, Kelly Armstrong appointed Jonathan Holth commissioner of Recovery & Reentry in 2025. In this role, he connects state agencies and local governments to reduce barriers for individuals in recovery and those reentering from incarceration. Previously, Holth served as Managing Director of Recovery Reinvented, an initiative launched by Governor Doug Burgum and First Lady Kathryn Burgum to end the stigma of addiction. Holth has been in long-term recovery from alcohol use disorder for 17 years and openly shares his story to inspire others.

Eight Recovery Centers (one in each region throughout the state) employ peer staff and are contracted through the state-operated 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.

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 54 peer support trainings, training over 1400 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 ongoing continuing education for the peer support workforce and peer support endorsements; an endorsement is a continuing education training that is available to peer support specialists once they are certified. Endorsements help promote the professional development of a peer support specialist. Current peer support endorsements training includes brain injury, military, and New American/Foreign Born Immigrant.

The 1915i State Medicaid Amendment Plan continues to reimburse Peer Support and Family Peer Support. There are currently 22 Peer Support Enrolled Group Providers and 9 Family Peer Support Enrolled Group Providers.

Throughout the year the state hosts free and low-cost continuing education for peer support specialists and peer support supervisors, some examples of training include “Making Ethical Decisions in Peer Work”, “Utilization of Supervision for Peer Support Specialists”, “Ethics for Peer Support Specialists”, “Self-Care for Peer Support Specialists”, “Trauma-Informed Care”.

During the 2019 Legislative Assembly, the State established the Recovery Housing Assistance Program (RHAP) through dedicated funding. RHAP supports individuals in early recovery by reducing financial barriers to accessing recovery housing. The program aims to expand access to supportive, best-practice recovery environments and improve health and stability outcomes. Recovery residences offer a substance-free living environment with 24/7 access to peer support, helping individuals initiate and sustain their recovery within a safe, structured, and empowering setting.

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

N/A

6. Please indicate areas of technical assistance needs related to this section.

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Footnotes:

Environmental Factors and Plan

11. 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 disorder 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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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 on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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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 use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: 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**

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 use 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 Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides 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 Substance Abuse and Mental Health Services (SAMHSA) System of Care (SOC) Expansion and

Sustainability Grant in September 2022 to enhance mental health outcomes for children and youth. The purpose of the grant is to build and expand a comprehensive set of community-based behavioral health services and supports for children and youth with serious emotional disturbances (SED), birth – age 21, and their families. The grant focuses on two geographical catchment areas: Lake Region Community Behavioral Health Clinic (Devils Lake) partnering with both public and private providers in six counties in the region and West Central Community Behavioral Health Clinic partnering with both public and private providers in 10 counties in the region. These two regions include four tribal nations: Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians and Mandan Hidatsa Arikara Nation.

North Dakota System of Care grant initiative aligns with the Behavioral Health Strategic Plan, AIM 5 - to enhance and streamline a system of care for children with complex needs and their families. The two primary goals include:
1. To increase access to high-quality and culturally appropriate services and supports for children with SED and their families in the identified regions.
2. To develop a sustainable infrastructure to support the System of Care approach for North Dakota children with SED and their families.

In the current Grant Year 3, service implementation includes partial hospitalization/intensive day treatment, Functional Family Therapy, Parent and Caregiver Peer Support, and expansion of both school and community-based, evidence-based treatment and care coordination.

Service Highlights include:
The opening of a Child and Adolescent Partial Hospitalization Program in Bismarck (April 2025)
The launch of Parent and Caregiver Peer Support training and integration of parent peers in Human Service Centers
Investments in local service expansion including community and school-based services:
Group evidence-based treatments (SPARCS, Seeking Safety)
Expanding the number of clinical providers in rural and tribal communities
Training and workforce development in evidence-based practices
Early childhood interventions including Child Parent Psychotherapy (CPP), Parent Child Interaction Therapy (PCIT), and Child Parent Relationship Therapy (CPRT)
Care coordination
Supporting the expansion of FamilyFirst Prevention services including Functional Family Therapy (FFT), Family Check Up, and Healthy Families

Through the SOC grant, the Department has developed a contract with University of Connecticut Innovations to develop a roadmap for North Dakota to implement High Fidelity Wraparound for children with complex needs and at risk for out of home placement.

The System of Care initiative has prioritized developing partnerships locally, regionally, and statewide across child-serving systems. SOC Regional Steering Committees have convened since April 2023 and bring together stakeholders from Human Service Centers, private behavioral health providers, hospitals, child welfare, juvenile justice, schools, tribal communities, family organizations, and youth and parents with lived experience. The steering committees guide and advise grant implementation and develop local priorities and action planning. Each of the regional steering committees have created working groups related to the youth crisis continuum, care coordination, and service array.

Beyond the SOC work across public and private agencies, there are a number of other crisis services, addiction services, behavioral health and education services and other initiatives that have been implemented and expanded to improve the children's behavioral health system in ND.

North Dakota law enforcement agencies can access Avel eCare virtual crisis services through an effort funded in the 2023 and 2025 North Dakota Legislative Sessions. AVEL provides law enforcement with 24/7 access to behavioral health professionals who can assist in responding to people experiencing a mental health crisis. The program virtually connects law enforcement with behavioral health professionals to assist with de-escalation, stabilization and safety assessment during crisis situations regardless of location. The regional state-operated behavioral health clinics are also provided information for people who have utilized this service and follows up within 24-48 hours to provide support and information for regional mental health services. This service is beneficial, often resulting in the person staying safety in the community and not needing a higher level of care.

North Dakota administers a state-funded Substance Use Disorder (SUD) Voucher program for individuals to utilize to increase access to treatment services and allow for choice of provider. In 2024 the age limit for the SUD Voucher was changed from age 14 down to 12 to ensure services are available. When a youth accesses the SUD Voucher, they are provided with individualized support to sign up for Medicaid. There are currently 15 providers across the state providing adolescent addiction treatment services with levels of care extending from outpatient to high intensity residential.

The North Dakota Mental Health Program Directory provides a single place for North Dakota citizens to search for mental health services that meet their needs. This registry allows users to search by location, view program information (including program name, address and phone number) and includes search feature to find providers specifically for youth, specific treatment modalities and for SUD services for youth.

North Dakota licenses six Psychiatric Residential Treatment Facilities (PRTFs). Two of those facilities integrate SUD care into treatment.

Currently, the State is in a planning grant phase for CCBHC, completing community needs assessments and finalizing criteria. Although the Behavioral Health Division remains responsible for 24-hour crisis services, carried out through the clinics, CCBHC criteria mirrors this by identifying crisis services as a necessary component of certification. Expansion of mobile crisis competencies in youth-specific interventions is a priority for the 5% set-aside this next biennium. The Division hopes to contract with an agency to provide training and consultation support to mobile crisis staff in youth-specific interventions and best practices. An additional area of need includes a "safe place to be" for youth. The Division continues to work with community partners including the psychiatric residential treatment facilities and acute hospitals for opportunities to expand the current service provision to include crisis assessment and short-term crisis stabilization.

The transition to CCBHC's will enhance individuals' front door experience. The Department along with its regional partners aims to build a behavioral health system where access is simple, welcoming, and barrier-free. A place to support youth and families in navigating behavioral health, school-based, and community/financial resources and to ensure timely access to diagnostic assessment and care coordination tailored to youth and family needs. This transition will standardize documentation and intake workflows to reduce repetition and support smoother referrals between schools, court, and behavioral health providers and develop guidance focused on the unique needs of youth and families to minimize confusion and service delays.

Twelve care coordinators have been hired to date at the community behavioral health clinics. These care coordinators are available to provide supports to families in accessing the right behavioral health services at the right time. They will connect youth and families to providers, resources, and supports across systems (health, education, social services, etc.) and reduces gaps in care by coordinating communication between providers and systems. This will help to ensure continuity of care during transitions and ultimately improve outcomes by creating a unified, team-based approach around the youth and family.

The implementation of Functional Family Therapy (FFT) in the community behavioral health clinics started in September 2023 with consultation leading to 20 approved full-time employees in February 2024. In August 2024, a statewide training was held to train the employees in FFT. As of today, 11 of the 20 positions have been filled with the other positions actively recruiting.

One community behavioral health clinic has implemented Multi-Systemic Therapy (MST) Services - an evidence-based treatment for youth ages 12–17 with serious behavioral challenges. This service focuses on youth at risk of out-of-home placement due to delinquency, substance use, or other complex issues. It is a family- and community-based approach that addresses the multiple systems influencing the youth (family, peers, school, neighborhood). Therapists work intensively with families in their homes and are available 24/7. 64 families were served at the community behavioral health clinic during the past two years.

Juvenile Drug Courts were established in May 2000 (N.D. Sup. Ct. Admin. R.56), by the North Dakota Supreme Court. Juvenile Drug Court (JDC) is a post-petition/post-adjudication program with the option of the petition being dismissed after the participant successfully completes the program. The mission of JDC is to "reduce juvenile delinquency and substance abuse by referring youth who are less likely to achieve a positive result in traditional juvenile court, into treatment court which holds them accountable and emphasizes personal responsibility." The program lasts a minimum of nine months. The program is aimed at intervening in alcohol and drug-using, delinquent and unruly behavior, through intense supervision and participation in recovery services. Initially, participants in JDC are required to appear before the judge every week. At each appearance, the judge reviews the progress or lack of progress of the participant. The continuum of services for the program includes participation in intensive treatment, alcohol and drug testing, community service, incentives and sanctions, and additional programs as determined by the team. The JDC team consists of a judge, prosecutor, defense counsel, probation officer, coordinator, treatment provider, school representative, and law enforcement. Over the past biennium, the Department has worked collaboratively with the North Dakota Supreme Court to begin the process of evaluating treatment best practices.

Ruth Meiers Adolescent Center (RMAC) is a state operated and owned Psychiatric Residential Treatment Facility (PRTF) that provides intensive, 24-hour care for youth and adolescents between the ages of 12-17 with severe emotional disturbance. The residential facility offers comprehensive mental health and substance use treatment including individual and group therapy, medication management and skill-building. Data indicates the primary diagnostic profile of the youth admitted to RMAC within the last two years consist of four core areas, often intersecting in complexity: conduct and behavior challenges, trauma, developmental/neurodivergence, and complex psychiatric diagnoses.

In April 2025, the Department launched Parent and Caregiver Peer Support training to integrate of parents with lived experience into HSCs and across child-serving systems. Parent and Caregiver Peers are individuals with lived experience raising a child with emotional, behavioral, developmental, or special healthcare needs. 23 parents/caregivers were trained in this first training. They use their journey to guide and support other families navigating complex systems. ND is focusing on integration of parent and caregiver peers into the community behavioral health clinic youth and family teams and has invested in family organizations through the System of Care grant.

In April 2025 using System of Care funds, a child and adolescent Partial Hospitalization Programs (PHP) was opened at CHI St. Alexius Hospital in Bismarck. PHP and intensive day treatment programs provide intensive, community-based therapeutic services

that respond to the chronicity and severity of an individual's behavioral health condition. PHP and day treatment programs can be for mental health conditions, substance use disorders, and co-occurring disorders. There is limited access to PHP programs for children and adolescents across the state. During this past legislative session, funds were supported to expand access in other parts of the state. Expansion of PHP and day treatment programs increase frequency and intensity of behavioral health services by multidisciplinary treatment teams closer to home, reduce costly emergency room visits, and inpatient hospitalization stays and reduce Emergency Department boarding and length of hospital and residential stays.

The integration of behavioral health and education continues to be a priority. To help address the need for coordination for youth with multi-agency involvement, North Dakota's 2019 legislative session established the requirement for each school within a district to designate an individual as a Behavioral Health Resource Coordinator (BHRC). The Department's - Behavioral Health Division is required to provide resources on mental health awareness and suicide prevention to the behavioral health resource coordinator at each school. Resources must include information on identifying warning signs, risk factors, and the availability of resources in the community. To carry out this requirement, the Department contracts with the Central Regional Education Association (CREA) to provide training and technical assistance resources to the BHRCs. Through this effort, the Behavioral Health in Education: Resources and Opportunities Technical Assistance Center (B-HERO) was created with a mission to engage K-12 Behavioral Health Resource Coordinators in training, technical assistance, and opportunities to facilitate connections. To date, over 2,200 educators have been trained in topics including: Trauma-sensitive schools, PREPaRE Crisis Prevention and Intervention, Classroom Wise, Question, Persuade, Refer (QPR) and Harvard Relationship Mapping Protocol.

The Department also provides grants to schools to provide behavioral health services and supports to address student behavioral health needs. The purpose of the grants is to address and identify gaps along the behavioral health continuum of care. During the last 24-25 school year, over $4 million dollars were awarded to 22 eligible school districts or special education units with almost $3 million of those dollars to provide direct services in the schools. The Department also developed a pilot to demonstrate improvement to children's behavioral health in a school setting and learn how to fully integrate a continuum of supports in a school. Toolkits were developed to assist schools in ND in creating Tier 1, 2 and 3 supports. The toolkits are available online and in print to assist school in creating multi-tiered systems of support.

Through a collaboration with Sanford Research North and the Treatment Collaborative for Traumatized Youth (TCTY), the Department implemented Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) in community and school settings during the 2024-2025 school year. SPARCS is an evidence-based group intervention for adolescents and young adults, ages 12-21. The project is training community-based clinicians and school personnel to co-facilitate groups. Over 100 youth were served in the first year and included implementation in Spirit Lake Nation and a Spanish group in Mandan Public Schools. In the 2025-2026 school year, we have expanded further into rural and tribal communities with 14 sites in SOC grant regions.

During the 2023 legislative session, funding was supported for a Behavioral Health Navigator position within the Department's Behavioral Health Division. The Behavioral Health Navigator's primary purpose is to facilitate connection to mental health and substance use services, identify resources for individuals and families and assist in interpreting clinical language. Since October 2023 when the Behavioral Health Navigator was hired, 413 individuals have been connected to services.

North Dakota's Children's Cabinet was created by 2019 Senate Bill 2313 to assess, guide and coordinate care for children across the state's branches of government and tribal nations. The 12-member cabinet members include legislators and representatives from various state agencies, the Governor's Office, the North Dakota Supreme Court and tribal nations. Other members appointed by the governor include parents, private service providers and other community partners.

North Dakota also continues to work to build infrastructure, provide training opportunities and education to support evidence-based programs that address the needs of children with serious emotional disturbances.

The Department contracts with the Treatment Collaborative for Traumatized Youth (TCTY) which is a network of clinicians whose mission is to implement, evaluate, and sustain the practice of evidence-based mental health treatments for children who have experienced traumatic life events.

This collaboration provides funding for the training of clinicians in both the public and private behavioral health service delivery system. The specific focus of the training is Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT). The funding provided by the Department also supports a minimum of six months of case staffing and consultation calls with the TF-CBT trainer and other clinicians who have received the training.

A separate collaborative effort between the Department and TCTY is Project HEAL. Project HEAL aims to expand resources to address gaps and improved access to culturally relevant trauma services for Native American children. The three primary goals of the project are to: (1) Educate child-serving professionals on the incidence and consequences of historical trauma on Native American youth and communities, (2) Train mental health clinicians in culturally-informed trauma treatment enhancements, and (3) Increase access to culturally-informed trauma treatments for Native American youth in the state.

The Department prioritized training 30 youth and family clinicians in Accelerated Resolution Therapy (ART) and collaborated with trainers to focus training content on adaptation for work with children, adolescents, and their families.

The Department is working to provide training and technical assistance on 988 and the connection to crisis mobilization services regionally. Regional efforts have included training school, child welfare, and other child-serving professionals on What Happens When You Call 988 and introducing Crisis Mobilization Teams in-person. The training and partnership building aims to increase the utilization of the crisis continuum for behavioral health needs and reduce law enforcement involvement and emergency room visits when a child can be stabilized in the community.

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.

While a significant amount of work has been done and expansion continues, there remain gaps and limitations in our children's behavioral health system. Regarding crisis services – Only one community behavioral health clinic provides Multisystemic Therapy and has a contract to provide youth specific mobile crisis. Limited behavioral health workforce remains a challenge and crisis residential for youth is not currently available. Partial Hospitalization Programs are currently only available in two regions and there is no acute hospitalization safety net. Care Coordination enhancements - this is a new service provided by the Community Behavioral Health Clinics and aligns with the Certified Community Behavioral Health Clinic model. Wraparound Intensive care coordination has been demonstrated as a best practice for youth with behavioral health needs and multisystemic involvement, but this is expensive and a heavy lift with limited workforce. Outpatient Services/Intensive Home and Community-Based Services are also limited especially in rural and tribal areas. Research indicates the need for enhanced community partnerships to adequately treat individuals needs. The need for services is outpacing the behavioral health workforce. And lastly, fee for service model is not adequate in funding services for individuals with complex needs.

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

N/A

8. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

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

The state partners with several organizations throughout the state to lead suicide prevention efforts, focusing on risk and protective factors and warning signs and recognizes that work to increase access to behavioral health care is suicide prevention. Other efforts include:

Continued 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 the high-risk population of service members, veterans and their families began this past year as well.

Funding opportunities for local government organizations, nonprofits, and tribal communities in suicide prevention training and supporting the implementation of prevention efforts using life skills and resilience, as well as connectedness, as areas of programmatic focus via community programming.

Suicide prevention training for Care Coordinators and Peer Support Specialists.

The North Dakota Suicide Fatality Review Commission reviews deaths by suicide in North Dakota. Findings are then used to generate data driven suicide prevention recommendations, which are shared with stakeholders and the HHS Commissioner to be incorporated into both HHS and statewide partner suicide prevention efforts/strategies.

Administration of Parents Lead, 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 the Zero Suicide Initiative? (●) Yes ( ) No

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

If yes, please describe how barriers are eliminated.

The State is currently in the planning grant stage of rolling out Certified Community Behavioral Health Clinics (CCBHC). Up to four of the state-operated community behavioral health clinics will become certified in the next several years. As such, there are several areas targeted for enhancement and focus, including improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

With the statewide media marketing and awareness campaign to promote the 988 suicide and crisis lifeline to the general population, we also added a specific campaign aimed at the high-risk population of service members, veterans and their families.

6. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, 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 justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- 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.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. 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 Behavioral Health Division 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. This state 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 through the state's System of Care grant. 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. Partnerships and collaboration with family advocacy organizations such as 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.

4. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

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, letter from the Council Chair etc.)

The Council meets quarterly to discuss community-based public behavioral health services and works closely to plan for the system of care and monitor its implementation. The agenda of each meeting involves review and discussion of the priority areas found in the block grant and discussion of the system of care. The Council's input is requested prior to submission of the block grant plan. The Council developed recommendations which drove the decisions regarding the Mental Health Block Grant budget allocations. The Council has also provided recommendations to both the Department of Health and Human Services and the Governor's Office.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

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

The State partners with the Human Services Resource Institute (HSRI) to continue to evaluate the state plan. Each Aim represents an area of focus within the state. Additional feedback is gathered through the Behavioral Health Planning Council to weigh in on Aim progress and additional areas of consideration. The Department utilizes contract administration to procure and manage contracts for services in alignment with these goals as well as provides direct care services through the state-operated behavioral health clinics.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

6. 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 duties and responsibilities include to monitor, review and evaluate the adequacy of behavioral health services in the state. The council reviews the state's combined (MHBG & SUPTRS) application and report and serves as advocates for people with mental illness (adults with SMI and children with SED) and a substance use disorder. The Council provides options for public comment during quarterly meetings and the public can provide recommendations at any time to the Department.

7. Please indicate areas of technical assistance needs related to this section.

None requested at this time.

Footnotes:

ND Behavioral Health Planning Council (BHPC)

Quarterly Business Meeting

July 17, 2024

Meeting Minutes

Council Members in Attendance: Emma Quinn (Consumer- Indiv. in recovery MH); Carlotta McCleary (ND Federation of Families for Children's Behavioral Health); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Denise Harvey (Protection and Advocacy); Matthew McCleary (Mental Health America of ND); Mandy Dendy (Principal State Agency: Medicaid); Brenda Bergsrud (Consumer Family Network); Dan Cramer (DHHS Behavioral Health Delivery System; Melanie Gaebe, (Consumer, Indiv. in Recovery SUD; Tania Zerr (Consumer, Family Member of a Child w/SED); Kristi Kilen (Private Mental Health Provider); Heather Call (ND National Guard); Kurt Snyder (Consumer- Indiv. in Recovery); Pamela Sagness (Principal State Agency: DHHS Mental Health); Jennifer Henderson (Principal State Agency: Housing); Mark Schaefer (Private Substance Use Disorder Treatment Provider); Tim Wicks (Consumer, Veteran); Robin Lang attending on behalf of Amanda Peterson (Principal State Agency: NDDPI Education); Brad Hawk (Indian Affairs Commission) Dr. Amy Veith (Principal State Agency/Criminal Justice); Cheryl Hess Anderson (DHHS, Vocational Rehabilitation) Michelle Gayette (DHHS Aging Services).

Council Members Absent: Paul Stroklund (Consumer, Family Member of an Adult with SMI); Michelle Masset (Principal State Agency: Social Services);; Dr. Lisa Peterson (Consumer, Family Member of a Veteran); Lorraine Davis (Consumer- member at large); Michael Salwei (Healthcare Representative); Glenn Longie (Tribal Behavioral Health Representative); Carl Young (Consumer, Family Member of a Child with SED- has resigned with position now vacant); Deb Jendro (Consumer Member Indiv. in Recovery MH – has resigned with position now vacant).

Staff: Tami Conrad (DHS, Behavioral Health)

Facilitator: Janell Regimbal of Insight to Solutions

Call to Order: Vice Chair Matthew McCleary called the meeting to order at 10:00 AM CT, via videoconference and with members present at the ND Job Service office in Bismarck.

Quorum. Members introduced themselves via the roll call process. Roll call indicated a majority of members were present. A quorum was declared**.**

Approval of Minutes. MELANIE GAEBE MADE AND PAMELA SAGNESS SECONDED A MOTION TO APPROVE THE APRIL 10, 2024, BHPC MEETING MINUTES AS PRESENTED. THE MOTION PASSED UNANIMOUSLY.

Approval of Agenda. Vice Chair McCleary called for approval of the agenda with two changes requested: the report on NDPMHCA School Consortium will now be provided by Anne Williamson rather than Lyndsi Engstrom and a request from Pamela Sagness to join the timeframe of the State Hospital report due to an anticipated conflict during the 2:40 PM timeslot. CARLOTTA MCCLEARY MADE AND PAMELA SAGNESS SECONDED A MOTION TO APPROVE THE JULY 17 AGENDA WITH THE NOTED CHANGES. THE MOTION PASSED UNANIMOUSLY.

Members were reminded of the mission and goals of the BHPC.

BHPC Updates: Tami Conrad provided a brief report on membership, sharing two current consumer positions are still open, specifically for a family member of a child with SED and individual in recovery from SUD or MH. Online applications are currently being accepted. Three members were reappointed: Melanie Gaebe, Paul Stroklund and Heather Call.

Janell Regimbal provided background information on how we will proceed with the nomination process and elections in advance of our annual meeting in October. We will elect a Vice Chair who will take office following the annual meeting in October with a planned succession to Chair following a year in that position. A position is also open on the Executive Committee for an individual with lived experience or a family member. An electronic ballot will go out between this meeting and the next. The following members volunteered to have their names placed on the ballot: Melanie Gaebe, Vice Chair; Kurt Snyder and Tania Zerr, Executive Committee. The slate will remain open with Janell calling for additional nominations in September. Electronic voting will occur just prior to the annual meeting.

Summary Report of ND Behavioral Health Strategic Plan and Future Activities: (PPT slides provided) Bevin Croft of the Human Services Research Institute. Ms. Croft reviewed recent achievements aim by aim of the thirteen stated aims of the ND Behavioral Health Strategic Plan which came out of the 2018 comprehensive study of the system. BHPC members who are liaisons on the various aims were thanked for their work.

Aim 1	April 2024 dashboard is live; July 2024 under development.
Aim 2	Two new prevention goals are under development.
Aim 3	Brain injury system study nearing completion; 988 communications continue.
Aim 4	School based service grants and BHERO continuing for coming school year; CCBHC goal underway.
Aim 5	New System of Care Lead Administrator; working to dev. family peer support into SOC efforts.
Aim 6	Integrating trauma reform projects info DOCR strategic plan.
Aim 7	New position at BHD focused on workforce issues; summit focused on university partnerships planned for October 2024; developing new goal focused on peer workforce.
Aim 8	Tele-behavioral health crisis enhancement goal underway.
Aim 9	Initiated person -centered practices self-assessment process with BHD policy team.
Aim 10	Working on a new goal focusing on lived experience involvement with BH initiatives.
Aim 11	Working on expanding access to training resources in tribal communities
Aim 12	Exploring options for strengthening and expanding financial support for peer support.
Aim 13	Developing HHS guidance on best practice for data collection in support of id and tracking disparities.

In response to a question regarding permanent supportive housing and what is being done for persons with mental illness, Ms. Croft responded the recommendation in the plan is for an expansion of evidenced based culturally responsive supportive housing for people with MI/SUD. Much of the plan has focused on developing financing for these models and quality standards. There is a quality checklist that has been developed for any permanent supportive housing sites receiving funding with Heather Brandt of DHHS lead staff on this. The tool and checklist have not yet been fully incorporated into the financing model yet. Ms. Croft was asked if there are any aims that will need advocacy in the upcoming legislative session. She indicated the system of care work and the certified community behavioral health clinics (CCBHC). Both pieces are very comprehensive and evidenced based practice models for modern behavioral health systems.

BHPC Policy and Procedure Handbook Review: Janell Regimbal, facilitator. Regimbal reminded members that this process began as we identified items last year in our bylaws that were no

longer accurate and in need of change. Upon consultation with the Governor's office, we were advised it would be best to transition from a bylaw driven group to one of the policies and procedures manual to allow for more detailed and adaptable guidelines. This advice was congruent with the best practices document shared by SAMHSA for state behavioral health planning councils. The process employed included the Executive Committee taking the lead in reviewing and providing direction on draft policies and procedures that were based upon the content of the current bylaws. Following their review and edits the draft went to the full BHPC with a 30-dayreview period in May. Those comments were taken into consideration for the final draft sent to the BHPC members via email on June 27 in preparation for today's discussion about finalizing their adoption if the membership deems ready. The bylaws will stay in effect until they are formally repealed. CARLOTTA MCCLEARY MADE AND MELANIE GAEBE SECONDED A MOTION TO REPEAL THE CURRENT BYLAWS IN ORDER TO ALLOW FOR THE ADOPTION OF A POLICY AND PROCEDURE MANUAL WHICH WILL BE USED TO GUID OPERATIONS AND GOVERNANCE OF THE GROUP GOING FORWARD. THE MOTION PASSED UNANIMOUSLY. Following discussion of 03-01 Abstention, related to concerns of not clearly have defined conflict of interest as well as the need to consider a policy and procedure which lays out the process by which future policy and procedures can be amended or added, ANDREA HOCHHALTER MADE AND TIM WICKS SECONDED A MOTION FOR THE ADOPTION OF THE DRAFTED POLICIES AND PROCEDURES AS PROVIDED WHILE WE CONTINUE TO REVIEW FOR EDITS 03-01 AND CONSIDER HOW TO BEST INCOROPRATE THE PROCESS BY WHICH FUTURE CHANGES ARE MADE TO THOSE PROVIDED WHICH ARE ROOTED IN THE BYLAWS AND WERE PROVIDED FOLLOWING FEEDBACK FROM MEMBERSHIP. THE MOTION PASSED UNANIMOUSLY. The two issues raised for further consideration will be on the October agenda. Mandy Dendy agreed to provide recommended language for conflict-of-interest.

DHHS FY26-27 Budget Overview & Needs, Pamela Sagness, Executive Director/Behavioral Health, NDDHHS. Ms. Sagness shared the timeline for the budget. They are presently in the middle of budgeting and will be submitting the DHHS budget in September. Prior to that it will be presented to the HHS internal Executive Team in mid-August when different divisions come forward with decision packages. They have been talking with providers/vendors for the last six months about needs. Once the Executive Team formulates it into one budget, it then goes to the Governor's office who looks across all agencies to develop the budget presented to legislators in December. Department heads will not know what is included until it is publicly announced in December. If it does not align with what was submitted there will be a need for re-budgeting. The budget will be categorized in, allowing for the ability to see more specific line items. The department is looking to re-establish a letter system of communication sent to vendors about the budget. Pamela also shared several initiatives that are going on related to systems change. Please feel free to reach out to her to share ideas. Issues such as full geriatric facilities impacting people getting into the right facilities for their needs, paroled people not being able to get into skilled nursing due to their backgrounds, FTR/Community Connect not able to meet demands of requests for service and issues around residential facilities for kids. A conversation around what minimum expectations for service in a best practice world would be expected per region as it relates to behavioral health would be helpful to have with the BHPC. CCBHC funds will now be freed up for another location due to no RFP responses for Dickinson 10 bed facility.

State Hospital Building and Operations Update, Aaron Olson/Superintendent of State Hospital. They are now in the last phase of design development with the state hospital staff and community providing lots of valuable input. They currently have 680,000 sq ft across six buildings and in the new design will have 280,000 sq ft. Having one environmental group vs six will be very helpful to staffing efficiencies and a new hospital may also have an impact on people wanting to work there. They have been zeroing in on three things: culture, people, and financials (having a more

transparent budget). When asked where current funding levels are for the building, he shared there is $12.5M appropriated for pre-design work provided last session. This money will run out in September. They have a proposal to not pause, but to request the Emergency Commission review their proposal to continue moving forward as it will be more cost effective. It is hoped to begin construction in summer 2025. Current licensing of the state hospital is 125 beds plus sex offenders. The new number is proposed to be the same. They are currently staffed with 81 beds and are not proposing to increase the licensed number of beds. Immediate access is not as accessible as people want to see, with waiting lists at times. When asked if patients were talked to about what is needed, it was shared that staff have asked for patient input and there has been much focus on therapeutic environment. The advocacy of the team at the hospital has been heard clearly in the process as well as through a community meeting.

Adjourned for lunch at 12:05 PM

Vice Chair Matthew McCleary reconvened the meeting at 1:00 PM.

School Based Medicaid & Behavioral Health Services, (PPT slides provided) Mandy Dendy/Medical Services Division, DHHS. Ms. Dendy provided an overview of the public entitlement program, Medicaid, which is jointly funded by federal and state governments. Historically Medicaid was only available for children on IEPs. In 2014 CMS allowed state Medicaid agencies to expand to those not on IEPs. In 2021 ND expanded school-based services beyond medically necessary IEP services to include non-IEP services. When this occurred, ND did not have to do a state plan amendment – just a policy change. Medicaid covers all Medicaid services covered under our state plan in a school-based environment. This includes things like speech therapy, OT, PT, school nursing, ABA, TCM, etc. Most of the times these providers work for the schools but community providers who come into the school would also be considered school-based services. These billed services can include behavioral interventions, counseling services, skills training, and the like. ND is seeing an increase in community providers billing Medicaid for services offered in the school settings, but youth are still getting more services in their community vs school-based settings. ND is fee for service based. The state pays the state share of Medicaid up to 50% in any given year, so ND schools currently pay the state match share for IEP services. IN FY24 the federal share is 53.82% so if a school does not bill Medicaid, they 100% fund things out of their budgets. When a school bills non-IEP services there are no state match requirements, so the school keeps 100% which is a huge incentive for schools to bill for behavioral health services. If a private provider comes into the school to provide services but it is not the school that bills Medicaid, then none of the match comes out of the school's budget. When asked about billing for counseling outside of an IEP when the student has private insurance and the unique intricacies of those situations as to whether Medicaid is a payer of first resort or last resort is covered in federal law, but Mandy will need to seek out that specific information to be certain. DHHS has a behavioral health grant funding program. These grants allow units or districts who are billing Medicaid to apply for a grant up to the amount of their Medicaid Match. See the ppt slides for service requirements related to student eligibility, provider qualifications and covered service array. North Dakota has submitted a state plan amendment to CMS to add school psychologist effective 7/1 and are working on processes around this change. Mental health technicians, primarily through the human services centers, are looking at work that can be brought into schools. A request to CMS to add Behavioral Analysts will also occur in 2024. Ms. Dendy asked members to go back to their home communities and be champions for getting increased behavioral health services in schools, by finding out what the needs are of students in the district, what if any behavioral health services are being offered in the school; knowing if the district is billing to ND Medicaid and what the barriers may be. There is help and technical assistance provided by ND Medicaid. See school-based-medicaid.pdf (nd.gov) for more information

UPDATES: DHHS Behavioral Health Division

1. **NDPMHCA School Consortium Update:(PPT slides provided) Anne Williamson, Program Manager/Central Regional Education Association** Ms. Williamson joined to update on the prior school year happenings and some of the innovations utilized. The grant funds provided support to the consortium network of school partner and additional schools through the B-HERO technical assistance center which was made available due to extra funds received in February. Several years ago, the state legislature required all schools to designate a behavioral health resource coordinator within their school. Those staff became a natural partnership with the B-HERO team. See the slide deck for a snapshot of training and services that were accessed in phase one of the rollout. Experiences like the Cook Center for Family Health offering targeted parent coaching services and the Check and Connect evidenced based dropout prevention intervention were shared as examples of ways they engaged with schools. Their role is to offer statewide supports to schools in implementation and access to trainers. Access to high quality training has been appreciated by schools. Regarding technical assistance, all engaged schools were a part of a school-wide PBIS tiered inventory walk through to assess their current state of behavior systems. Check and Connect is for K-12 grades, working to intervene early before students are credit deficient. When asked where their service area is, B-HERO is statewide and CREA, while having a traditional catchment area that is in south central ND, does try to operate without borders as much as possible. See the slide deck for phase one learnings and upcoming plans for phase 2. As an entity they have many data collection processes in place with the schools they work with, so have a good sense of their current state of programming and interest in things such as 1915i, etc. When asked about what if anything has changed in programming offered since the grant is no longer oversaw by Sanford, Laura Anderson indicated Sara Kapp could provide that information to the Council, but with an indication most high-level tings remained consistent. She will provide an update to the members when the minutes are sent out.

Sara Kapp Program Administrator DHHS provided this additional information in response to question posed during the meeting and is inserted here to address what changes have occurred: *The ND PMHCA program continues its previous efforts that were being implemented within the previous grant cycle from 2018-2023 as well as implementation of new efforts. The current goals for the program include Goal* ***1: Increase the capacity of primary care providers to screen, diagnose and treat children for behavioral health disorders in primary care settings.*** *Objective 1-a: Increase the number of children receiving access to Tele-behavioral health care in primary care settings by 25% by 2026. Objective 1-b: For North Dakota's PMHCA efforts to work towards achieving health equity related to racial, ethnic, and geographical disparities in access to behavioral health services.* ***Goal 2: Develop and create capacity for telehealth programs in community-based settings by expanding partnerships within Emergency Departments and schools.*** *Objective 2-a: Strengthen and expand training and implementation of integrated behavioral health support in schools to increase the number of students receiving tele-behavioral health services. Objective 2-b: Build capacity within the Emergency Departments and provide training and technical assistance to identify risk factors and early warning signs. Some current activities include Consultation line, Care Coordination offered through Family Voices, Behavioral Health specific trainings through: ECHO sessions, grand rounds and BHD/CFS conference, Reaching Teens, and Reach Institute. Our current efforts within CREA are expanding through statewide schools as presented at the council meeting. Other engagement strategies include increased communication with primary care*

providers, new partnership with Critical Access clinics, UND Pediatric Residency Program and expansion beyond just primary providers within clinics but touch points of Nurses, PA's, NP's etc.

2. **Overview of SUPTRS Prevention and MHBG Prevention Requirements: (PPT slides provided) Laura Anderson, Policy Director, DHHS.** Ms. Anderson presented an overview of North Dakota's substance use prevention initiatives, covering a range of topics including prevention strategies, federal grant administration, training and technical assistance, communication approaches, and early intervention efforts. She highlighted

   the Behavioral Health Continuum of Care and the Strategic Prevention Framework (SPF) model; and emphasized the importance of addressing risk and protective factors that influence the likelihood of developing substance use or behavioral health problems. Effective prevention, Anderson noted, focuses on reducing risk factors while strengthening protective factors. The BHD's role in prevention involves administering federal grants, specifically the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and the Partnership for Success (PFS) Grant. These grants fund primary prevention strategies aimed at individuals not identified as needing treatment. The SUPTRS Block Grant requires at least 20% of the funds to be allocated to primary prevention, focusing on underage drinking, adult binge drinking, and opioid misuse. Local prevention providers, including local public health units (LPHUs) and tribes, play a key role in these efforts. Anderson highlighted examples of community implementation, such as Responsible Beverage Service Training in Cavalier County and sober rides during the county fair in Wells County. To support these prevention initiatives, the BHD provides extensive training and technical assistance, to strengthen the capacity of individuals, groups, and organizations to implement and sustain effective strategies. This support includes in-person training, consultations, online events, collaboration, resource sharing, and information dissemination. A free resource center is available to assist with these efforts. When asked if there is a way to look at how we can prevent based upon the child's mental health needs, she stated although mostly the funds are targeted to substance use prevention, they are able to implement universal or environmental strategies rather than more individual risk level circumstances efforts which has the potential to impact all on some level. Statewide messaging is another crucial component of the prevention strategy. Based on research, the key messages to parents and caregivers focus on love, looking (being present), and listening to children. These messages aim to promote positive behavioral health through parental engagement and monitoring. The target audience for these messages includes parents, caregivers, professionals in contact with high-risk parents, and communities sharing these tools locally. Early intervention was highlighted as a critical aspect of the prevention strategy. Early intervention involves recognizing the warning signs of mental health or substance use disorders and providing timely intervention to prevent further development and consequences. Laura shared data as an example high school alcohol use by one indicator in the YRBS data has dropped more than half since 1995 from 60.7% to 19.5%. Another data indicator they look at is the age of initiation of using alcohol. It has gone from in 1995 more than a third of high school students reported having their first drink before the age of 13, to now 11% had their first drink by age 13. The purpose of the MHBG is to provide community mental health services for adults with serious mental illness and children with serious emotional disturbances. A significant portion of these funds must support evidence-based programs addressing early serious mental illness, including psychotic

disorders, regardless of the individual's age at onset. When asked about legislative priority ideas, it was noted that since the federal dollars don't provide funding for MH prevention promotion, funds could be used for MI prevention strategies. It was pointed out that there is now less effort for family level programming on the treatment side, which is really a target rich prevention opportunity. It was recommended the state consider offering technical assistance training for providers in this area around good prevention materials to families. Concerns about the high level of vaping were raised, with Ms. Anderson pointing out vaping is addressed via funding that comes from the DC and therefore is run through the health department side and public health partner. See slides for other specific data points and programming highlights addressing prevention efforts. This year a PFS discretionary grant of $1.25M/year for up to five years was also awarded. It targets military, college students and children living with adults with SUD. The BHD is currently selecting five communities to target. This link was provided to order free prevention resources. Behavioral Health Free Resources > Catalog (x-shops.com)

3. **Family Network Update with Q&A: (PPT slides provided) Matthew McCleary, Deputy Director/Mental Health America.** Mr. McCleary shared about the CFN contract recent happenings. In June they hosted a conference in Bismarck with 85 in attendance. Sessions focused on indigenous mental health related topics and a variety of other topics, including one on cleanliness of homes and public housing challenges. He shared an example of a client who helped where there was a risk of homelessness that involved systems collaboration. Since his last report they have visited Jamestown, Williston, Bismarck, and Minot human service centers, also visiting recovery centers in those communities. During those visits they hand out promotional materials at community outlets such as libraries, rec centers, etc. Call volumes have increased. Katie Sims joined as a full-time navigator and part-time parent coordinator this month.

IMD Waiver Interim Activities Update: (PPT slides provided) Carlotta McCleary, Executive Director, ND Federation of Families for Children's Mental Health. McCleary of Mental Health America of North Dakota presented on the IMD Exclusion, a critical component of the Social Security Act affecting Medicaid payments for mental health services by providing an overview to help us understand what is involved. The IMD Exclusion prohibits Medicaid payments for services provided to individuals under 65 residing in institutions for mental diseases (IMDs), defined as facilities with more than 16 beds primarily engaged in mental health care. This exclusion is rooted in the historical shift from institutionalization to community-based services, promoting state responsibility and encouraging the development of community services. The IMD Exclusion does not apply to individuals 65 and older or children under 21 in certain psychiatric settings. Managed care enrollees can receive IMD services for up to 15 days per month, and states can apply for waivers to receive federal funds for specific services within IMDs. Before applying for an IMD waiver, states must develop strategies for budget neutrality, infrastructure, and service integration. She shared evidence suggests that increasing psychiatric beds can drain resources from community-based services, leading to higher costs without improving access to psychiatric care or reducing emergency room visits. The presentation emphasized the importance of balancing institutional care with community integration, aligning with Congress's intent as reflected in laws such as the Americans with Disabilities Act and the Olmstead decision. As a group, the BHPC did take a stand against the waiver during this past session for those reasons. During the April 2024 Interim Human Services Committee meeting, the issue has arisen again. Various organizations, including Prairie St. Johns as well as her testimony on behalf of the Mental Health Advocacy Network (MHAN) were offered. Prairie St. Johns supported the pursuit of an IMD Exclusion Waiver, while MHAN, represented by McCleary, opposed it, highlighting concerns about

budget neutrality and advocating for the expansion of community-based services instead. Sara Aker from the ND Department of Health and Human Services also noted the need for a comprehensive behavioral health care continuum before pursuing an IMD Exclusion Waiver. There was no time allotted for public comment. McCleary indicated concern of some misleading issues coming up related to uncompensated care, which in her estimation was not taking into consideration SUD vouchers and payments coming from human service centers. A member shared an example of the types of barriers that occur related to uncompensated care for things the SUD voucher does not cover, such as when someone in care needs to leave the facility to seek medical care for an injury. It was stated DHHS needs to be aware of this barrier. There was discussion of the request by providers of the immediate pursuit of ND's "in lieu of" authority to provide Medicaid Expansion reimbursement for up to 15 days, which would be a policy change. This could provide an opportunity for getting people the care they have needed and not been tending to and to stabilize medically. At the end of the 15 days, you could move them into an outpatient service or continue to keep them in care using the SUD voucher. It was also discussed that providers can certainly offer more than 16 beds; you just need to follow the rules to do it. As an example, having beds spread across communities in settings of no more than 16 beds. Members indicated a desire to know what Medicaid's position on this may be. The question was raised as to whether, if the waiver were put in place, if jails and the State Hospital would be impacted. It was noted it would not. It was also noted that there is not a single report in published record related to North Dakota's behavioral health service needs where there is a recommendation to expand institutional facilities. Regimbal reminded members of the educational materials still available from December 2022 and January of 2023 provided via out of state presenters who assisted us in understanding the issues around the waiver so that we could decide if we should take a position and if so, what it would be. It was requested the material be provided again to refresh understanding and the BHPC would like to further consider gathering more information on the "in lieu of" option to form an opinion before the next legislative session.

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

Lightening Round Sharing by Members- Besides the hiring of Katie Simms as reported earlier, the Federation of Families also hired two new parent coordinators, Katie McNamara in Bismarck region and Penny Nygaard in Devils Lake. Kurt Snyder shared about Heartview's training consortium, and the grant recently received grant from the opioid settlement that will allow tuition assistance for those pursuing addiction counseling degrees. NDTAAP addresses the pipeline for licensed addiction counselor trainees. Tami Conrad reminded of the BHD conference set for September 16-19. Free attendance option is available for members. She provided a code via email earlier this summer. Denise Harvey shared about training this fall related to employment that will bring in national experts. See their website for more information.

Next Meeting- October 16, 2024, via videoconference or in person at Bismarck Job Service at 1601 East Century. This will be our annual meeting.

Adjournment. Having completed all agenda items and hearing no further comments from BHPC members, Vice Chair McCleary called for a motion to adjourn the meeting at 4:00 PM CT, with CARLOTTA MCCLEARY MAKING AND DENISE HARVEY SECONDED A MOTION TO ADJOURN.

Respectfully submitted,

Janell Regimbal/Facilitator

Insight to Solutions

Behavioral Health Planning Council (BHPC) Annual Meeting

October 16, 2024

Meeting Minutes

Council Members in Attendance

Emma Quinn (Consumer - Individual in Recovery MH); Carlotta McCleary (ND Federation of Families for Children's Behavioral Health); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Denise Harvey (Protection and Advocacy); Matthew McCleary (Mental Health America of ND); Brenda Bergsrud (Consumer Family Network); Melanie Gaebe (Consumer, Individual in Recovery SUD); Kristi Kilen (Private Mental Health Provider); Kurt Snyder (Consumer - Individual in Recovery); Pamela Sagness (Principal State Agency: DHHS Mental Health); Jennifer Henderson (Principal State Agency: Housing); Mark Schaefer (Private Substance Use Disorder Treatment Provider); Michelle Masset (Principal State Agency: Social Services; Robin Lang (on behalf of Amanda Peterson, Principal State Agency: NDDPI Education); Cheryl Hess Anderson (DHHS, Vocational Rehabilitation); Lorraine Davis (Consumer, member at large);and Paul Stroklund (Consumer, Family Member of an Adult with SMI).

Council Members Absent: Michelle Gayette (DHHS Aging Services); Dr. Amy Veith (Principal State Agency/Criminal Justice); Brad Hawk (Indian Affairs Commission); Tim Wicks (Consumer, Veteran); Heather Call (ND National Guard); Dan Cramer (DHHS Behavioral Health Delivery System); Mandy Dendy (Principal State Agency: Medicaid); Michael Salwei (Healthcare Representative); Dr. Lisa Peterson (Consumer, Family Member of a Veteran); Tania Zerr (Consumer, Family Member of a Child w/SED); and Glenn Longie (Tribal Behavioral Health Representative).

Staff: Tami Conrad (DHHS Behavioral Health Representative)

Facilitator: Janell Regimbal of Insight to Solutions

Call to Order

Chair Lorraine Davis called the meeting to order at 10:00 AM CT, via videoconference and in-person at the ND Job Service office in Bismarck.

Quorum

A roll call was conducted, confirming a quorum with majority attendance. The Chair declared a quorum and welcomed members.

Approval of Minutes

KURT SNYDER moved to APPROVE THE JULY 17, 2024; MEETING MINUTES AS PRESENTED. PAUL STROKLUND seconded the motion. The motion passed unanimously.

Approval of Agenda

A motion to APPROVE THE AGENDA WITH AMENDMENTS (moving the 1915(i) report to the afternoon session to be provided by Sarah Aker) was made by CARLOTTA MCCLEARY and seconded by MELANIE GAEBE. The motion passed unanimously.

BHPC UPDATES

Membership

Tami Conrad announced two positions remain open: a family member of a child with SED and an individual in recovery with MH. The Governor's office is currently reviewing applications for these roles. Members were encouraged to recommend applicants if they knew of interested individuals.

Election Results

Facilitator Janell Regimbal presented the results of the electronic voting held from September 30 to October 7. Melanie Gaebe was elected as Vice Chair, and Kurt Snyder was appointed to the Executive Committee. A MOTION TO APPROVE THESE ELECTION RESULTS WAS MADE BY ANDREA HOCHHALTER and seconded by MATTHEW MCCLEARY. The motion carried unanimously.

Slate of 2025 Meeting Dates of the BHPC

A MOTION TO APPROVE THE SLATE OF DATES AS PRESENTED FOR 2025 WAS MADE BY CARLOTTA MCCLEARY and seconded by KURT SNYDER. The motion was carried unanimously with dates adopted of May 14, July 16, October 15 (Annual Meeting) and December 17.

Introduction of BHPC Policy and Procedures Proposed Actions, the following key points were discussed, and actions were recommended as it relates to how policies and procedures would be added, deleted, or revised. It was noted that while the council had previously moved from a bylaw-driven structure to one guided by a policy and procedures manual, there were gaps identified regarding how amendments or new policies would be proposed and approved.

- **Feedback on Supermajority Requirement**: Members discussed whether changes to policies should require a simple majority or a supermajority (e.g., two-thirds of the membership). Feedback leaned towards favoring a supermajority to ensure that significant changes reflect a strong consensus. The language of the policy will be revised to include a supermajority vote requirement for adopting or amending policies. The policy should clarify that the process applies not only to amendments but also to the adoption of new policies.
- **Formal Procedure for Policy Introduction**: Members proposed assuring a step for reviewing new policy suggestions before the final vote, potentially allowing for initial feedback at one meeting followed by formal adoption at the next.

The **discussion on the formation of a conflict-of-interest policy** included the following points and recommendations:

- **Need for a Formal Policy**: The importance of having a clear conflict of interest policy in place to guide council members on when and how to declare conflicts

was discussed. This was seen as essential for maintaining transparency and integrity during meetings, especially when decisions involve potential conflicts related to funding or policy positions, however it was noted the authority of this group is quite limited.

- **Draft Policy Overview**: A proposed conflict of interest policy was presented, detailing procedures for council members to declare conflicts during meetings. This included steps for identifying potential conflicts and a formalized process for recusal from discussions or votes when necessary.
- **Feedback on Specificity**: Some members noted that the draft policy was detailed, outlining several types of conflicts and the appropriate responses. This level of detail was seen as beneficial for providing clear guidance but prompted questions about whether such detail might be overly prescriptive. Members agreed that the draft policy should undergo further review to ensure it is practical and aligns with the council's needs. This review would involve considering feedback about the policy's specificity and any potential adjustments.
- There was a recommendation to include a designated agenda item for members to declare any conflicts at the beginning of meetings and again before voting on specific items. Adopting such a policy would strengthen the council's governance framework yet this needs to be balanced with the role of the group and assuring it is not taken further than needed so that we lose the ability of those with lived experiences etc. to share their views and experiences freely.

These recommendations and discussions reflected a shared goal of ensuring robust and transparent governance within the Behavioral Health Planning Council. The revised policy is expected to be brought back for further review and potential adoption at the December meeting.

Summary Report on ND Behavioral Health Strategic Plan (PPT slides provided)

Bevin Croft from the Human Services Research Institute provided a summary of the ND Behavioral Health Strategic Plan's status and ongoing activities. Updates on goals and progress across strategic initiatives were discussed. Highlights included:

- **Aim 1:** New updates on behavioral health dashboard metrics with work progressing on quarterly releases.
- **Aim 4:** Continued implementation of school-based behavioral health programs, with a focus on the Behavioral Health in Education (BHERO) model.
- **Aim 7:** Workforce initiatives including a new position focused on addressing workforce shortages, particularly through partnerships with local universities.
- **Aim 10:** Increased emphasis on involving individuals with lived experience in behavioral health initiatives across the state.

Council members were encouraged to participate in these aims through ongoing liaison roles. Ms. Croft noted that the System of Care work and the establishment of Certified Community Behavioral Health Clinics (CCBHCs) will require advocacy during the legislative session to ensure continued support and funding.

Member Feedback: BHPC Prospective Legislative Advocacy Agenda (PPT slides provided)

Facilitator Regimbal provided information about activities of the last session by way of review. Members provided feedback emphasizing the importance of ensuring that key legislative priorities align with the current needs in behavioral health. It was noted that there might be a need for advocacy around comprehensive care frameworks, particularly for programs that support families and community-based mental health services. Members also highlighted the relevance of supporting initiatives that focus on improving access to behavioral health services, integrating peer support, and reinforcing financial sustainability through state funding. There was agreement to consider setting priorities for advocacy for the BHPC ahead of the session so we can provide a priority document versus testimony. We can be broad in what is needed to move things forward. The December agenda will allow for discussion and planning to take place for the Executive Committee to move forward during the session.

Consumer Family Network Report (PPT slides provided)

The Consumer Family Network overview, presented by Matthew McCleary, included updates on initiatives supporting families dealing with children's mental health challenges. The report covered ongoing efforts to provide resources, support, and advocacy for families. It was noted that the network has been engaging in outreach activities aimed at improving family involvement in behavioral health service planning and policy discussions. The need for continued collaboration with state agencies to ensure that family voices are incorporated into decision-making processes was raised as well as highlighting recent success stories from the network’s outreach programs.

Adjourned for lunch at 11:55 AM

Chair Lorraine Davis reconvened the meeting at 1:00 PM.

1915i Provider Status & Clients Served Update (PPT slides provided)

Sarah Aker, Executive Director of Medical Services of DHHS, presented updates on the 1915i program, which included changes aimed at improving service delivery and reducing administrative barriers for providers. Key updates included:

- Removal of service authorization requirements for most services, effective November 1, 2024, to streamline access.
- Implementation of post-payment audit processes to ensure accountability without delaying care.
- Simplification of the provider enrollment process to encourage new providers to join the 1915i network.

Acre shared that enrollment had increased rapidly, doubling to over 700 clients in the last quarter, highlighting significant growth and increased access to behavioral health services. Until a new point of contact for the 1915i program is named, it was recommended to use the general 1915i program group email for inquiries until further updates are provided.

Institution for Mental Disease and the Managed Care in Lieu of Authority (PPT slides provided)

Sarah Aker provided information on the topic of Institutions for Mental Disease (IMD) and the Managed Care in Lieu of Authority. Key points included:

- **Definition and Regulations**: Aker explained that IMDs are facilities with more than 16 beds that primarily provide care for individuals with mental health or substance use disorders. Federal financial participation for Medicaid services at these facilities is restricted for individuals under 65 unless for inpatient psychiatric services for individuals under 21.
- **Current Payment Practices**: The presentation detailed how North Dakota manages payments for Medicaid services, including the process of suspending eligibility during IMD stays, affecting both fee-for-service and managed care models.
- **Managed Care In Lieu of Authority**: Aker discussed the option under Medicaid to use managed care plans for providing certain alternative services. She highlighted the benefits and limitations, such as the 15-day limit on stays and the potential impact on Medicaid expansion populations.
- **Challenges and Considerations**: The session included insights into how this authority could address current payment gaps but also raised concerns about its applicability, especially given the average length of stays for treatment being around 45 days, far exceeding the 15-day limit.

Aker responded to several questions including:

- **Extension of Stay Payments**: Aker clarified that service authorization payments for Prairie St. John's could extend past 14 days if a transfer to the state hospital is planned and delayed. In such cases, payments continue until the transfer is completed.
- **Funding for Extended Stays**: Payment for stays longer than 14 days requires specific conditions, such as approval for a transfer, and cannot generally use other funding like the SUV voucher to supplement Medicaid payments during those stays.
- **"In Lieu of" Authority**: The "in lieu of" option could be used to provide managed care alternatives, but it has limitations, notably the **15-day cap** on stays. Aker noted that this option could create differences in service access between Medicaid expansion members and traditional Medicaid members, potentially influencing provider choices.
- **Federal Guidance and Limitations**: Aker emphasized that solutions beyond waivers or the "in lieu of" option require changes to the **Social Security Act**, which restricts payments for IMD services. She mentioned that CMS's role is limited, and substantial changes would require congressional action.
- **CMS's Solutions**: CMS has provided options like the **30-day state plan amendment** and 1115 waivers, but these have not yielded consistently strong outcomes across states. Aker mentioned that initial results were mixed and noted that COVID-19 affected outcome reliability.

- **Unintended Consequences**: Aker expressed concern about potential disparities between populations eligible for managed care (Medicaid expansion members) and those using fee-for-service Medicaid, which might lead to shifts in providers' willingness to serve certain groups.
- **Inpatient vs. Residential Care**: Aker acknowledged that there has been some discussion at the federal level about differentiating between inpatient and residential settings. She noted that the burden falls on states to demonstrate that a residential setting is community-based, which complicates policy definitions and funding.

Panel Discussion

A panel comprised of representatives of provider organizations of Dave Marion, Business Development Director of Prairie Recovery, Kurt Snyder, Executive Director of Heartview Foundation, and Jeremy Traen, President/CEO of ShareHouse provided information and insights, and shared field examples of challenges and needs related to serving clients.

- **Advocacy for Flexibility**: Marion advocated increased flexibility in Medicaid policies, suggesting that states should be allowed more leeway to use federal funds for IMD services. He stressed that without such flexibility, states face significant hurdles in providing comprehensive care for individuals with serious mental health and substance use disorders.
- **Impact on Service Providers**: Kurt Snyder emphasized the operational difficulties that service providers experienced due to the IMD exclusion. He explained that suspension of Medicaid eligibility for patients during their stay at IMDs complicates continuity of care and burdens both patients and providers.
- **Recommendations for Waiver Utilization**: Snyder recommended that North Dakota explore the use of 1115 waivers more extensively to mitigate some of these challenges. He noted that while the waivers have limitations, they could offer a pathway to support care for individuals in IMDs, especially when services extend beyond short-term stays.
- **Concerns about "In Lieu of" Authority**: He also expressed caution about relying solely on the managed care "in lieu of" authority due to its 15-day stay limitation. This constraint, he argued, does not align with the typical duration needed for effective residential treatment, which often exceeds this period.
- **Financial and Administrative Concerns**: Jeremy Traen focused on the financial and administrative implications of the IMD exclusion. He pointed out the strain on funding mechanisms and the need for innovative approaches to ensure financial sustainability.
- **Coordination of Services**: Traen suggested that better coordination between state and federal resources could help bridge gaps created by the IMD exclusion. He mentioned that while some states have successfully used combinations of state funding and Medicaid waivers to extend coverage, this requires careful planning and robust state-level advocacy.

- **Outcome Monitoring**: He recommended implementing strong outcome monitoring if waiver programs were expanded or adopted. This would ensure that the programs meet intended goals, such as reducing emergency department use and improving treatment outcomes.

Recommendations and Next Steps:

- The panel collectively recommended that North Dakota should consider applying for or expanding existing 1115 waivers to address the IMD payment issue while ensuring coverage continuity for patients needing long-term care. Advocacy at both state and federal levels was deemed necessary to push for policy changes that could provide more funding flexibility and bridge existing gaps. Strengthening coordination between state and service providers and establishing rigorous monitoring frameworks were suggested to support the sustainable implementation of waivers and alternative payment structures.

The discussion underscored the complexity of the IMD waiver issue and highlighted the importance of pursuing multifaceted strategies to enhance behavioral health service delivery in North Dakota. Plans were made for the providers to have further discussion with Ms. Aker on the various items and she offered to join the BHPC again to share further information.

DHHS BEHAVIORAL HEALTH DIVISION UPDATES & RELATED DISCUSSIONS

System of Care Grant Update (PPT slides provided)

Katie Houle, Clinical Administrator at DHHS, discussed the ongoing System of Care (SOC) Grant activities aimed at supporting children and families in need of behavioral health services. Key points included:

- Expanding family peer support services within the SOC framework.
- Addressing service delivery gaps in rural and underserved areas.
- Integrating care coordination efforts for youth with serious emotional disturbances She also reviewed the recent granting process in each area of service. They recently awarded eight grantees in each region and three that will be provided in both regions. Houle emphasized the importance of community partnerships in achieving SOC objectives and welcomed Council feedback on expanding family-centered care practices.

NDPMHCA (PPT slides provided)

Sara Kapp explained that the PMHCA grant is designed to enhance pediatric mental health services by improving the integration of primary and behavioral health care for children and adolescents. The goal of the program is to strengthen the support available to primary care providers who manage mental health needs in younger populations. One of the primary successes of the grant has been in providing training programs for primary care providers. These sessions focus on identifying and managing mental health conditions such as anxiety, depression, and behavioral disorders in pediatric patients. The grant has facilitated the development of added resources that assist primary care clinics in managing pediatric mental health cases effectively. This includes access to consultation and collaborative care models that allow healthcare providers to consult

with child psychiatrists and other mental health specialists. The grant has fostered stronger collaborations within the medical community, enabling a networked approach to mental health care for children. These efforts aim to reduce barriers to accessing specialized care and enhance the overall capacity of primary care settings to address mental health needs. A challenge noted in Kapp's report was the sustainability of grant-funded initiatives beyond the grant period. She stressed the importance of developing plans for continued funding and integration to maintain the momentum achieved through the PMHCA. Moving forward, Kapp mentioned that efforts would focus on expanding the reach of the program to more rural and underserved areas where access to pediatric mental health services remains limited. Preliminary data was shared showing that the grant has improved early identification and treatment outcomes for pediatric patients with mental health needs. She highlighted positive feedback from primary care providers who have benefited from increased support and training, leading to more confident and effective management of mental health cases in their practices.

MHBG/SUPTRS (PPT slides provided)

Shauna Eberhardt and Lacresha Graham from the DHHS Behavioral Health Division provided updates on the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS). Notable items included:

- MHBG initiatives aimed at expanding access to crisis services and peer support programs.
- SUPTRS funding allocations toward community recovery services and support for addiction treatment facilities.
- Status updates on contract renewals and funding disbursements to support continued service provision statewide.

Eberhardt and Graham underscored the importance of these grants for maintaining essential services and encouraged Council members to participate in discussions regarding program improvements and provider feedback.

Regional Service Expectations Discussion & CCBHC Implementation Update

Pamela Sagness, Executive Director of the Behavioral Health Division, provided an update on division initiatives, specifically Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC model is designed to offer comprehensive, coordinated care for individuals needing mental health and substance use disorder treatment. The model focuses on integrating services to ensure a holistic approach to behavioral health care providing accessible and person-centered services that include crisis intervention, treatment, and support. She highlighted ongoing efforts to expand the reach of these clinics and increase their capacity to serve diverse populations, leading to improved access to services and better integration of care. All eight regions are working on this. Minot was the first to declare and be approved. Fargo and Williston have submitted. Dickinson is nearing their submission. We were reminded it is a two-to-four-year process. A significant focus has been on maintaining compliance with federal and state guidelines to secure necessary funding and support for CCBHC operations. Sagness

shared that an increase in service has been seen in every Human Service Center. As an example, there has been a 36% increase in Badlands, getting more people service and access.

With regards to an interim legislative update there will be new legislation related to behavioral health priorities, including potential policies to enhance community-based care and initiatives and budget allocations to support workforce development, crisis intervention, and community programs. Sagness also discussed interim findings on Medicaid funding improvements and encouraged Council input on priorities for the upcoming legislative session especially as it relates to "What's the right level to bring forward a proposal to say to policy makers, to government agencies, these are the services that we believe should exist in the state in every region for all ages. This would assist policymakers in having full vision and understanding what pieces may be missing and where. Sagness emphasized the importance of setting clear service expectations for different regions to ensure that residents have equitable access to quality care. She discussed the need for tailored approaches that consider the unique needs and resources of each region. There was also an acknowledgment of the challenges faced by more rural or underserved areas, where building the infrastructure for comprehensive services can be more difficult. Sagness noted that targeted efforts were being made to bridge these gaps through strategic partnerships and resource allocation. Sagness outlined several challenges in implementing the CCBHC model, including workforce shortages and the logistical complexities of expanding services to rural areas. She mentioned that recruiting and retaining qualified staff remains a significant barrier that affects service delivery. Funding sustainability was also highlighted as a key concern, with the need for ongoing advocacy to ensure state and federal support for the CCBHC model. Continued collaboration between state agencies, local service providers, and community stakeholders will be needed to support the expansion and effectiveness of CCBHCs. Enhancing the tracking of patient outcomes and service delivery metrics to demonstrate the value of the CCBHC model will be needed with this data helping to support future funding requests and program adjustments. Addressing workforce shortages through training programs and incentives was recommended as a critical step to ensure the sustainability of regional services.

Sagness agreed to bring this conversation back to the BHPC at the December meeting, to discuss what we think is foundational, to share what is in the current budget before the legislature, and the bills legislators are planning to bring forward.

Public Comments

Chair Davis invited public comments; none were provided.

Adjournment

A MOTION TO ADJOURN THE MEETING WAS MADE BY CARLOTTA MCCLEARY AND A SECOND BY MATTHEW MCCLEARY passed unanimously. The meeting was adjourned at 4:00 PM CT. The group will next convene on December 11, 2024.

Respectfully submitted by Janell Regimbal, facilitator of Insight to Solutions

North Dakota Behavioral Health Planning Council Meeting Minutes

Date: December 11, 2024
Location: Job Service ND Office, Dakota Room, Bismarck, ND, and Microsoft Teams
Time: 10:00 AM – 4:00 PM CT

Council Members in Attendance

Brenda Bergsrud (Consumer Family Network); Heather Call (ND National Guard); Dan Cramer (DHHS Behavioral Health Delivery System); Lorraine Davis (Consumer, Member-at-Large); Melanie Gaebe (Consumer, Individual in Recovery SUD, Chair); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Denise Harvey (Protection and Advocacy); Jennifer Henderson (Principal State Agency: Housing); Megan Indvik (MH & SU Advocacy Org); Melissa Kaine on behalf of Mandy Dendy (Principal State Agency, Medicaid); Kristi Kilen (Private Mental Health Provider); Michelle Massett (Principal State Agency: Social Services); Amanda Peterson (Principal State Agency: NDDPI Education); Emma Quinn (Consumer, Individual in Recovery MH); Pamela Sagness (Principal State Agency: DHHS Mental Health); Paul Stroklund (Consumer, Family Member of an Adult with SMI); Tania Zerr (Consumer, Family Member of a Child with SED); Richard Smith (Consumer, Family Member of Veteran) Kurt Snyder (Consumer, Individual in Recovery);Timothy Wicks (Consumer, Veteran).

Council Members Absent

Cheryl Anderson (DHHS Vocational Rehabilitation); Brad Hawk (Indian Affairs Commission); Joseph Jahner (Individual in Recovery MH);Glenn Longie (Tribal Behavioral Health); Carlotta McCleary (Youth MH & SU Advocacy); Michael Salwei (Consumer, Health Care); Mark Schaefer (Consumer, Private SUD Treatment Provider); Dr. Amy Veith (Principal State Agency- DOCR Criminal Justice).

Janell Regimbal confirmed a quorum was present.

Staff Present: Tami Conrad (DHHS Behavioral Health Representative)

Facilitator: Janell Regimbal of Insight to Solutions

Call to Order

The meeting was called to order by Acting Chair Melanie Gaebe at 10:04 AM CT, via videoconference and in person at the ND Job Service office in Bismarck.

Approval of Minutes

Motion by Andrea Hochhalter to approve the October 16, 2024, meeting minutes as presented. Seconded by Paul Stroklund. Motion carried unanimously.

Printed: 8/29/2025 11:02 AM - North Dakota - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Approval of Agenda

Motion by Amanda Peterson to approve the agenda as amended to include adjustments for executive committee appointments and policy/procedure change later in the meeting. Seconded by Tania Zerr. Motion carried unanimously.

Meeting Business

Membership Report

Tami Conrad announced new members appointed by the Governor's Office:

- Rich Smith, Behavioral Health Coordinator for Dickinson Public Schools, but appointed as a representative of a family member of a veteran.
- Megan Indvik, Chief Advancement Officer of F5, appointed as a representative of a MH & SU Advocacy Organization.
- Joseph Jahner, representing a consumer in recovery MH.

Open positions remain for a tribal behavioral health representative and a family member of a child with SED. Members were encouraged to recommend candidates. Michelle Gayette recently retired from state employment so the aging division will be providing a replacement for their position.

Matthew McCleary was thanked for his time and dedication to the BHPC as his term ended. Matthew with continue to be with us in the future for his reports relating to the Consumer Family Network contract. A question was raised as to whether the Governor's office would reconsider the interruption of Matthew McCleary's appointment as he was to succeed as Vice Chair to the Chair role, beginning this meeting. Because his term ended, Melanie Gaebe as per BHPC Policies and Procedures has now transitioned to Chair, leaving the Vice Chair position open. It was agreed to seek guidance from the Governor's office during this meeting as to whether they would reconsider with flexibility, given the leadership position McCleary occupied. As a result, the agenda was adjusted to allow time for a response before proceeding to an election for the open position.

ND Behavioral Health Strategic Plan Update (PPT slides provided)

Bevin Croft from the Human Services Research Institute provided updates on:

- Progress in behavioral health dashboard metrics up through September were shared via the October Dashboard. Croft noted that a lot of the activity occurring is around the Systems of Care work and much progress in prevention and early intervention activities. A new suicide data dashboard was shared. Several new goals and objectives added to the plan were highlighted.
- Workforce initiatives addressing critical shortages.

- Advocacy efforts for Certified Community Behavioral Health Clinics (CCBHCs). Members emphasized the importance of legislative advocacy for continued funding and support due to its importance of system building capacity.

Continuum of Care Conversation with Shauna Eberhardt (PPT slides provided)

Shauna Eberhardt, Clinical Director for Behavioral Health Policy Division, provided an in-depth presentation on the continuum of youth mental health care in North Dakota. The presentation addressed:

- **Current Continuum:** A detailed overview of prevention, early intervention, outpatient services, intensive home- and community-based services, partial hospitalization programs, psychiatric residential treatment facilities (PRTFs), and acute hospitalization. She highlighted care coordination and crisis services as elements spanning all levels of care.
- **Gaps Identified:**
    - Limited youth-specific crisis services.
    - Behavioral health workforce shortages.
    - Inadequate funding through fee-for-service models.
    - Lack of crisis residential services for youth.
    - Challenges in navigating services for complex cases.
- **Enhancements:**
    - Implementation of high-fidelity wraparound care coordination for youth and families.
    - Partnerships with Medicaid and CFS to align clinical criteria for PRTF services.
    - New behavioral health navigator role assisting families with access and follow-up care.
    - Funding for partial hospitalization programs, including new referrals through St. Alexius starting December 2024.
- **Future:**
    - Expansion of CCBHC models to address funding gaps and improve access.
    - Increased regional collaboration to improve service integration.
    - Technical assistance and staffing support for PRTFs.

Attendees expressed appreciation for the detailed analysis and discussed challenges related to systemic barriers, workforce limitations, and funding models. Members emphasized the importance of ongoing updates and cross-agency collaboration.

DHHS and Contractor Q&A Session (PPT slides/reports provided)

Update reports were provided in writing to BHPC members related to the MHBG, SUPTRS, and NDPMHCA reports from DHHS Behavioral Health staff and from the Consumer Family Network contract. When asked if there are plans for increased peer support opportunities for youth and families it was noted there is a pilot project within the system of care regions to expand peer support into family and caregiver peer support as well. Consultants from the University of Connecticut and the Innovations Institute are assisting with this. Two positions will be funded through SOC (one at WCHSC and one at LRHSC) for parents with lived experience navigating the child serving system on behalf of their children into those clinical teams. They hope to have the first parent and caregiver peer support training in April of 2025. There will also be some funds from SOC going to the Federation of Families to expand their workforce. Youth peer support would be the next venture. There were no other questions submitted to the staff to respond to. A member made a recommendation to consider breaking up the reported age groups in the reports further to reflect further delineation from the ages 26 and up. It would be better to indicate from 26-44 and then 45-65 and 65+.

State Hospital Update with A&E and Building Project Management Teams (PPT slides provided via this link 241211_NDSH Design Update.pdf)

Representatives from JLG Architects and TEGRA Group presented updates on the State Hospital modernization project, highlighting infrastructure improvements and enhanced patient care capabilities. Representatives from JLG Architects and TEGRA Group provided a detailed update on the modernization project at the State Hospital, which included providing a historical context. Key points included:

- **Infrastructure Improvements:** Plans to enhance safety, accessibility, and efficiency within the hospital's facilities, including updated HVAC systems, expanded patient areas, and upgraded technology for care delivery.
- **Design Philosophy:** A focus on creating trauma-informed environments, incorporating natural light, private spaces for patients, and outdoor therapeutic areas to improve patient well-being.
- **Project Timeline:** They will be finishing construction related documents over the next six months with the hopes construction could begin in July or August of 2025 if funded. From that point on it would be about a 29-month project. Updates on current progress and upcoming milestones were shared.
- **Community Integration:** Plans to improve transitional services for patients reentering community settings, aligning with broader behavioral health initiatives in North Dakota.

Questions and Comments:

- **Workforce Needs:** Members raised concerns about whether facility updates would address ongoing workforce shortages and asked how the design would support staff efficiency and satisfaction.
- **Crisis Management:** Questions were posed regarding how the updated facilities would improve crisis response for acute patients. Representatives emphasized the importance of flexible care spaces and improved coordination with external crisis services.
- **Patient Capacity:** Council members inquired about the hospital's ability to accommodate increasing patient numbers. The project team assured attendees that capacity planning had been integral to the redesign process.

The discussion concluded with members expressing appreciation for the comprehensive plan and its alignment with statewide behavioral health goals and being updated on the status of funding for the project. Currently the appropriated funds are for design only. The design team is meeting with the new Armstrong administration next week. The goal would be to bring a bill to fund the building project, with of course the question being at what level would be funded and how would it be paid for.

Recessed for Lunch/Reconvened at 1PM

Reinitiate BHPC Updates from morning session re: Leadership Position & Policy and Procedure Revisions

Tami Conrad reported back the Governor's office responded to the inquiry sent this morning that new members were appointed to bring a fresh perspective to the Council and Chair and Vice Chair positions do not impact those appointment decisions. Given this we will continue with following our policy and procedure of succession of Vice Chair to Chair, with Melanie Gaebe assuming the current role of Chair and a call for nominations for Vice Chair was placed to allow for a hybrid vote to take place supporting our current meeting structure. Paul Stroklund and Tanya Zerr made self-nominations. A motion was made by Tim Wick and second by Andrea Hochhalter to close nominations, passed unanimously. Each candidate provided a brief overview of why they are interested in serving and what they would bring to the position. Paper ballots were provided to in person attendees and those attending online were asked to email their vote to facilitator Regimbal by 2:15 PM when the voting window would be closed and result announced following the break.

Proposed changes to the policy and procedure first presented in October related to changes, revisions or new policies and procedures created were reviewed. Key updates included:

- Policy changes now require a supermajority of 2/3 of members present for approval.

- Clarifications were added for consistency in adoption and revision processes.

Motion to approve the revised policy as presented by Paul Stroklund. Second, by Amanda Peterson. Motion carried unanimously.

The conflict-of-interest policy redraft was not yet ready to be considered as we are awaiting further guidance from the Attorney General's office. Information will be brought back to the Council at the May meeting.

DHHS Budget and Legislative Bill Draft Overview (Handout provided)

Pamela Sagness provided an overview and update on this topic. While the DHHS budget was due in August, the various budgets submitted across state agencies then come together in the Governor's budget which was presented last week by outgoing Governor Burgum. While the information provided in that budget is what will be shared today with the Council, members were urged to remember the Armstrong administration will adjust the budget. Everything is fairly stable in committee chairs in Human Services committee except for the Committee Chair. The new Chair is Matt Ruby. Term limits are impacting assignments, with people moving into appropriations assignments more quickly.

A key item the department is working on in preparation for the session is being able to clearly communicate about minimum standards and how to best communicate about levels of services and service categories using everyday language. The importance of being able to clearly report on what is available in each region and how much further there is to go to get to the minimum standards set will be important. Also to communicate what the consequences are to people when these services are not available or if they must leave their home communities to get access and the issue of keeping in mind the whole continuum of residents – i.e., across age spectrums and rural as well as more urban centers.

Ms. Sagness reviewed the Decision Packages coming from behavioral health division (formerly known as OAR- Optional Adjustment Requests). See handout attached. There will be things in other departments that will be related to the interest of behavioral health such as things in aging and housing, etc. so we may want to request their decision package list too. If something does not come forward in the Governor's budget, it could be brought forward by a legislator via a bill draft. There will also be some policy bills such as one to put into code the CCBHC certification and the changing of language from "human service centers" to "behavioral health clinics" to help avert the confusion between human service zones and centers. Comment shared to help interpret the handout provided include:

- If green, it was funded exactly as proposed. If salmon, it was partially funded with edit made at the Gov office. If grey, it was completely removed.
- When the department puts forth their budget it was to meet current need as it is hard to ask for expansion when you are not able to meet current needs.
- Funds to build the new State Hospital were not placed in the Governor's budget.

- There were some legislators who shared at the budget section that only 1-2 CCBHCS should be done rather than working on all 8, which is the opposite communication of what had previously been shared.
- It is important to “level set” expectations. Not all these decision package items will get funding. They will need to be prioritized and there will need to be clarity about what is expansion versus what is meeting the already existing need.

Ms. Sagness was requested to provide the Council with the one-page document on each of the decision package items referenced on the list to promote greater understanding of the budgeted items and as an aid for the Council to decide on prioritized items.

Following a brief break, the meeting was reconvened at 2:32 PM

Behavioral Health Workforce Initiatives Update (PPT slides provided)

Monica Haugen, Administrator BH Workforce, DHHS and Kurt Snyder, Executive Director, Heartview Foundation presented updates on workforce strategies. As of 11/1/24 Ms. Haugen indicated her new role is to lead efforts to grow and sustain the behavioral health workforce, working at the macro level across all initiatives. Including working with the Aim 7 work group and the public and private partners. Haugen shared the wide variety of groups she met with in her first sixty days to establish a foundation for what is happening with regards to the workforce across the state and the various needs. She has also been reviewing previous legislative bills related to the workforce, researching what other states have done and reviewed authored reports. She has also been revising the behavioral health toolkit for employers. A mapping of workforce project is underway.
Mr. Snyder shared the expansion of training sites and clinical supervision resources and the establishment of scholarships to boost entry into behavioral health professions. Through their work there was a gain of 16 training sites. They are forecast to graduate 28 trainees through the course of the grant. They provided 20 different scholarships ranging from $1700-$10,000. New partnerships with Dickinson State University and Minot State, Bismarck State College and United Tribes Technical College have increased capacity. Online clinical supervision training has made an impact on trainee completion. It has also helped people get the opportunities they need to get trained and stay in their home communities to serve. When asked about the sustainability to continue to fund the efforts, Mr. Snyder indicated the Opioid Settlement Funding is expected to provide $8MM for every biennium into this effort but the legislature must allocate the money to be spent, and they must write the grant to compete for the award.

Election for Vice Chair Results

Facilitator Regimbal announced Tania Zerr received the most votes via online email ballots submitted and paper ballot collected from those attending in person.

Legislative Advocacy Planning

The following BHPC members volunteered to be appointed to the Legislative Committee joining the Executive Committee members: Rich Smith, Megan Indvik, Paul Stroklund and

Emma Quinn. This formally established group will meet a total of 8 times between December and April for one-hour virtual meetings. All members of the BHPC are welcome to attend at any time. Agendas and minutes will be publicly posted. The Facilitator will keep all member appraised by emailing the notices and minutes to the full BHPC. Members were asked to assist in outlining advocacy goals for the legislative session, to help guide the work of the committee. Past priorities were reviewed and approach taken. Items noted in October were provided as a starting point with additional items from today's discussion. The following list was provided for the committee to begin its work on how to best proceed:

- HSRI aims
- Comprehensive care frameworks
    - Community based
    - Across all populations
    - High fidelity wraparound for children that supports the entire family
- Improving BH access
- Integrated peer support
    - Youth & Family
- Increase financial stability through state funding of critical items/core services x region.
- IMD Waiver – continued opposition to it but with focus on the following to assist:
    - State plan changes needed to do increase days of care
    - SUD voucher set aside for IMDs (decision package item)
    - Policy changes to increase flexibility to address gaps
    - Increased coordination between providers and state
    - Establish rigorous monitoring framework
- Implement culturally responsive BH traditional healing services into state systems
- Meet minimums (at least) of service expectations in each region of the state
- Fund the building of the state hospital
- Fund school grants -without match school incentives decrease to deliver BH
- Supported housing –
    - access across state
    - address addiction and criminal background issues
- Decision package items

Public Comments

Attendees shared perspectives on improving community engagement and addressing service gaps in underserved areas.

Lightening Round Updates

Council members provided brief updates on their ongoing projects, collaborations, and initiatives supporting behavioral health.

Adjournment

The meeting adjourned at 3:50 PM CT. The next meeting is scheduled for May 14, 2025, at the Job Service ND Office and via Microsoft Teams.

Submitted by: Janell Regimbal, Facilitator

North Dakota Behavioral Health Planning Council Meeting Minutes

Date: July 16, 2025
Location: Job Service ND Office, Dakota Room, Bismarck, ND/10:00 AM – 4:00 PM CT with no virtual option available this meeting due to meeting format.

Council Members in Attendance

Heather Call (ND National Guard); Melanie Gaebe (Consumer, Individual in Recovery SUD, Chair); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Denise Harvey (Protection and Advocacy); Jennifer Henderson (Principal State Agency: Housing); Megan Indvik (MH & SU Advocacy Org); Kristi Kilen (Private Mental Health Provider); Amanda Peterson (Principal State Agency: NDDPI Education); Emma Quinn (Consumer, Individual in Recovery MH); Paul Stroklund (Consumer, Family Member of an Adult with SMI); Richard Smith (Consumer, Family Member of Veteran) Kurt Snyder (Consumer, Individual in Recovery); Brad Hawk (Indian Affairs Commission); Joseph Jahner (Individual in Recovery MH); Carlotta McCleary (Youth MH & SU Advocacy); Michael Salwei (Consumer, Health Care); Antonia Berning-Scilley on behalf of Dan Cramer (DHHS Behavioral Health Delivery System);and Kelly McGrady (Consumer, Member at Large).

Council Members Absent

Cheryl Anderson (DHHS Vocational Rehabilitation); Brenda Bergsrud (Consumer Family Network); Melissa Kainz (Principal State Agency, Medicaid); Michelle Massett (Principal State Agency: Social Services); Glenn Longie (Tribal Behavioral Health); Pamela Sagness (Principal State Agency: DHHS Mental Health) Phil Sorenson (Consumer, Veteran). Tania Zerr (Consumer, Family Member of a Child with SED); Nancy Maier (DHHS Aging Services) and Mark Schaefer (Consumer, Private SUD Treatment Provider).

Janell Regimbal, facilitator, confirmed a quorum was present.

Call to Order

The meeting was called to order by Chair Melanie Gaebe at 10:02 AM CT, at the ND Job Service office in Bismarck.

Approval of Minutes

Motion by Denise Harvey to approve May 14, 2025, meeting minutes as presented. Seconded by Megan Indvik. Motion carried unanimously.

Approval of Agenda

Motion by Andrea Hochhalter to approve the agenda as presented. Seconded by Paul Stroklund. Motion carried unanimously.

Meeting Business

BHPC Administrative Updates/Discussion Items:

Tami Conrad reported membership updates with new members Kelly McGrady, Phil Sorenson and Nancy Maier appointed effective July 1. Andrea Hochhalter, Kurt Snyder, Tania Zerr, Emma Quinn, and Mark Schaefer were re-appointed for another three-year term. We continue to have an opening for a consumer family member of a child with SED and are awaiting a replacement appointee from the DOCR to replace Dr. Amy Veith.

Janell Regimbal reviewed the DRAFT Conflict of Interest Policy provided as a first review. The history of the evolution of the proposed document was highlighted along with the advisement that had been received from the Attorney General's Office as to appointees being subject to the ethics commission rules found in NDAC Chapter 115-04-01. Feedback to the simplified approach to the drafted policy was positive. A final vote on the item will be taken at the October meeting at its second review as per policy.

Members were reminded that the October meeting of the BHPC is the annual meeting, with election results being announced for Vice Chair. Interested members will be solicited via email and an electronic ballot will be prepared and sent in September in advance of the meeting. We will also set the slate of meeting dates for 2026.

Submitted report Q&A

Members received reports submitted in advance of the meeting by DHHS BHD staff related to the combined application timeline, SUPTRS, MHBG, PMHCA and Pregnant and Parenting Women's program updates, as well as the July report of the Consumer Family Network contract. Staff were available to answer questions. Attendees presented none.

2025 Assessment of Progress Towards the North Dakota Behavioral Health Strategic Plan Activities (see PPT slide deck)

Bevin Croft, Director of Behavioral Health, Human Servies Research Institute, facilitated activities for the remainder of the meeting related to assessing progress of the plan that had its roots in 2016 when she first began working in North Dakota, interviewing well over 100 North Dakotans. Following this an in-depth study was published in 2018. She was the lead writer. The aims outlined in the report are rooted in data of service use and needs of communities. It is important to note that while the contract HSRI has is with the NDHHS BHD, the governance of the plan is with the "community." The BHPC is the accountable body that oversees the plan and its aims.

The first page of the dashboard will be replaced by what the BHPC thinks progress is based on.

BHPC members engaged in a community building activity, with each in attendance sharing “if they had a single use magic wand, what’s the one thing you’d do to change the system to better align with the BHPC’s vision”?

Survey results were reviewed from the survey completed by BHPC members prior to the meeting. The World Café model that was used to review progress was overviewed. Station hosts were introduced and included BHD staff members Lacresha Graham, Tiffany Pinckney, Monica Haugen, Katie Houle, Tami Conrad and BHPC facilitator, Janell Regimbal.:

Recessed for Lunch at 11:30 AM/Reconvened at 12:15 PM

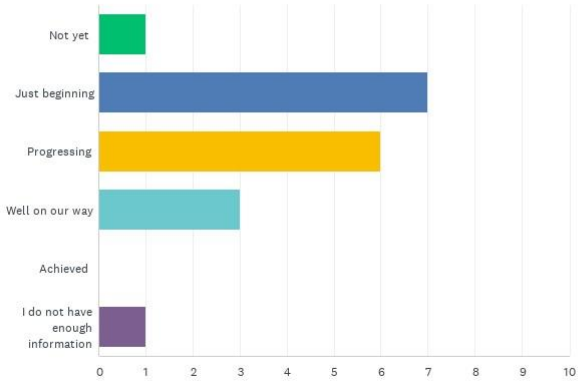
World Café Activities

Members rotated through the various stations to provide feedback on the Aims.

World Café Session Summaries- the graphics provided reflect BHPC member survey results taken prior to the meeting. Each station group was to reflect on the survey rating and survey comments to underscore ideas agreed with; add new ideas; and indicate if the median score seems too high, too low, or just right.

Station A – *Prevention and Community Partnership (Aims 2 & 10)*

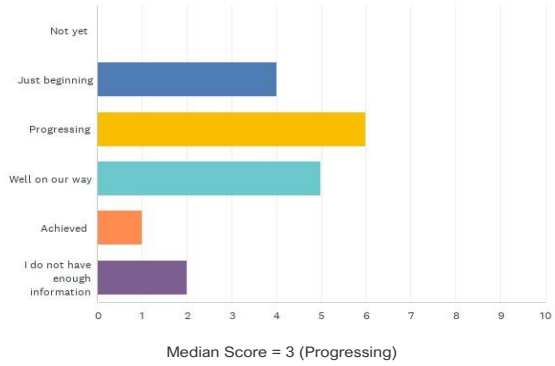
Aim 2: Invest in prevention and early intervention



Median Score = 3 (Progressing)

- Need more progress with mental health prevention and early intervention including school-based programming and trauma-informed early childhood supports
- It might look like a lot has been accomplished on the dashboard, but in practice we’re lacking
- Geographical variation in progress; some areas of the state are more comfortable acknowledging behavioral health issues exist

Aim 10: Encourage and support communities to share responsibility with the state for promoting high - quality behavioral health services



Median Score = 3 (Progressing)

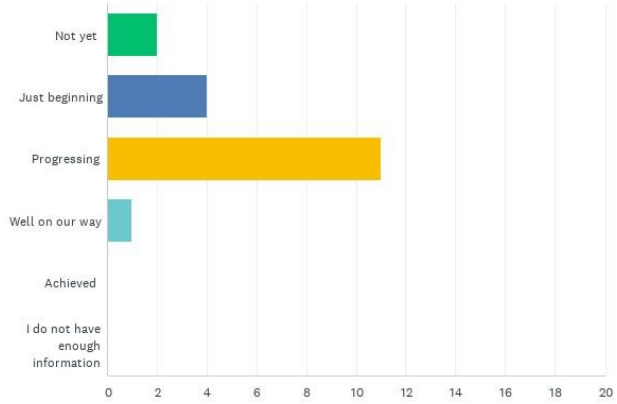
- Need to revisit and refresh this aim – feels stagnant
- It is essential to continue including the voices of persons with lived experience

Small Group Discussion Themes:

- Strong call to **shift systems** and move beyond crisis-based response.
- More **collaborative infrastructure** and **cross-system accountability** are needed.
- A need to **clarify Aim 10's intent**—whether it's monetary, programmatic, or cultural.
- Interest in **diversifying the advocacy community** to include a broader base
- **Prevention work** is underfunded, undervalued.
- **Legislative orientation** and education needs were emphasized.
- Calls for **better clarity and measurement** of community support expectations.
- The consensus was that both aims were scored too high.

Station B – ***Access and Tele behavioral Health (Aims 3 & 8)***

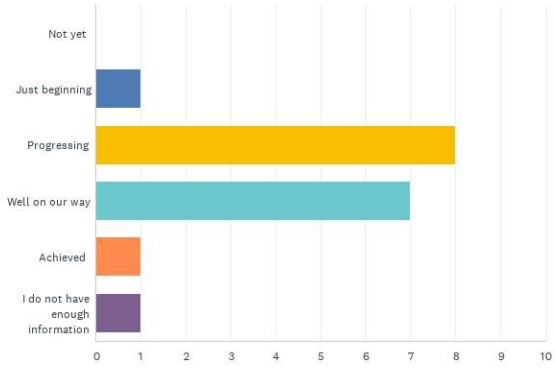
Aim 3: Ensure all North Dakotans have timely access to behavioral health services



Median Score = 3 (Progressing)

- There are still programs with waitlists. Need to increase program capacity
- Rural communities are often left out of progress. Still issues with crisis response in frontier areas
- Access issues persist for veterans (telehealth ineffective)
- We can say "well on our way" when CCBHCs are in place and more mobile units are accessible to residents
- It remains incredibly difficult for people to know where to go and how to access resources

Aim 8: Continue to expand the use of telebehavioral health interventions



Median Score = 3 (Progressing)

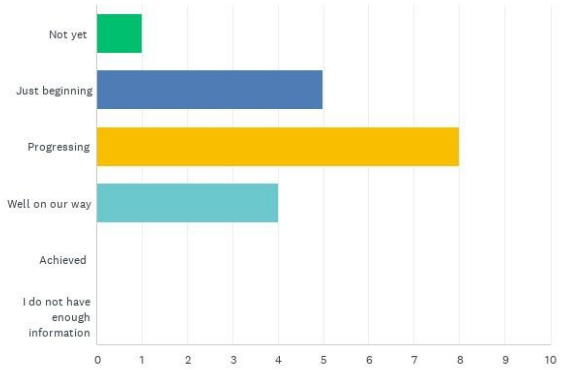
- ND has been at the forefront of rolling out telehealth out of necessity, and we have done it well
- Still have a ways to go because ND is such a rural state. Telehealth is still not available in all parts of the state
- Not everyone likes to use telehealth

Themes:

- **Access issues persist**, especially in rural areas, for veterans, and older populations.
- **Workforce shortage** continues to be a barrier.
- Telehealth praised but **limitations acknowledged** (e.g., platform security, lack of utilization, replacement vs. supplement, broadband issues).
- Need for **system-wide education** for providers and the public on telehealth.
- Aim 8 could possibly be combined within Aim 3.
- Expansion seen, but many feel the **aims remain unfinished ("Not Yet")**.

Station C – *Service Array and System of Care (Aims 4 & 5)*

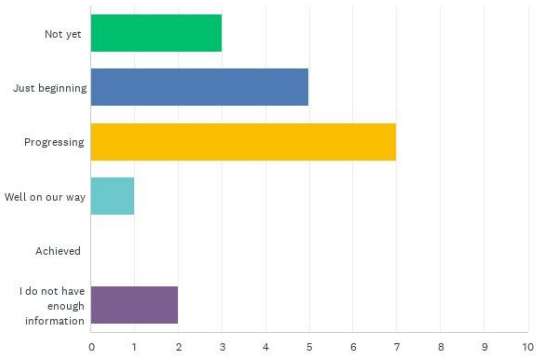
Aim 4: Expand outpatient and community-based service array



Median Score = 3 (Progressing)

- Have made significant strides in peer support especially with Free through Recovery and Community Connect
- Recent legislative session provides more resources for this aim
- Housing continues to be a major challenge
- Rural areas continue to lack services
- State hospital remains a catch-all. Need to shift resources upstream

Aim 5: Enhance and streamline system of care for children with complex needs and their families



Median Score = 2.5 (between Just Beginning and Progressing)

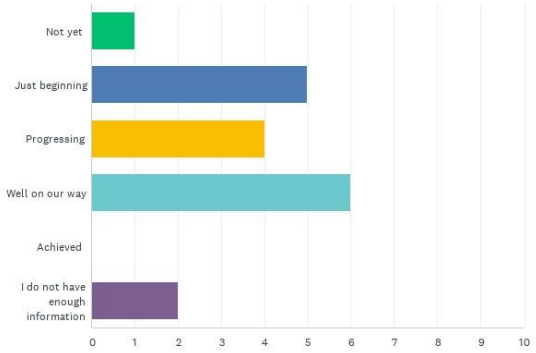
- This is an area that needs significant efforts. Because it is such a huge area, we have a long way to go
- Have made good foundational steps: securing funding, starting services in two regions, partnering with Tribal Nations and advocacy groups
- We lack services for children with complex needs
- For families, it is overwhelming, confusing, and frustrating. Families are left to react to crises rather than getting support early
- Obtaining more information from families would be helpful

Themes:

- **Wraparound services** highlighted as crucial.
- We have built access but there are **limits, and it depends on what population.**
- Concerns about **provider shortages** and **lack of individualized services**.
- System of Care has made progress but needs **deeper integration** and **local control**.
- Desire to **improve transitions** and ensure **peer/family involvement**.
- Expansion needed in **mobile crisis and outpatient care**. We are still **not rural enough**.
- Progress is seen as being in the **early stages**

Station D – *Workforce and Justice Strategy (Aims 6 & 7)*

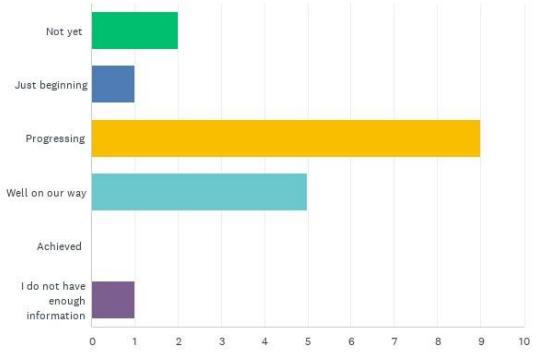
Aim 6: Continue to implement and refine the current criminal justice strategy



Median Score = 3 (Progressing)

- DHHS and DOCR have done a great job implementing strategies in this area. Seems to be a priority for the Governor
- Continue to work on youth diversion
- Revocation of probation issues are filling up jails
- Gaps remain. Continue to strengthen CIT, trauma-informed treatment, and connections to community care
- Seems like this aim might need refreshing/updating

Aim 7: Engage in targeted efforts to recruit and retain a qualified and competent behavioral health workforce



Median Score = 3 (Progressing)

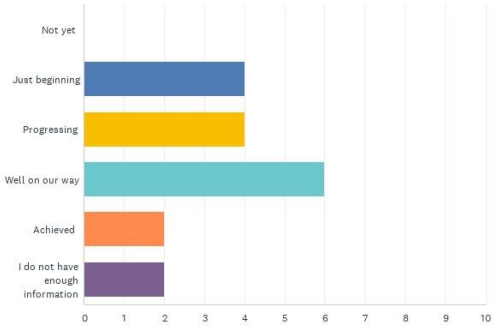
- Still have much work to do around workforce
- Recruitment and retention issues continue to be a major problem
- New legislative changes may ease workforce issues (ACCESS Grant, interstate licensure compacts)

Themes:

- **Workforce recruitment and retention** remain a top concern.
- Good ideas often **lost in implementation** due to lack of role clarity or accountability.
- Mixed reviews of justice systems—**jail settings may have more structure than prisons**.
- **Communication and reentry support** improving, but still inconsistent.
- Highlighted **need for collaboration** across corrections, healthcare, and community partners.
- Both Aim 6 & 7 seen as rated too high – we are just beginning.

Station E – *Person-Centered and Tribal Equity (Aims 9 & 11)*

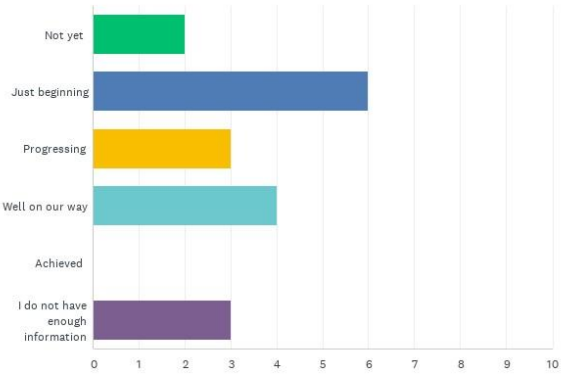
Aim 9: Ensure the system reflects its values of person - centeredness, health equity, and trauma -informed approaches



Median Score = 3.5 (between Progressing and Well on Our Way

- Need to continue to work on trauma-informed approaches across education, justice, and healthcare
- Complete system-wide assessments and use findings to shape action plans
- Have made progress using more person-centered language in laws and policies

Aim 11: Partner with Tribal Nations to increase health equity for American Indian populations



Median Score = 2 (Just Beginning)

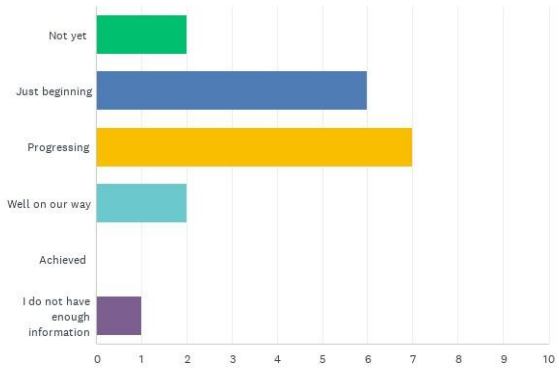
- Partnerships with Tribal Nations continue to strengthen
- Need to expand culturally appropriate services and grants statewide
- This area takes time. Need to move slowly to meet communities on their terms and not simply push for adoption of methods and approaches used in the broader state

Themes:

- System lacks **consistency in trauma-informed care**.
- Recognition that **cultural humility and equity** are needed.
- Need to shift toward **more individualized, whole-person approaches**.
- **Trust-building and partnerships** with Tribal Nations must be authentic and sustained.
- Participants described it as a **"beautiful beginning"** needing continued curiosity and follow-through.
- Ratings are seen as too high- we are just beginning or should be seen as progressing.

Station F – *Funding and Data Monitoring (Aims 12 & 13)*

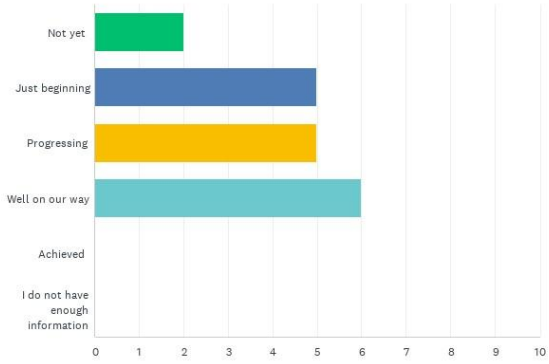
Aim 12: Diversify and enhance funding for behavioral health



Median Score = 3 (Progressing)

- This is a continued work in progress
- 1915(i) rollout was not person-centered - complicated for providers and cumbersome for people seeking services
- Grant freezes at the federal level impede progress
- More resources needed for rural areas

Aim 13: Conduct ongoing, system-wide, data-driven monitoring of need and access



Median Score = 3 (Progressing)

- Data are inconsistent and contradictory
- If there's one thing we have, it's data!
- Silos prevent data flows between agencies and among partners
- Data is only useful if it is applied

Themes:

- Clear call for **diversified, simplified, and equitable funding**.
- 1915(i) waivers and Medicaid initiatives seen as **progress but burdensome**.
- Calls to **collaborate with nonprofits and private sector** for sustainability.
- **Data** is underutilized, inconsistent, and often not translated into practice.
- Emphasis on using data to **demonstrate need and impact**, especially in rural areas.
- Progress is overrated in these areas.

Overarching Takeaways Across All Sessions

1. **Workforce Strain Is a System-Wide Concern**
    - Nearly every station raised challenges around recruitment, retention, and the need for specialized providers (peers, rural outreach, culturally informed clinicians).
2. **System Fragmentation Hinders Progress**
    - Participants consistently noted siloed services, lack of clear accountability, and poor integration across systems (healthcare, justice, schools, social services).
3. **Need for More Upstream Investment**
    - There was a strong collective emphasis on **prevention**, **early intervention**, and **supporting community-based care** over reactive or institutionalized models.
4. **Equity and Inclusion Must Be More Than Aspirational**
    - Equity for rural populations, tribal nations, and underserved groups was a shared priority—but participants called for **clear action plans**, **resources**, and **metrics**.
5. **Data Must Become Actionable**
    - Calls were made for **streamlined data systems**, cross-agency sharing, and tools that support **real-time decision-making and accountability**.
6. **Tele Behavioral Health Holds Promise but is Just One Strategy for Access**
    - Widely discussed as an access solution, but concerns remain over underuse, lack of training, and inability to replace in-person care in many situations.
7. **A Desire for Systemic Cultural Change**
    - There's a growing push for trauma-informed, person-centered, and collaborative systems—participants are seeking more than operational fixes; they want a shift in values and leadership culture.
8. **A Need to Add Metrics to Each Aim**
    - It was noted for dashboard purposes; the vocabulary of the ratings may need to be looked at. Consider starting with the consensus ratings of the BHPC members and then work to add metrics to each Aim.

Outcomes re: Next Steps for Plan/Process

- Immediate: Add consensus ratings to next dashboard
- Immediate: Change wording of "just beginning" rating to "modest progress"
- Shorter-term: Revisit vision statement at future meetings. Be sure to include "across the lifespan" in the language
- Shorter-term: Create a process for summarizing or "clearing out" older goals within each aim
- Shorter-term: Invite all BHPC members to step into liaison roles for aims

- Longer-term: Establish key metrics/indicators for each aim and display on the dashboard alongside consensus ratings

Aims – adjustments to be made in the fall

- Aim 2 - separate prevention and early intervention into two separate aims
- Aim 10 - Clarify intent and reframe
- Condense Aim 8 into Aim 3
- Aim 6 – Reframe/reorient to *Bolster diversion efforts and reentry support across the criminal legal system*
- Create new goals/focus on rurality
- Aim 12 – include a new goal focused on the 1915(i) rollout/implementation

Public Comments

None provided.

Lightening Round Updates

Updates were not provided due to meeting conclusion.

Adjournment

The meeting was adjourned by Chair, Melaine Gaebe at 3:57 PM

The next meeting is scheduled for Wednesday, October 15, 2025, at the Job Service ND Office. Please note this meeting will resume as a hybrid offering via Microsoft Teams.

Submitted by: Janell Regimbal, Facilitator

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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Brenda Bergsrud	Providers			bbergsrud@yahoo.com
Heather Call	Providers			heather.l.call.civ@army.mil
Dan Cramer	State Employees			dcramer@nd.gov
Melanie Gaebe	Persons in Recovery from or providing treatment for or advocating for SUD services			mmgaebe@alz.org
Denise Harvey	State Employees			drharvey@nd.gov
Brad Hawk	State Employees			bhawk@nd.gov
Jennifer Henderson	State Employees			jhenderson@nd.gov
Cheryl Hess-Anderson	State Employees			chess@nd.gov
Andrea Hochhalter	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			andrea_hochhalter@msn.com
Megan Indvik	Persons in Recovery from or providing treatment for or advocating for SUD services			meganindvik@gmail.com
Joseph Jahner	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			jahner81@yahoo.com
Melissa Kainz	State Employees			mkkainz@nd.gov
Kristi Kilen	Providers			kkilen@sharehouse.org
Glenn Longie	Representatives from Federally Recognized Tribes			glongie@outlook.com
Nancy Maier	State Employees			nmaier@nd.gov

Michelle Masset	State Employees			mmasset@nd.gov
Carlotta McCleary	Youth/adolescent representative (or member from an organization serving young people)			cmccleary@mhand.org
Kelly McGrady	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			kmcgrady007@gmail.com
Amanda Peterson	State Employees			amandapeterson@nd.gov
Emma Quinn	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			equinn@sharehouse.org
Pamela Sagness	State Employees			psagness@nd.gov
Michael Salwei	Providers			Michael.salwei@sanfordhealth.org
Mark Schaefer	Persons in Recovery from or providing treatment for or advocating for SUD services			Mark.schaefer@cmsgiveshope.com
Rich Smith	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			rsmith@dpsnd.org
Kurt Snyder	Persons in Recovery from or providing treatment for or advocating for SUD services			kurt@heartview.org
Phil Sorenson	Advocates/representatives who are not state employees or providers			philsorenson@evolutioncompletions.com
Paul Stroklund	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			paulstroklund@gmail.com
Tania Zerr	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			Zerr@ymcanorthernsky.org

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

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	3	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	4	
3. Parents of children with SED	0	
4. Vacancies (individuals and family members)	1	
5. Total individuals in recovery, family members, and parents of children with SED	**8**	**26.67%**
6. State Employees	10	
7. Providers	4	
8. Vacancies (state employees and providers)	1	
9. Total State Employees & Providers	**15**	**50.00%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	4	
11. Representatives from Federally Recognized Tribes	1	
12. Youth/adolescent representative (or member from an organization serving young people)	1	
13. Advocates/representatives who are not state employees or providers	1	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**7**	**23.33%**
16. Total membership (all members of the council)	**30**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

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/bhpc/blockgrants

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

https://www.hhs.nd.gov/bhpc/blockgrants

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

d) Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

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 SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG 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 SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (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. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. 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 SUPTRS BG 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.

2. 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 SUPTRS BG 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.

3. 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 SUPTRS BG 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 use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes: